

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
RUC RECOMMENDATIONS FOR CPT 2014**

**TABLE OF CONTENTS**

<b><u>New/Revised CPT Codes CPT 2014</u></b>	<b><u>TAB</u></b>
Drainage of Abscess	1
Breast Biopsy	2
Shoulder Prosthesis Removal	3
Elbow Prosthesis Removal	4
Transcatheter Aortic Valve Replacement	5
Fenestrated Endovascular Repair	6
Retrograde Treatment Open Carotid Stent	7
Transcatheter Placement of Intravascular Stent	8
Embolization and Occlusion Procedures	9
Esophagoscopy	10
Esophagoscopy Gastroscopy Duodenoscopy (EGD)	11
Endoscopic Retrograde Cholangiopancreatography (ERCP)	12
Cystourethroscopy	13
Chemodenervation of Neck Muscles	14
Chemodenervation of Extremity and Trunk Muscles	15
Insertion of Anterior Segment Device	16
Removal of Cerumen	17
Respiratory Motion Management Simulation	18
Molecular Pathology-Tier 1	19
Immunohistochemistry	20
Optical Endomicroscopy	21

Breath Hydrogen Methane Test	22
Percutaneous Closure Patent Ductus Arteriosus	23
Percutaneous Alcohol Ablation of Septum	24
Mechanical Chest Wall Oscillations	25
Ultrasonic Wound Assessment	26
Anogenital Exam Colposcopy-PE Only	27
Interprofessional Telephone Consultative Services	28
Total Body and Selective Head Hypothermia	29

<b><u>CMS Requests and Relativity Assessment Issues</u></b>	<b>TAB</b>
Destruction of Premalignant Lesions	30
Mohs Surgery	31
Nasal/Sinus Endoscopy	32
Implantation and Removal of Patient Activated Cardiac Event Recorder	33
Renal Allotransplantation	34
Percutaneous Implantation of Neurostimulator-PE Only	35
Aqueous Shunt	36
Repair of Eyelid	37
MRI-Spine	38
CT-Angiography-Abdomen and Pelvis	39
Fluoroscopic Guidance	40
IMRT-PE Only	41
Continuing Medical Physics Consultation-PE Only	42
Radiation Treatment Delivery-PE Only	43
Hyperthermia-PE Only	44



High Dose Rate Brachytherapy-PE Only	45
Cytopatholgy	46
In Situ Hybridization	47
Psychotherapy for Crisis and Interactive Complexity	48
Evoked Potentials and Reflex Tests	49
Negative Pressure Wound Therapy	50

<b><u>HCPAC Recommendation</u></b>	<b><u>TAB</u></b>
Pharmacologic Management with Psychotherapy	51
Speech Evaluation	52

## CPT 2014 RUC Recommendations

CPT	Global Period	Coding Change	CPT Meeting Date	Main Tab	Issue	Tracking Number	RUC Meeting Date	RUC Agenda Tab	SS to Survey	SS Recommendation	RUC Recommendation	Same RVU as last year?	Comments
10030	000	N	Oct12	06	Drainage of Abscess	N1	Jan13	04	ACR, SIR	3.00	3.00		
13150	010	D	Oct12	05	Complex Repair		Deleted						
19081	000	N	Oct12	08	Breast Biopsy	O1	Apr13	4	ACR, ACS, ASBS	3.50	3.29		
19082	ZZZ	N	Oct12	08	Breast Biopsy	O2	Apr13	4	ACR, ACS, ASBS	1.90	1.65		
19083	000	N	Oct12	08	Breast Biopsy	O3	Apr13	4	ACR, ACS, ASBS	3.10	3.10		
19084	ZZZ	N	Oct12	08	Breast Biopsy	O4	Apr13	4	ACR, ACS, ASBS	1.55	1.55		
19085	000	N	Oct12	08	Breast Biopsy	O5	Apr13	4	ACR, ACS, ASBS	3.64	3.64		
19086	ZZZ	N	Oct12	08	Breast Biopsy	O6	Apr13	4	ACR, ACS, ASBS	1.82	1.82		
19102	000	D	Oct12	08	Breast Biopsy		Apr13	4	ACR, ACS, ASBS				
19103	000	D	Oct12	08	Breast Biopsy		Apr13	4	ACR, ACS, ASBS				
19281	000	N	Oct12	08	Breast Biopsy	O7	Apr13	4	ACR, ACS, ASBS	2.00	2.00		
19282	ZZZ	N	Oct12	08	Breast Biopsy	O8	Apr13	4	ACR, ACS, ASBS	1.00	1.00		
19283	000	N	Oct12	08	Breast Biopsy	O9	Apr13	4	ACR, ACS, ASBS	2.00	2.00		
19284	ZZZ	N	Oct12	08	Breast Biopsy	O10	Apr13	4	ACR, ACS, ASBS	1.00	1.00		
19285	000	N	Oct12	08	Breast Biopsy	O11	Apr13	4	ACR, ACS, ASBS	1.70	1.70		
19286	ZZZ	N	Oct12	08	Breast Biopsy	O12	Apr13	4	ACR, ACS, ASBS	0.85	0.85		
19287	000	N	Oct12	08	Breast Biopsy	O13	Apr13	4	ACR, ACS, ASBS	3.02	3.02		
19288	ZZZ	N	Oct12	08	Breast Biopsy	O14	Apr13	4	ACR, ACS, ASBS	1.51	1.51		
19290	000	D	Oct12	08	Breast Biopsy		Apr13	4	ACR, ACS, ASBS				
19291	ZZZ	D	Oct12	08	Breast Biopsy		Apr13	4	ACR, ACS, ASBS				

## CPT 2014 RUC Recommendations

CPT	Global Period	Coding Change	CPT Meeting Date	Main Tab	Issue	Tracking Number	RUC Meeting Date	RUC Agenda Tab	SS to Survey	SS Recommendation	RUC Recommendation	Same RVU as last year?	Comments
19295	ZZZ	D	Oct12	08	Breast Biopsy		Apr13	4	ACR, ACS, ASBS				
23331	090	D	Oct12	11	Shoulder Prosthesis Removal		Jan13	06	ASSH, AAOS				
23332	090	D	Oct12	11	Shoulder Prosthesis Removal		Jan13	06	ASSH, AAOS				
23333	090	N	Oct12	11	Shoulder Prosthesis Removal	P1	Jan13	06	ASSH, AAOS	6.00	6.00		
23334	090	N	Oct12	11	Shoulder Prosthesis Removal	P2	Jan13	06	ASSH, AAOS	18.89	18.89		
23335	090	N	Oct12	11	Shoulder Prosthesis Removal	P3	Jan13	06	ASSH, AAOS	22.13	22.13		
24160	090	R	Oct12	12	Elbow Prosthesis Removal	Q1	Jan13	07	ASSH, AAOS	18.63	18.63		
24164	090	R	Oct12	12	Elbow Prosthesis Removal	Q2	Jan13	07	ASSH, AAOS	10.00	10.00		
32201	000	D	Oct12	06	Drainage of Abscess		Jan13	04	ACR, SIR				
33222	090	R	May12	5	Relocation of skin pocket for pacemaker		Editorial			5.10	5.10	Yes	
33223	090	R	May12	5	Relocation of skin pocket for pacemaker		Editorial			6.55	6.55	Yes	
33366	000	N	Feb13	51	Transcatheter Aortic Valve Replacement	BB1	Apr13	5	ACC, STS, SCAI	40.00	40.00		Reaffirm RUC recommendation
34841	090	N	Feb13	52	Fenestrated Endovascular Repair	CC1	Apr13	6	SVS				Carrier Price
34842	090	N	Feb13	52	Fenestrated Endovascular Repair	CC2	Apr13	6	SVS				Carrier Price
34843	090	N	Feb13	52	Fenestrated Endovascular Repair	CC3	Apr13	6	SVS				Carrier Price
34844	090	N	Feb13	52	Fenestrated Endovascular Repair	CC4	Apr13	6	SVS				Carrier Price
34845	090	N	Feb13	52	Fenestrated Endovascular Repair	CC5	Apr13	6	SVS				Carrier Price
34846	090	N	Feb13	52	Fenestrated Endovascular Repair	CC6	Apr13	6	SVS				Carrier Price
34847	090	N	Feb13	52	Fenestrated Endovascular Repair	CC7	Apr13	6	SVS				Carrier Price
34848	090	N	Feb13	52	Fenestrated Endovascular Repair	CC8	Apr13	6	SVS				Carrier Price
37204	000	D	Feb13	09	Embolization and Occlusion Procedures	U2	Apr13	8	SVS, SIR, ACR				Referred to CPT Editorial Panel

## CPT 2014 RUC Recommendations

CPT	Global Period	Coding Change	CPT Meeting Date	Main Tab	Issue	Tracking Number	RUC Meeting Date	RUC Agenda Tab	SS to Survey	SS Recommendation	RUC Recommendation	Same RVU as last year?	Comments
37205	000	D	Feb13	10	Transcatheter Placement of		Apr13	9	ACC, ACR, SCAI,				
37206	ZZZ	D	Feb13	10	Transcatheter Placement of		Apr13	9	ACC, ACR, SCAI,				
37207	000	D	Feb13	10	Transcatheter Placement of		Apr13	9	ACC, ACR, SCAI,				
37208	ZZZ	D	Feb13	10	Transcatheter Placement of		Apr13	9	ACC, ACR, SCAI,				
37210	000	D	Feb13	09	Embolization and Occlusion Procedures		Apr13	8	SVS, SIR, ACR				
37217	090	N	Feb13	11	Retrograde Treatment Open Carotid Stent	Y1	Apr13	7	SVS, AANS,	22.00	22.00		
37236	000	N	Feb13	10	Transcatheter Placement of	X1	Apr13	9	ACC, ACR, SCAI,	9.00	9.00		
37237	ZZZ	N	Feb13	10	Transcatheter Placement of	X2	Apr13	9	ACC, ACR, SCAI,	4.25	4.25		
37238	000	N	Feb13	10	Transcatheter Placement of	X3	Apr13	9	ACC, ACR, SCAI,	6.29	6.29		
37239	ZZZ	N	Feb13	10	Transcatheter Placement of Intravascular Stent	X4	Apr13	9	ACC, ACR, SCAI, SVS, SIR	3.34	3.34		
37241	000	N	Feb13	09	Embolization and Occlusion Procedures	W1	Apr13	8	SVS, SIR, ACR	11.50	9.00		
37242	000	N	Feb13	09	Embolization and Occlusion Procedures	W2	Apr13	8	SVS, SIR, ACR	11.98	11.98		
37243	000	N	Feb13	09	Embolization and Occlusion Procedures	W3	Apr13	8	SVS, SIR, ACR	14.00	14.00		
37244	000	N	Feb13	09	Embolization and Occlusion Procedures	W4	Apr13	8	SVS, SIR, ACR	14.00	14.00		
42802	010	D	May12	08	Esophagoscopy		Oct12	10	AGA, ASGE				
43191	000	N	May12	08	Esophagoscopy	C1	Oct12	10	AGA, ASGE	2.78	2.78		
43192	000	N	May12	08	Esophagoscopy	C2	Oct12	10	AGA, ASGE	3.21	3.21		
43193	000	N	May12	08	Esophagoscopy	C3	Oct12	10	AGA, ASGE	3.36	3.36		
43194	000	N	May12	08	Esophagoscopy	C4	Oct12	10	AGA, ASGE	3.99	3.99		
43195	000	N	May12	08	Esophagoscopy	C5	Oct12	10	AGA, ASGE	3.21	3.21		

CPT 2014 RUC Recommendations

CPT	Global Period	Coding Change	CPT Meeting Date	Main Tab	Issue	Tracking Number	RUC Meeting Date	RUC Agenda Tab	SS to Survey	SS Recommendation	RUC Recommendation	Same RVU as last year?	Comments
43196	000	N	May12	08	Esophagoscopy	C6	Oct12	10	AGA, ASGE	3.36	3.36		
43197	000	N	May12	08	Esophagoscopy	C7	Oct12	10	AGA, ASGE	1.59	1.59		
43198	000	N	May12	08	Esophagoscopy	C8	Oct12	10	AGA, ASGE	1.89	1.89		
43200	000	R	May12	08	Esophagoscopy	C9	Oct12	10	AGA, ASGE	1.59	1.59	Yes	
43201	000	F	May12	08	Esophagoscopy	C11	Oct12	10	AGA, ASGE	2.09	1.90		
43202	000	F	May12	08	Esophagoscopy	C12	Oct12	10	AGA, ASGE	1.89	1.89	Yes	
43204	000	F	May12	08	Esophagoscopy	C13	Oct12	10	AGA, ASGE	2.89	2.89		
43205	000	F	May12	08	Esophagoscopy	C14	Oct12	10	AGA, ASGE	3.00	3.00		
43206	000	F	May12	08	Esophagoscopy	C10	Oct12	10	AGA, ASGE	2.39	2.39		
43211	000	N	Oct12	14	Esophagoscopy	C25	Jan13	09	AGA, ASGE	4.58	4.58		
43212	000	N	Oct12	14	Esophagoscopy	C26	Jan13	09	AGA, ASGE	3.73	3.73		
43213	000	N	Oct12	14	Esophagoscopy	C27	Jan13	09	AGA, ASGE	5.00	5.00		
43214	000	N	Oct12	14	Esophagoscopy	C28	Jan13	09	AGA, ASGE	3.78	3.78		
43215	000	F	May12	08	Esophagoscopy	C15	Oct12	10	AGA, ASGE	2.60	2.60	Yes	
43216	000	F	May12	08	Esophagoscopy	C16	Oct12	10	AGA, ASGE	2.40	2.40	Yes	
43217	000	F	May12	08	Esophagoscopy	C17	Oct12	10	AGA, ASGE	2.90	2.90	Yes	
43219	000	D	Oct12	14	Esophagoscopy		Jan13	09	AGA, ASGE				
43220	000	F	May12	08	Esophagoscopy	C26	Oct12	10	AGA, ASGE	2.10	2.10	Yes	
43226	000	F	May12	08	Esophagoscopy	C20	Oct12	10	AGA, ASGE	2.34	2.34	Yes	
43227	000	F	May12	08	Esophagoscopy	C21	Oct12	10	AGA, ASGE	3.26	3.26		
43228	000	D	Oct12	14	Esophagoscopy		Jan13	09	AGA, ASGE				

CPT 2014 RUC Recommendations

CPT	Global Period	Coding Change	CPT Meeting Date	Main Tab	Issue	Tracking Number	RUC Meeting Date	RUC Agenda Tab	SS to Survey	SS Recommendation	RUC Recommendation	Same RVU as last year?	Comments
43229	000	N	Oct12	14	Esophagoscopy	C29	Jan13	09	AGA, ASGE	3.72	3.72		
43231	000	F	May12	08	Esophagoscopy	C23	Apr13	10	AGA, ASGE	3.19	3.19	Yes	
43232	000	F	May12	08	Esophagoscopy	C24	Apr13	10	AGA, ASGE	3.83	3.83		
43233	000	N	Oct12	08	EGD	I16	Jan13	08	AGA, SAGES,	4.26	4.45		
43235	000	R	Oct12	08	EGD	I1	Jan13	08	AGA, SAGES,	2.39	2.26		
43236	000	F	Oct12	08	EGD	I2	Jan13	08	AGA, SAGES,	2.69	2.57		
43237	000	F	Feb13	12	EGD	I3	Apr13	11	AGA, SAGES,	3.85	3.85		
43238	000	F	Feb13	12	EGD	I4	Apr13	11	AGA, SAGES,	4.50	4.50		
43239	000	F	Oct12	08	EGD	I5	Jan13	08	AGA, SAGES,	2.69	2.56		
43240	000	R	Feb13	12	EGD	I6	Apr13	11	AGA, SAGES,	7.25	7.25		
43241	000	R	Oct12	08	EGD	I7	Jan13	08	AGA, SAGES,	2.59	2.59		
43242	000	R	Feb13	12	EGD	I8	Apr13	11	AGA, SAGES,	5.39	5.39		
43243	000	R	Oct12	08	EGD	I9	Jan13	08	AGA, SAGES,	4.37	4.37		
43244	000	R	Oct12	08	EGD	I10	Jan13	08	AGA, SAGES,	4.50	4.50		
43245	000	R	Oct12	08	EGD	I11	Jan13	08	AGA, SAGES,	3.18	3.18	Yes	
43246	000	F	Feb13	12	EGD	I12	Apr13	11	AGA, SAGES,	4.32	4.32	Yes	
43247	000	F	Oct12	08	EGD	I13	Jan13	08	AGA, SAGES,	3.38	3.27		
43248	000	R	Oct12	08	EGD	I14	Jan13	08	AGA, SAGES,	3.15	3.01		
43249	000	R	Oct12	08	EGD	I15	Jan13	08	AGA, SAGES,	2.90	2.77		
43250	000	F	Oct12	08	EGD	I17	Jan13	08	AGA, SAGES,	3.20	3.07		
43251	000	F	Feb13	12	EGD	I18	Apr13	11	AGA, SAGES,	3.57	3.57		

CPT 2014 RUC Recommendations

CPT	Global Period	Coding Change	CPT Meeting Date	Main Tab	Issue	Tracking Number	RUC Meeting Date	RUC Agenda Tab	SS to Survey	SS Recommendation	RUC Recommendation	Same RVU as last year?	Comments
43252	000	F	Oct12	08	EGD	I19	Jan13	08	AGA, SAGES,	3.19	3.06		
43253	000	N	Feb13	12	EGD	I20	Apr13	11	AGA, SAGES,	5.39	5.39		
43254	000	N	Oct12	08	EGD	I21	Jan13	08	AGA, SAGES,	5.42	5.25		
43255	000	F	Oct12	08	EGD	I22	Jan13	08	AGA, SAGES,	4.20	4.20		
43256	000	D	Oct12	08	EGD		Jan13	08	AGA, SAGES,				
43257	000	F	Oct12	08	EGD	I24	Jan13	08	AGA, SAGES,	4.25	4.25		
43258	000	D	Oct12	08	EGD		Jan13	08	AGA, SAGES,				
43259	000	R	Feb13	12	EGD	I26	Apr13	11	AGA, SAGES,	4.74	4.74		
43260	000	R	Feb13	13	ERCP	EE1	Apr13	12	AGA, ASGE,	5.95	5.95	Yes	
43261	000	F	Feb13	13	ERCP	EE2	Apr13	12	AGA, ASGE,	6.25	6.25		
43262	000	F	Feb13	13	ERCP	EE3	Apr13	12	AGA, ASGE,	6.60	6.60		
43263	000	R	Feb13	13	ERCP	EE4	Apr13	12	AGA, ASGE,	7.28	7.28	Yes	
43264	000	R	Feb13	13	ERCP	EE5	Apr13	12	AGA, ASGE,	6.73	6.73		
43265	000	R	Feb13	13	ERCP	EE6	Apr13	12	AGA, ASGE,	8.03	8.03		
43266	000	N	Oct12	08	EGD	I23	Jan13	08	AGA, SAGES,	4.34	4.40		
43267	000	D	Feb13	13	ERCP		Apr13	12	AGA, ASGE,				
43268	000	D	Feb13	13	ERCP		Apr13	12	AGA, ASGE,				
43269	000	D	Feb13	13	ERCP		Apr13	12	AGA, ASGE,				
43270	000	N	Oct12	08	EGD	I25	Jan13	08	AGA, SAGES,	5.05	4.39		
43271	000	D	Feb13	13	ERCP		Apr13	12	AGA, ASGE,				
43272	000	D	Feb13	13	ERCP		Apr13	12	AGA, ASGE,				

CPT 2014 RUC Recommendations

CPT	Global Period	Coding Change	CPT Meeting Date	Main Tab	Issue	Tracking Number	RUC Meeting Date	RUC Agenda Tab	SS to Survey	SS Recommendation	RUC Recommendation	Same RVU as last year?	Comments
43273	000	R	Feb13	13	ERCP	EE12	Apr13	12	AGA, ASGE,	2.24	2.24	Yes	
43274	000	N	Feb13	13	ERCP	EE7	Apr13	12	AGA, ASGE,	8.74	8.74		
43275	000	N	Feb13	13	ERCP	EE8	Apr13	12	AGA, ASGE,	6.96	6.96		
43276	000	N	Feb13	13	ERCP	EE9	Apr13	12	AGA, ASGE,	9.10	9.10		
43277	000	N	Feb13	13	ERCP	EE10	Apr13	12	AGA, ASGE,	7.11	7.11		
43278	000	N	Feb13	13	ERCP	EE11	Apr13	12	AGA, ASGE,	8.08	8.08		
43456	000	D	Oct12	08	EGD		Jan13	08	AGA, SAGES,				
43458	000	D	Oct12	08	EGD		Jan13	08	AGA, SAGES,				
44901	000	D	Oct12	06	Drainage of Abscess		Jan13	04	ACR, SIR				
47011	000	D	Oct12	06	Drainage of Abscess		Jan13	04	ACR, SIR				
47552	000	R	Feb13	13	Biliary endoscopy		Editorial			6.03	6.03	Yes	
48511	000	D	Oct12	06	Drainage of Abscess		Jan13	04	ACR, SIR				
49021	000	D	Oct12	06	Drainage of Abscess		Jan13	04	ACR, SIR				
49041	000	D	Oct12	06	Drainage of Abscess		Jan13	04	ACR, SIR				
49061	000	D	Oct12	06	Drainage of Abscess		Jan13	04	ACR, SIR				
49405	000	N	Oct12	06	Drainage of Abscess	N2	Jan13	04	ACR, SIR	4.28	4.25		
49406	000	N	Oct12	06	Drainage of Abscess	N3	Jan13	04	ACR, SIR	4.28	4.25		
49407	000	N	Oct12	06	Drainage of Abscess	N4	Jan13	04	ACR, SIR	4.50	4.50		
50021	000	D	Oct12	06	Drainage of Abscess		Jan13	04	ACR, SIR				
52332	000	F	Feb13	15	Cystourethroscopy	Z1	Apr13	15	AUA	2.82	2.82	Yes	Reaffirm RUC recommendation
52353	000	F	Feb13	15	Cystourethroscopy	Z2	Apr13	15	AUA	7.50	7.50	Yes	Reaffirm RUC recommendation



## CPT 2014 RUC Recommendations

CPT	Global Period	Coding Change	CPT Meeting Date	Main Tab	Issue	Tracking Number	RUC Meeting Date	RUC Agenda Tab	SS to Survey	SS Recommendation	RUC Recommendation	Same RVU as last year?	Comments
52356	000	N	Feb13	15	Cystourethroscopy	Z3	Apr13	15	AUA	8.00	8.00		
58823	000	D	Oct12	06	Drainage of Abscess		Jan13	04	ACR, SIR				
64612	010	F	Oct12	49	Chemodenervation of Neck Muscles	S1	Jan13	11	AAN, AANEM,	1.41	1.41	Yes	Reaffirm RUC recommendation
64613	010	D	Oct12	49	Chemodenervation of Neck Muscles		Jan13	11	AAN, AANEM				
64614	010	D	Oct12	17	Chemodenervation of Extremity and Trunk		Jan13	10	AAN, AAPMR,				
64615	010	F	Oct12	17	Chemodenervation of Extremity and Trunk	R1	Jan13	10	AAN, AAPMR,	1.85	1.85	Yes	Reaffirm RUC recommendation
64616	000	N	Oct12	49	Chemodenervation of Neck Muscles	S2	Jan13	11	AAN, AANEM	1.79	1.79		
64617	000	N	Oct12	49	Chemodenervation of Neck Muscles	S3	Jan13	11	AAO-HNS	2.19	2.06		
64642	010	N	Oct12	17	Chemodenervation of Extremity and Trunk	R2	Jan13	10	AAN, AAPMR,	1.85	1.65		
64643	ZZZ	N	Oct12	17	Chemodenervation of Extremity and Trunk	R3	Jan13	10	AAN, AAPMR,	1.43	1.32		
64644	000	N	Oct12	17	Chemodenervation of Extremity and Trunk	R4	Jan13	10	AAN, AAPMR,	2.20	1.82		
64645	ZZZ	N	Oct12	17	Chemodenervation of Extremity and Trunk Muscles	R5	Jan13	10	AAN, AAPMR, AANEM	1.70	1.52		
64646	000	N	Oct12	17	Chemodenervation of Extremity and Trunk Muscles	R6	Jan13	10	AAN, AAPMR, AANEM	1.80	1.80		
64647	000	N	Oct12	17	Chemodenervation of Extremity and Trunk Muscles	R7	Jan13	10	AAO, AAN, AAPMR, ASIPP	2.11	2.11		
65778	010	R	Oct12	52	Amniotic Membrane Placement		Editorial			1.19	1.19	Yes	
65779	010	R	Oct12	52	Amniotic Membrane Placement		Editorial			3.92	3.92	Yes	

CPT 2014 RUC Recommendations

CPT	Global Period	Coding Change	CPT Meeting Date	Main Tab	Issue	Tracking Number	RUC Meeting Date	RUC Agenda Tab	SS to Survey	SS Recommendation	RUC Recommendation	Same RVU as last year?	Comments
66183	000	N	Oct12	18	Insertion of Anterior Segment Device	J1	Apr13	14	AAO	13.20	13.20		
69210	000	R	Oct12	19	Removal of Cerumen	L1	Jan13	13	AAFP, AAO-HNS	0.58	0.58		
72040	XXX	R	Feb13	EC-G	X-ray of cervical spine		Editorial			0.22	0.22	Yes	
75894	XXX	F	Oct12	30	Percutaneous Closure Patent Ductus	U3	Jan13	16	ACC, SCAI	1.31	1.31	Yes	Referred to CPT Editorial Panel;
75960	XXX	D	Feb13	10/11	Transcatheter Placement of		Apr13	7/9	ACC, ACR, SCAI, ACR, ACS, ASBS				
77031	XXX	D	Oct12	08	Breast Biopsy		Apr13	4	ACR, ACS, ASBS				
77032	XXX	D	Oct12	08	Breast Biopsy		Apr13	4	ACR, ACS, ASBS				
77280	XXX	F	Oct12	22	Respiratory Motion Management	T1	Jan13	14	ASTRO	0.70	0.70	Yes	
77285	XXX	F	Oct12	22	Respiratory Motion Management	T2	Jan13	14	ASTRO	1.05	1.05	Yes	
77290	XXX	F	Oct12	22	Respiratory Motion Management	T3	Jan13	14	ASTRO	1.56	1.56	Yes	
77293	ZZZ	N	Oct12	22	Respiratory Motion Management	T4	Jan13	14	ASTRO	2.00	2.00		
77295	XXX	R	Oct12	22	Respiratory Motion Management	T5	Jan13	14	ASTRO	4.29	4.29		
81161	XXX	N	May12	16	Molecular Pathology-Tier 1	D1	Oct12	11	CAP	1.85	1.85		
81287	XXX	N	May13	37	Molecular Pathology-Tier 1-MGMT		CLFS						
81371	XXX	R	Feb13	28	Molecular Pathology-Tier 1		CLFS						
81376	XXX	R	Feb13	28	Molecular Pathology-Tier 1		CLFS						
81382	XXX	R	Feb13	28	Molecular Pathology-Tier 1		CLFS						
81400	XXX	R	Feb13	30	Molecular Pathology Workgroup-Tier 2		CLFS						
81401	XXX	R	Feb13	30	Molecular Pathology Workgroup-Tier 2		CLFS						

## CPT 2014 RUC Recommendations

CPT	Global Period	Coding Change	CPT Meeting Date	Main Tab	Issue	Tracking Number	RUC Meeting Date	RUC Agenda Tab	SS to Survey	SS Recommendation	RUC Recommendation	Same RVU as last year?	Comments
81402	XXX	R	Feb13	32	Molecular Pathology Workgroup-Tier 2		CLFS						
81403	XXX	R	Feb13	30	Molecular Pathology Workgroup-Tier 2		CLFS						
81404	XXX	R	Feb13	31	Molecular Pathology Workgroup-Tier 2		CLFS						
81405	XXX	R	Feb13	31	Molecular Pathology Workgroup-Tier 2		CLFS						
81406	XXX	R	Feb13	31	Molecular Pathology Workgroup-Tier 2		CLFS						
81407	XXX	R	Feb13	31	Molecular Pathology Workgroup-Tier 2		CLFS						
81408	XXX	R	Feb13	31	Molecular Pathology Workgroup-Tier 2		CLFS						
81504	XXX	N	Feb13	39	MAAA		CLFS						
81507	XXX	N	Feb13	42	MAAA-Fetal Aneuploidy		CLFS						
84112	XXX	R	Feb13	43	PAMG-1		CLFS						
87470		R	May13	16	Reverse Transcription		CLFS						
87498		R	May13	16	Reverse Transcription		CLFS						
87521		R	May13	16	Reverse Transcription		CLFS						
87522		R	May13	16	Reverse Transcription		CLFS						
87535		R	May13	16	Reverse Transcription		CLFS						
87536		R	May13	16	Reverse Transcription		CLFS						
87538		R	May13	16	Reverse Transcription		CLFS						
87539		R	May13	16	Reverse Transcription		CLFS						
87661	XXX	N	Oct12	27	Trichomonas Vaginalis		CLFS						
88342	XXX	R	May12	21	Immunohistochemistry	B1	Oct12	12	CAP	0.60	0.60		
88343	XXX	N	May12	21	Immunohistochemistry	B2	Oct12	12	CAP	0.24	0.24		

## CPT 2014 RUC Recommendations

CPT	Global Period	Coding Change	CPT Meeting Date	Main Tab	Issue	Tracking Number	RUC Meeting Date	RUC Agenda Tab	SS to Survey	SS Recommendation	RUC Recommendation	Same RVU as last year?	Comments
88375	XXX	F	Feb12	23	Optical Endomicroscopy	NN39	Jan13	15	CAP	1.08	1.08		
90673	XXX	N	May13	25	Influenza Vaccine		Vaccine						
90685	XXX	N	May12	24	Influenza Vaccine Quadrivalent		Vaccine						
90686	XXX	N	May12	24	Influenza Vaccine Quadrivalent		Vaccine						
90687	XXX	N	May12	24	Influenza Vaccine Quadrivalent		Vaccine						
90688	XXX	N	May12	24	Influenza Vaccine Quadrivalent		Vaccine						
91065	000	R	May12	47	Breath Hydrogen Methane Test	H1	Oct12	15	AGA, ASGE				PE Inputs Recommendation
93582	000	N	Oct12	30	Percutaneous Closure Patent Ductus	U1	Jan13	16	ACC, SCAI	14.00	14.00		
93583	000	N	Oct12	31	Percutaneous Alcohol Ablation of Septum	V1	Jan13	17	ACC, SCAI	18.00	14.00		
93653	000	R	May13	26	Intracardiac Electrophysiological		Editorial			15.00	15.00	Yes	
94667	XXX	F	Feb13	21	Mechanical Chest Wall Oscillations	AA1	Apr13	15	ATS, ACCP			Yes	PE Inputs Recommendation
94668	XXX	F	Feb13	21	Mechanical Chest Wall Oscillations	AA2	Apr13	15	ATS, ACCP			Yes	PE Inputs Recommendation
94669	XXX	N	Feb13	21	Mechanical Chest Wall Oscillations	AA3	Apr13	15	ATS, ACCP				PE Inputs Recommendation
97610	XXX	N	Feb13	54	Ultrasonic Wound Assessment		Apr13	16	APTA(HCP AC),				Carrier Price/Referral to
99170	000	R	May12	22	Anogenital Exam Colposcopy	A1	Oct12	13	AAP				PE Inputs Recommendation
99446	XXX	N	May12	41	Interprofessional Telephone	E1	Oct12	14	AAP, AAN, AACE,	0.35	0.35		
99447	XXX	N	May12	41	Interprofessional Telephone	E2	Oct12	14	AAP, AAN, AACE,	0.70	0.70		
99448	XXX	N	May12	41	Interprofessional Telephone	E3	Oct12	14	AAP, AAN, AACE,	1.05	1.05		
99449	XXX	N	May12	41	Interprofessional Telephone	E4	Oct12	14	AAP, AAN, AACE,	1.40	1.40		
99481	ZZZ	N	Oct12	38	Total Body and Selective Head	K1	Jan13	18	AAP				Carrier Price/Referral to
99482	ZZZ	N	Oct12	38	Total Body and Selective Head	K2	Jan13	18	AAP				Carrier Price/Referral to

# CPT 2014 HCPAC Recommendations

CPT	Global Period	Coding Change	CPT Meeting Date	Main Tab	Issue	Tracking Number	RUC Meeting Date	RUC Agenda Tab	SS to Survey	SS Recommendation	RUC Recommendation	Same RVU as last year?	Comments
92506	XXX	D	Oct12	28	Speech Evaluation		HCPAC	32	ASHA				HCPAC
92521	XXX	N	Oct12	28	Speech Evaluation	M1	HCPAC	32	ASHA	1.75	1.75		HCPAC
92522	XXX	N	Oct12	28	Speech Evaluation	M2	HCPAC	32	ASHA	1.5	1.5		HCPAC
92523	XXX	N	Oct12	28	Speech Evaluation	M3	HCPAC	32	ASHA	3.72	3.36		HCPAC
92524	XXX	N	Oct12	28	Speech Evaluation	M4	HCPAC	32	ASHA	1.75	1.75		HCPAC

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
RUC RECOMMENDATIONS FOR CPT 2014**

**INTRODUCTORY MATERIALS**

**TABLE OF CONTENTS**

<b>RUC Cover Letter</b>	<b>A</b>
<b>HCPAC Cover Letter</b>	<b>B</b>
<b>Five Year Review Progress Report</b>	<b>C</b>
<b>RUC Recommendations for Existing Codes</b>	<b>D</b>
<b>RUC Recommendations Status Report: New and Revised Codes</b>	<b>E</b>
<b>HCPAC Recommendations Status Report: New and Revised Codes</b>	<b>F</b>
<b>RUC Recommendations Status Report: Codes Identified by the Relativity Assessment Workgroup</b>	<b>G</b>
<b>Specialty and Acronym List</b>	<b>H</b>
<b>RUC Recommendations to Develop CPT Assistant Articles</b>	<b>I</b>
<b>RUC Referrals to CPT Editorial Panel</b>	<b>J</b>
<b>Physician Time File for Codes Reviewed in CPT 2014 Cycle</b>	<b>K</b>
<b>Pre-Service Time Packages Table</b>	<b>L</b>
<b>PLI Crosswalk Table</b>	<b>M</b>
<b>Utilization Data Crosswalk – 2012 to 2014</b>	<b>N</b>
<b>New Technology/New Services List</b>	<b>O</b>
<b>New Technology/Services Timeline</b>	<b>P</b>
<b>PE Subcommittee (recommendation on the migration of film to digital technology for imaging services &amp; pathology consultations recommendation from January 2012 with supporting documents from CAP study)</b>	<b>Q</b>



May 24, 2013

Marilyn B. Tavenner  
Administrator  
Center for Medicare  
Centers for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Subject: RUC Recommendations

Dear Ms. Tavenner:

The American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC) submits the enclosed recommendations for work relative values and direct practice expense inputs to the Centers for Medicare and Medicaid Services (CMS). These recommendations relate to new and revised codes for *CPT 2014*, as well as to existing services identified by the RUC's Relativity Assessment Workgroup and CMS. If implemented, the RUC recommendations should result in a positive adjustment to the Medicare conversion factor.

*CPT 2014 New and Revised Codes*

Enclosed are two binders containing RUC recommendations, including those for new and revised CPT codes. The total number of coding changes for *CPT 2014* is 227, including 98 additions, 51 revisions, and 41 deletions. In addition, 37 new codes were identified as part of the family for review in relationship to the new/revised codes. The 186 new/revised/related family CPT codes are summarized as follows:

- 30 services are not payable on the RBRVS or do not require physician work at this time (eg, laboratory services and vaccines), and accordingly, the RUC does not submit any information on these codes.
- Four new and revised codes were addressed by the RUC HCPAC Review Board and that recommendation is submitted directly by the HCPAC.
- The RUC recommends that 11 codes be carrier priced.

The RUC submits work value and/or practice expense inputs for 141 new/ revised/related family CPT codes.

Over seventy-five percent of the CPT code revisions for CPT 2014 originated from the potentially misvalued services process.

Existing Services Identified by RUC and CMS for Review

In addition to the new/revised CPT code submission, the RUC submits recommendations for 74 services identified by the RUC or CMS as potentially misvalued and reviewed at the April 2013 RUC meeting. These recommendations are in addition to the 39 recommendations for existing services submitted to CMS following the RUC's October 2012 and January 2013 meetings.

Practice Expense Subcommittee

The attached materials include direct expense input (medical staff, supplies and equipment) recommendations for each code reviewed. As a reminder, cost estimates for medical supplies and equipment not listed on the "CMS labor, Supply, and Equipment List for the Year 2013" are based on provided source(s) as noted, such as manufacturer's catalogue prices and may not reflect the wholesale prices, quantity, or cash discounts, prices for used equipment or any other factors that may alter the cost estimates. The RUC shares this information with CMS without making specific recommendations on the pricing for supplies and equipment.

The Migration from Film to Digital Imaging Workgroup has concluded its work and recommendations are included in the attached submission. The Workgroup has identified 604 imaging CPT codes as being transitioned to digital equipment and the supplies and equipment to be removed from these codes. The Workgroup has also identified the recommended PACS equipment to replace film components that will be removed from the codes and clinical labor activities that the PE Subcommittee will implement as codes are reviewed moving forward.

In the Final Rule CMS asked for comment and data on the number of blocks assumed in the determination of practice expense recommendations for CPT codes 88302-88309. In response, the College of American Pathologists (CAP) and other stakeholders conducted a national study of the number of blocks typically produced for CPT codes 88302-88309. This independent evidence confirms the conservative estimation made by the CAP, and approved by the RUC, in January 2012 of the appropriate typical number of blocks associated with each of these services and which the RUC previously recommended, based on the data presented and on the RUC's clinical knowledge. The PE Subcommittee confirmed the number of blocks approved by the RUC at January 2012 RUC Meeting. The *Pathology Consultations* recommendation from January 2012 and supporting documents from the CAP study are included with this submission.

Enclosed Recommendations and Supporting Materials:

Included in these binders and on the enclosed CD are:

- RUC Recommendation Status Report for New and Revised Codes
- RUC Recommendation Status Report for more than 1,500 services identified to date by the Relativity Assessment Workgroup and CMS as potentially misvalued. In addition, a spreadsheet containing the codes specific to this submission is included.
- RUC Referrals to the CPT Editorial Panel – both for CPT nomenclature revisions and *CPT Assistant* articles.



- Physician Time File: A list of the physician time data for each of the CPT codes reviewed at the October 2012, January 2013, and April 2013 RUC meetings. In addition, a new physician time file for all services within the RBRVS is enclosed.
- Pre-Service Time Packages Definitions: The RUC developed physician pre-service time packages which have been incorporated into these recommendations. The intent of these packages is to streamline the RUC review process as well as create standard pre-service time data for all codes reviewed by the RUC.
- PLI Crosswalk Table: The RUC has committed to selecting appropriate professional liability insurance crosswalks for new and revised codes and existing codes under review. We have provided a PLI Crosswalk Table listing the reviewed code and its crosswalk code for easy reference. We hope that the provision of this table will assist CMS in reviewing and implementing the RUC recommendations.
- Source Code Utilization Crosswalk Table – A table estimating the flow of claims data from existing codes to the new/revised codes. This information is used to project the work relative value savings to be included in the 2014 conversion factor increase.
- New Technology List and Flow Chart – In April 2006, the RUC adopted a process to identify and review codes that represent new technology or services that have the potential to change in value. To date, the RUC has identified 416 of these procedures through the review of new CPT codes. A table of these codes identified as new technology services and the date of review is enclosed, as well as a flow chart providing a detailed description of the process to be utilized to review these services.
- Practice Expense Subcommittee recommendation on the migration of film to digital technology for imaging services is also included.

We appreciate your consideration of these RUC recommendations. If you have any questions regarding the attached materials, please contact Sherry Smith at (312) 464-5604.

Sincerely,



Barbara Levy, MD

Enclosures

cc: Kathy Bryant  
Edith Hambrick, MD  
Steve Phurrough, MD  
Ryan Howe  
RUC Participants



American Medical Association

515 N. State Street  
Chicago, Illinois 60654

ama-assn.org  
312.464.5000

May 24, 2013

Marilyn B. Tavenner  
Administrator  
Center for Medicare  
Centers for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Subject: HCPAC Recommendations

Dear Ms. Tavenner:

The RUC Health Care Professionals Advisory Committee (HCPAC) Review Board submits the enclosed recommendations to the Centers for Medicare and Medicaid Services (CMS). At its January and April 2013 meetings, the HCPAC reviewed four speech evaluation CPT codes and one pharmacologic management CPT code.

The RUC and HCPAC are fully committed to this ongoing effort to improve relativity in the work, practice expense, and professional liability insurance values. The HCPAC appreciates the opportunity to provide recommendations related to the 2014 Medicare Physician Payment Schedule. If you have any questions regarding this submission, please contact Susan Clark via (202) 789-7495 or [Susan.Clark@ama-assn.org](mailto:Susan.Clark@ama-assn.org) at the AMA for clarification regarding these recommendations.

Sincerely,

A handwritten signature in black ink, appearing to read "W. Mangold, Jr.", written over a light blue horizontal line.

William J. Mangold, Jr, MD  
HCPAC Chair

A handwritten signature in black ink, appearing to read "Anthony W. Hamm, D.C.", written over a light blue horizontal line.

Anthony Hamm, DC  
HCPAC Co-Chair

cc: HCPAC Participants  
Edith Hambrick, MD  
Steve Phurrough, MD  
Kathy Bryant  
Ryan Howe

Attachments



## **The RUC Relativity Assessment Workgroup Progress Report**

In 2006, the RUC established the Five-Year Identification Workgroup (now referred to as the Relativity Assessment Workgroup) to identify potentially misvalued services using objective mechanisms for reevaluation prior to the next Five-Year Review. The RUC formed this Workgroup in response to criticisms that, despite reducing the work RVUs for nearly 400 services in the past, the process contains “bias in the 5-year review in favor of undervalued codes as compared to overvalued codes.”<sup>1</sup> Since the inception of the Relativity Assessment Workgroup, the Workgroup and CMS have identified over 1,500 services through thirteen different screening criteria for further review by the RUC. Additionally, the RUC charged the Workgroup with maintaining the “new technology” list of services that will be re-reviewed by the RUC as reporting and cost data become available.

### **New Technology**

As the RUC identifies new technology services that should be re-reviewed, a list of these services is maintained and forwarded to CMS. Currently, codes are identified as new technology based on recommendations from the specialty society and consensus among RUC members at the time of the RUC review for these services. RUC members consider several factors to evaluate potential new technology services, including: recent FDA-approval, newness or novelty of the service, use of an existing service in a new or novel way, and migration of the service from a Category III to Category I CPT code. The Relativity Assessment Workgroup maintains and develops all standards and procedures associated with the list, which contains 416 services. In September 2010, the re-review cycle began and since then the RUC has recommended 5 services to be re-examined. The remaining services are rarely performed (ie, less than 500 times per year in the Medicare population) and will not be re-examined. The Workgroup will continue to review the remaining 249 services every October after three years of Medicare claims data is available for each service.

### **Site of Service Anomalies**

The Workgroup initiated its effort by reviewing services with anomalous sites of service when compared to Medicare utilization data. Specifically, these services are performed less than 50% of the time in the inpatient setting, yet include inpatient hospital Evaluation and Management services within their global period.

The RUC identified 194 services through the site of service anomaly screen. The RUC required the specialties to resurvey 129 services to capture the appropriate physician work involved. These services were reviewed by the RUC between April 2008 and February 2011. CMS implemented 124 of these recommendations in the 2009, 2010 and 2011 Medicare Physician Payment Schedules. The RUC submitted another 5 recommendations as well as re-reviewed and submitted 44 recommendations to previously reviewed site-of-service identified codes to CMS for the 2012 Medicare Physician Payment Schedule.

---

<sup>1</sup> MedPAC comments to CMS regarding the 2008 Medicare Physician Payment Schedule proposed rule, submitted August 30, 2007.



Of the remaining 65 services that were not re-surveyed, the RUC modified the discharge day management for 46 services, maintained 3 codes and removed 2 codes from the screen as the typical patient was not a Medicare beneficiary and would be an inpatient. The CPT Editorial Panel deleted 13 codes and the RUC will re-review 1 service in the CPT 2016 cycle. The RUC will reassess the data each year going forward to determine if any new site of service anomalies arise.

During this review, the RUC uncovered several services that are reported in the outpatient setting, yet, according to several expert panels and survey data from physicians who performed the procedure, the service, typically requires a hospital stay of greater than 23 hours. The RUC maintains that physician work that is typically performed, such as visits on the date of service and discharge work the following day, should be included within the overall valuation. Subsequent observation day visits and discharge day management service as appropriate proxies for this work.

### **High Volume Growth**

The Workgroup assembled a list of all services with a total Medicare utilization of 1,000 or more that have increased by at least 100% from 2004 through 2006. The query initially resulted in the identification of 81 services, but was expanded by 15 services to include the family of services, totaling 96 services. Specialty societies submitted comments to the Workgroup in April 2008 to provide feedback or explanations for the growth in reporting. Following this review, the RUC required the specialties to survey 35 services to capture the appropriate work effort and/or practice expense inputs. These services were reviewed by the RUC between February 2009 and April 2010.

The RUC recommended removing 23 services from the screen as the volume growth did not impact the resources required to provide the service. The CPT Editorial Panel deleted 21 codes and will review another 3 services in the CPT 2014 cycle. In September 2011, the RUC began review of services after two years of utilization data were collected. The RUC submitted recommendations to CMS for 8 services for the 2012-2014 Medicare Physician Payment Schedules. The RUC will continue to review the remaining 6 services after additional utilization data is collected.

In April 2013, the RUC assembled a list of all services with a total Medicare utilization of 10,000 or more that have increased by at least 100% from 2006 through 2011. The query resulted in the identification of 40 services. Specialty societies will submit action plans to the RUC in October 2013 to provide feedback or explanations for the growth in reporting. The RUC will determine next steps to address these services after it has reviewed this information.

### **CMS Fastest Growing**

In 2008, CMS developed the Fastest Growing Screen to identify all services with growth of at least 10% per year over the course of 3 years from 2005-2007. Through this screen, CMS identified 114 fastest growing services and the RUC added 69 services to include the family of services, totaling 183. The RUC required the specialties to survey 72 services to capture the appropriate work effort and/or practice expense inputs. These services were reviewed by the RUC from February 2008 through April 2010 and submitted to CMS for the Medicare Physician Payment Schedule.



The RUC recommended removing 51 services from the screen as the volume growth did not impact the resources required to provide the service. The CPT Editorial Panel deleted 25 codes and will review another 4 services in the CPT 2014 cycle. The RUC submitted 13 recommendations to CMS for the 2012 -2013 Medicare Physician Payment Schedules. The RUC will review 4 services for the 2015 cycle and the remaining 14 services after additional utilization data is available.

### **High IWPOT**

The Workgroup assembled a list of all services with a total Medicare utilization of 1,000 or more that have an intra-service work per unit of time (IWPOT) calculation greater than 0.14, indicating an outlier intensity. The query resulted in identification of 32 services. Specialty societies submitted comments to the Workgroup in April 2008 for these services. As a result of this screen, the RUC has reviewed and submitted recommendations to CMS for 28 codes, removing 4 services from the screen as the IWPOT was considered appropriate. The RUC completed review of services under this screen.

### **Services Surveyed by One Specialty – Now Performed by a Different Specialty**

In October 2009, services that were originally surveyed by one specialty, but now performed predominantly by other specialties were identified and reviewed. The RUC identified 21 services by this screen, adding 19 services to address various families of codes. The majority of these services required clarification within CPT. The CPT Editorial Panel deleted 18 codes. The RUC submitted 22 recommendations for physician work and practice expense to CMS for the 2011-2014 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

In April 2013, the RUC queried the top two dominant specialties performing services based on Medicare utilization more than 1,000 and compared it to who originally surveyed the service. Two services were identified and will be assessed to determine future action.

### **Harvard Valued**

#### *Utilization over 1 Million*

CMS requested that the RUC pay specific attention to Harvard valued codes that have a high utilization. The RUC identified 9 Harvard valued services with high utilization (performed over 1 million times per year). The RUC also incorporated an additional 12 Harvard valued codes within the initial family of services identified. The CPT Editorial Panel deleted 1 code. The RUC submitted 20 relative value work recommendations to CMS for the 2011 and 2012 Medicare Physician Payment Schedule. The RUC completed review of services under this screen.

#### *Utilization over 100,000*

The RUC continued to review Harvard-only valued codes with significant utilization. The Relativity Assessment Workgroup expanded the review of Harvard codes to those with utilization over 100,000 which totaled 38 services. The RUC expanded this screen by 101 codes to include the family of services, totaling 139 services. The CPT Editorial Panel deleted 27 codes. The RUC submitted 112 recommendations to CMS for the 2011-2014 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.



#### *Utilization over 30,000*

In April 2011, the RUC continued to identify Harvard-only valued codes with utilization over 30,000, based on 2009 Medicare claims data. The RUC determined that the specialty societies should survey the remaining 36 Harvard codes with utilization over 30,000 for September 2011. The RUC expanded the screen to include the family of services, totaling 65 services. The CPT Editorial Panel deleted 12 codes. The RUC submitted recommendations for 51 services for the 2013-2014 Medicare Physician Payment Schedules and will review 2 services in the 2015 cycle.

#### *Medicare Allowed Charges $\geq$ \$10 million*

In June 2012, CMS identified 16 services that were Harvard-Valued with Annual Allowed Charges (2011 data)  $\geq$  \$10 million. The RUC expanded this screen to 29 services to include the proper family of services. The RUC removed 2 services from review as the allowed charges are approximately \$1 million and did not meet the screen criteria. The RUC submitted recommendations for 17 services for the 2013-2014 Medicare Physician Payment Schedules. The CPT Editorial Panel deleted 1 service. The RUC will submit recommendations for the remaining 9 services for the 2015 Medicare Physician Payment Schedule.

#### **CMS/Other**

##### *Utilization over 500,000*

In April 2011, the RUC identified 410 codes with a source of "CMS/Other." CMS/Other codes are services which were not reviewed by the Harvard studies or the RUC and were either gap filled, most often via crosswalk by CMS or were part of a radiology fee schedule. "CMS/Other" source codes would not have been flagged in the Harvard only screens, therefore the RUC recommended that a list of all CMS/Other codes be developed and reviewed. The RUC established the threshold for CMS/Other source codes with Medicare utilization of 500,000 or more, which resulted in 19 codes. The RUC submitted recommendations for 9 services for the 2013-2014 Medicare Physician Payment Schedules. The RUC removed one service from the screen and will provide recommendations on the remaining 9 services for the 2015 Medicare Physician Payment Schedule.

##### *Utilization over 250,000*

In April 2013, the RUC lowered the threshold to the CMS/Other source codes with Medicare utilization of 250,000 or more, which resulted in 26 services. The RUC will review action plans from the specialty societies and determine how to address these services.

#### **Bundled CPT Services**

##### *Reported 95% or More Together*

The Relativity Assessment Workgroup solicited data from CMS regarding services inherently performed by the same physician on the same date of service (95% of the time) in an attempt to identify pairings of services that should be bundled together. The CPT Editorial Panel deleted 31 individual component codes and replaced them with 53 new codes that describe bundles of services. The RUC then surveyed and reviewed work and practice costs associated with these services to account for any efficiencies achieved through the bundling. The RUC completed review of all services under this screen.



#### *Reported 75% or More Together*

In February 2010, the Workgroup continued review of services provided on the same day by the same provider, this time lowering the threshold to 75% or more together. The Relativity Assessment Workgroup again analyzed the Medicare claims data and found 151 code pairs which met the threshold. The Workgroup then collected these code pairs into similar “groups” to ensure that the entire family of services would be coordinated under one code bundling proposal. The grouping effort resulted in 20 code groups, totaling 80 codes, and were sent to specialty societies to solicit action plans for consideration at the April 2010 RUC meeting. Resulting from the Relativity Assessment Workgroup review, 72 additional codes were added for review as part of the family of services to ensure duplication of work and practice expense was mitigated throughout the entire set of services. Of the 152 total codes under review, the CPT Editorial Panel deleted 26 individual component codes and replaced the component coding with 115 new and/or revised codes that described the bundles of services. The CPT Editorial Panel and the RUC are currently working on 16 services and expect to complete this screen for final implementation in the 2014 Medicare Physician Payment Schedule.

#### *Reported 75% or More Together – Part 2*

In August 2011, the Joint CPT/RUC Workgroup on Codes Reported Together Frequently reconvened to perform its third cycle of analysis of code pairs reported together with 75% or greater frequency. The Workgroup reviewed 30 code pair Groups and recommended code bundling for 64 individual codes. In October 2012, the CPT Editorial Panel started review of code bundling solutions, deleting 16 codes, creating 18 codes and is scheduled to review 66 codes in the 2014-2016 cycles. The RUC has submitted 21 code recommendations for the 2014 Medicare Physician Payment Schedule.

#### **Low Value/Billed in Multiple Units**

CMS has requested that services with low work RVUs that are commonly billed with multiple units in a single encounter be reviewed. CMS identified services that are reported in multiples of 5 or more per day, with work RVUs of less than or equal to 0.50 RVUs.

In October 2010, the Workgroup reviewed 12 CMS identified services and determined that 6 of the codes were improperly identified as the services were either not reported in multiple units or were reported in a few units, but that was assumed in the original valuation. The RUC submitted recommendations for the remaining 6 services for the 2012 Medicare Physician Payment Schedule. The RUC completed review of services under this screen.

#### **Low Value/High Volume Codes**

CMS has requested that services with low work RVUs and high utilization be reviewed. CMS has requested that the RUC review 24 services that have low work RVUs (less than or equal to 0.25) and high utilization. The RUC questioned the criteria CMS used to identify these services as it appeared some codes were missing from the screen criteria indicated. The RUC identified codes with a work RVU ranging from 0.01 - 0.50 and Medicare utilization greater than one million. In February 2011, the RUC reviewed the codes identified by this criteria and added 5 codes, totaling 29. The RUC submitted 24 recommendations to CMS for the 2012 Medicare Physician Payment Schedule and 5 recommendations to CMS for the 2013 Medicare Physician Payment Schedule. The RUC completed review of services under this screen.





### **Multi-Specialty Points of Comparison List**

CMS requested that services on the Multi-Specialty Points of Comparison (MPC) list should be reviewed. CMS prioritized the review of the MPC list to 33 codes, ranking the codes by allowed service units and charges based on CY 2009 claims data as well as those services reviewed by the RUC more than six years ago. The RUC expanded the list to 176 services to include additional codes as part of a family (105 codes of which are part of the review of GI endoscopy codes). The CPT Editorial Panel deleted 17 codes and will review 2 codes for revision. The RUC submitted recommendations for 103 codes for the 2012-2014 Medicare Physician Payment Schedules and will review the remaining 56 codes in the 2015 cycle.

### **CMS High Expenditure Procedural Codes**

In the July 19, 2011, Proposed Rule for 2012, CMS requests that the RUC review a list of 70 high PFS expenditure procedural codes representing services furnished by an array of specialties. CMS selected these codes since they have not been reviewed for at least 6 years, and in many cases the last review occurred more than 10 years ago.

The RUC reviewed the 70 services identified and expanded the list to 128 services to include additional codes as part of the family. The CPT Editorial Panel deleted 7 codes and will review 7 codes for the 2015 cycle. The RUC submitted 110 recommendations to CMS for the 2013-2014 Medicare Physician Payment Schedules, will submit 1 remaining recommendation for the 2015 Medicare Physician Payment Schedule and will review utilization data for 3 services in 2015.

### **Services with Stand-Alone PE Procedure Time**

In June 2012, CMS proposed adjustments to services with stand alone procedure time assumptions used in developing non-facility PE RVUs. These assumptions are not based on physician time assumptions. CMS prioritized CPT codes that have annual Medicare allowed charges of \$100,000 or more, include direct equipment inputs that amount to \$100 or more, and have PE procedure times greater than 5 minutes for review. The RUC reviewed 27 services identified through this screen, submitted 11 recommendations for the 2014 Medicare Physician Payment Schedule and will provide 2 recommendations for the 2015 Medicare Physician Payment Schedule. The RUC referred 9 services to the CPT Editorial Panel for revision.

### **Public Comment Requests**

In 2011, CMS announced that due to the ongoing identification of potentially misvalued services by CMS and the RUC, the Agency will no longer conduct a separate Five-Year Review. CMS will now call for public comments on an annual basis as part of the comment process on the Final Rule each year. In the Final Rule for the 2013 Medicare Physician Payment Schedule, the public and CMS identified 35 potentially misvalued services. The RUC reviewed these services and referred 3 services to the CPT Editorial Panel for revision. The RUC indicated they did not provide a recommendation for 1 service because it lacked specialty society interest. The RUC submitted recommendations for 20 services for the 2014 Medicare Physician Payment Schedule and will submit the remaining 11 recommendations for the 2015 cycle.

### **Other Issues**

In addition to the above screening criteria, the Relativity Assessment Workgroup performed an exhaustive search of the RUC database for services indicated by the RUC to be re-reviewed at a later date. Three codes were found that had not yet been re-reviewed. The RUC recommended a work RVU decrease for 2 codes and to maintain the work RVU for another code.





CMS also identified 72 services that required further practice expense review. The RUC submitted practice expense recommendations on 67 services and the CPT Editorial Panel deleted 5 services. The RUC also reviewed special requests for 19 audiology and speech-language pathology services. The RUC submitted recommendations for 10 services for the 2010 Medicare Physician Payment Schedule and the remaining 9 services for the 2011 Medicare Physician Payment Schedule.

**CMS Requests and RUC Relativity Assessment Workgroup Code Status**

<b>Total Number of Codes Identified*</b>	<b>1,537</b>
<b>Codes Completed</b>	<b>1,291</b>
Work and PE Maintained	406
Work Increased	114
Work Decreased	447
Direct Practice Expense Revised (beyond work changes)	121
Deleted from CPT	203
<b>Codes Under Review</b>	<b>246</b>
Referred to CPT	84
RUC to Review October 2013	117
RUC to Review January or April 2014	45

*\*The total number of codes identified will not equal the number of codes from each screen as some codes have been identified in more than one screen.*

The RUC's efforts for 2009-2014 have resulted in \$2.5 billion in redistribution within the Medicare Physician Payment Schedule.

## RUC Recommendations for Existing Codes

CPT Code	Descriptor	RUC Recommendation	CMS Fastest Growing	High Volume Growth	CMS/Other Source - Utilization over 500,000	Codes Reported Together	Low Value Billed in Multiple Units	MPC List	CMS Request - PE Review	Site of Service Anomaly	Harvard-Valued Annual Allowed Charges > \$10 million	CMS Request - Final Rule for 2013	CMS High Expenditure Procedural Codes	Services with Stand-Alone PE Procedure Time
17000	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion	0.61						X						
17003	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); second through 14 lesions, each (List separately in addition to code for first lesion)	0.04					X						X	
17004	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions	1.37											X	
17311	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (	6.20											X	
17312	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (	3.30											X	
17313	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (	5.56											X	

## RUC Recommendations for Existing Codes

CPT Code	Descriptor	RUC Recommendation	CMS Fastest Growing	High Volume Growth	CMS/Other Source - Utilization over 500,000	Codes Reported Together	Low Value Billed in Multiple Units	MPC List	CMS Request - PE Review	Site of Service Anomaly	Harvard-Valued Annual Allowed Charges > \$10 million	CMS Request - Final Rule for 2013	CMS High Expenditure Procedural Codes	Services with Stand-Alone PE Procedure Time
17314	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (	3.06											X	
17315	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (	0.87											X	
31237	Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)	2.60											X	
31238	Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage	2.74											X	
31239	Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy	9.04											X	
31240	Nasal/sinus endoscopy, surgical; with concha bullosa resection	2.61											X	
33282	Implantation of patient-activated cardiac event recorder	3.50										X		
33284	Removal of an implantable, patient-activated cardiac event recorder	3.00										X		
50360	Renal allotransplantation, implantation of graft; without recipient nephrectomy	43.00									X			
63650	Percutaneous implantation of neurostimulator electrode array, epidural	New PE Inputs	X							X		X		
66180	Aqueous shunt to extraocular reservoir (eg, Molteno, Schocket, Denver-Krupin)	Refer to CPT									X			
66185	Revision of aqueous shunt to extraocular reservoir	Refer to CPT									X			

## RUC Recommendations for Existing Codes

CPT Code	Descriptor	RUC Recommendation	CMS Fastest Growing	High Volume Growth	CMS/Other Source - Utilization over 500,000	Codes Reported Together	Low Value Billed in Multiple Units	MPC List	CMS Request - PE Review	Site of Service Anomaly	Harvard-Valued Annual Allowed Charges > \$10 million	CMS Request - Final Rule for 2013	CMS High Expenditure Procedural Codes	Services with Stand-Alone PE Procedure Time
67914	Repair of ectropion; suture	3.75									X			
67915	Repair of ectropion; thermocauterization	2.03									X			
67916	Repair of ectropion; excision tarsal wedge	5.48									X			
67917	Repair of ectropion; extensive (eg, tarsal strip operations)	5.93									X			
67921	Repair of entropion; suture	3.47									X			
67922	Repair of entropion; thermocauterization	2.03									X			
67923	Repair of entropion; excision tarsal wedge	5.48									X			
67924	Repair of entropion; extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)	5.93									X			
72141	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material	1.48											X	
72142	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; with contrast material(s)	1.78											X	
72146	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material	1.48											X	
72147	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; with contrast material(s)	1.78											X	
72148	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material	1.48			X								X	
72149	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; with contrast material(s)	1.78											X	

## RUC Recommendations for Existing Codes

CPT Code	Descriptor	RUC Recommendation	CMS Fastest Growing	High Volume Growth	CMS/Other Source - Utilization over 500,000	Codes Reported Together	Low Value Billed in Multiple Units	MPC List	CMS Request - PE Review	Site of Service Anomaly	Harvard-Valued Annual Allowed Charges > \$10 million	CMS Request - Final Rule for 2013	CMS High Expenditure Procedural Codes	Services with Stand-Alone PE Procedure Time
72156	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical	2.29											X	
72157	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic	2.29											X	
72158	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar	2.29											X	
72191	Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing	1.81 Interim. Resurvey for October 2013.	X	X		X						X		
74174	Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing	2.20 Interim. Resurvey for October 2013.				X						X		
74175	Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing	1.90 Interim. Resurvey for October 2013.	X			X						X		
77001	Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or c	0.38						X				X		

## RUC Recommendations for Existing Codes

CPT Code	Descriptor	RUC Recommendation	CMS Fastest Growing	High Volume Growth	CMS/Other Source - Utilization over 500,000	Codes Reported Together	Low Value Billed in Multiple Units	MPC List	CMS Request - PE Review	Site of Service Anomaly	Harvard-Valued Annual Allowed Charges > \$10 million	CMS Request - Final Rule for 2013	CMS High Expenditure Procedural Codes	Services with Stand-Alone PE Procedure Time
77002	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)	0.54						X				X		
77003	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural or subarachnoid)	0.60						X				X		
77301	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications	New PE Inputs	X						X				X	X
77336	Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy	New PE Inputs										X		
77338	Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan	New PE Inputs												X
77372	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based	New PE Inputs												X
77402	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; up to 5 MeV	Refer to CPT												X
77403	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 6-10 MeV	Refer to CPT												X

## RUC Recommendations for Existing Codes

CPT Code	Descriptor	RUC Recommendation	CMS Fastest Growing	High Volume Growth	CMS/Other Source - Utilization over 500,000	Codes Reported Together	Low Value Billed in Multiple Units	MPC List	CMS Request - PE Review	Site of Service Anomaly	Harvard-Valued Annual Allowed Charges > \$10 million	CMS Request - Final Rule for 2013	CMS High Expenditure Procedural Codes	Services with Stand-Alone PE Procedure Time
77404	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 11-19 MeV	Refer to CPT												X
77406	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 20 MeV or greater	Refer to CPT												X
77407	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; up to 5 MeV	Refer to CPT												X
77408	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 6-10 MeV	Refer to CPT												X
77409	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 11-19 MeV	Refer to CPT												X
77411	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 20 MeV or greater	Refer to CPT												X
77412	Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; up to 5 MeV	Refer to CPT												X
77413	Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 6-10 MeV	Refer to CPT												X

## RUC Recommendations for Existing Codes

CPT Code	Descriptor	RUC Recommendation	CMS Fastest Growing	High Volume Growth	CMS/Other Source - Utilization over 500,000	Codes Reported Together	Low Value Billed in Multiple Units	MPC List	CMS Request - PE Review	Site of Service Anomaly	Harvard-Valued Annual Allowed Charges > \$10 million	CMS Request - Final Rule for 2013	CMS High Expenditure Procedural Codes	Services with Stand-Alone PE Procedure Time
77414	Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 11-19 MeV	Refer to CPT												X
77416	Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 20 MeV or greater	Refer to CPT												X
77417	Therapeutic radiology port film(s)	Refer to CPT												X
77600	Hyperthermia, externally generated; superficial (ie, heating to a depth of 4 cm or less)	New PE Inputs												X
77785	Remote afterloading high dose rate radionuclide brachytherapy; 1 channel	1.42 and new PE inputs	X	X					X					X
77786	Remote afterloading high dose rate radionuclide brachytherapy; 2-12 channels	3.25 and new PE inputs	X	X					X					X
77787	Remote afterloading high dose rate radionuclide brachytherapy; over 12 channels	Refer to CPT. New PE Inputs	X	X		X			X					X



## CPT 2013 RUC Recommendations

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
10030	000	N	Oct12	06	Drainage of Abscess	N1	Jan13	04	ACR, SIR	3.00	3.00		<input checked="" type="checkbox"/>		<input type="checkbox"/>
13150	010	D	Oct12	05	Complex Repair		Deleted						<input checked="" type="checkbox"/>		<input type="checkbox"/>
19081	000	N	Oct12	08	Breast Biopsy	O1	Apr13	4	ACR, ACS, ASBS	3.50	3.29		<input checked="" type="checkbox"/>		<input type="checkbox"/>
19082	ZZZ	N	Oct12	08	Breast Biopsy	O2	Apr13	4	ACR, ACS, ASBS	1.90	1.65		<input checked="" type="checkbox"/>		<input type="checkbox"/>
19083	000	N	Oct12	08	Breast Biopsy	O3	Apr13	4	ACR, ACS, ASBS	3.10	3.10		<input checked="" type="checkbox"/>		<input type="checkbox"/>
19084	ZZZ	N	Oct12	08	Breast Biopsy	O4	Apr13	4	ACR, ACS, ASBS	1.55	1.55		<input checked="" type="checkbox"/>		<input type="checkbox"/>
19085	000	N	Oct12	08	Breast Biopsy	O5	Apr13	4	ACR, ACS, ASBS	3.64	3.64		<input checked="" type="checkbox"/>		<input type="checkbox"/>
19086	ZZZ	N	Oct12	08	Breast Biopsy	O6	Apr13	4	ACR, ACS, ASBS	1.82	1.82		<input checked="" type="checkbox"/>		<input type="checkbox"/>
19102	000	D	Oct12	08	Breast Biopsy		Apr13	4	ACR, ACS, ASBS				<input checked="" type="checkbox"/>		<input type="checkbox"/>
19103	000	D	Oct12	08	Breast Biopsy		Apr13	4	ACR, ACS, ASBS				<input checked="" type="checkbox"/>		<input type="checkbox"/>
19281	000	N	Oct12	08	Breast Biopsy	O7	Apr13	4	ACR, ACS, ASBS	2.00	2.00		<input checked="" type="checkbox"/>		<input type="checkbox"/>
19282	ZZZ	N	Oct12	08	Breast Biopsy	O8	Apr13	4	ACR, ACS, ASBS	1.00	1.00		<input checked="" type="checkbox"/>		<input type="checkbox"/>
19283	000	N	Oct12	08	Breast Biopsy	O9	Apr13	4	ACR, ACS, ASBS	2.00	2.00		<input checked="" type="checkbox"/>		<input type="checkbox"/>
19284	ZZZ	N	Oct12	08	Breast Biopsy	O10	Apr13	4	ACR, ACS, ASBS	1.00	1.00		<input checked="" type="checkbox"/>		<input type="checkbox"/>
19285	000	N	Oct12	08	Breast Biopsy	O11	Apr13	4	ACR, ACS, ASBS	1.70	1.70		<input checked="" type="checkbox"/>		<input type="checkbox"/>
19286	ZZZ	N	Oct12	08	Breast Biopsy	O12	Apr13	4	ACR, ACS, ASBS	0.85	0.85		<input checked="" type="checkbox"/>		<input type="checkbox"/>
19287	000	N	Oct12	08	Breast Biopsy	O13	Apr13	4	ACR, ACS, ASBS	3.02	3.02		<input checked="" type="checkbox"/>		<input type="checkbox"/>
19288	ZZZ	N	Oct12	08	Breast Biopsy	O14	Apr13	4	ACR, ACS, ASBS	1.51	1.51		<input checked="" type="checkbox"/>		<input type="checkbox"/>

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
19290	000	D	Oct12	08	Breast Biopsy		Apr13	4	ACR, ACS, ASBS				<input checked="" type="checkbox"/>		<input type="checkbox"/>
19291	ZZZ	D	Oct12	08	Breast Biopsy		Apr13	4	ACR, ACS, ASBS				<input checked="" type="checkbox"/>		<input type="checkbox"/>
19295	ZZZ	D	Oct12	08	Breast Biopsy		Apr13	4	ACR, ACS, ASBS				<input checked="" type="checkbox"/>		<input type="checkbox"/>
23331	090	D	Oct12	11	Shoulder Prosthesis Removal		Jan13	06	ASSH, AAOS				<input checked="" type="checkbox"/>		<input type="checkbox"/>
23332	090	D	Oct12	11	Shoulder Prosthesis Removal		Jan13	06	ASSH, AAOS				<input checked="" type="checkbox"/>		<input type="checkbox"/>
23333	090	N	Oct12	11	Shoulder Prosthesis Removal	P1	Jan13	06	ASSH, AAOS	6.00	6.00		<input checked="" type="checkbox"/>		<input type="checkbox"/>
23334	090	N	Oct12	11	Shoulder Prosthesis Removal	P2	Jan13	06	ASSH, AAOS	18.89	18.89		<input checked="" type="checkbox"/>		<input type="checkbox"/>
23335	090	N	Oct12	11	Shoulder Prosthesis Removal	P3	Jan13	06	ASSH, AAOS	22.13	22.13		<input checked="" type="checkbox"/>		<input type="checkbox"/>
24160	090	R	Oct12	12	Elbow Prosthesis Removal	Q1	Jan13	07	ASSH, AAOS	18.63	18.63		<input checked="" type="checkbox"/>		<input type="checkbox"/>
24164	090	R	Oct12	12	Elbow Prosthesis Removal	Q2	Jan13	07	ASSH, AAOS	10.00	10.00		<input checked="" type="checkbox"/>		<input type="checkbox"/>
32201	000	D	Oct12	06	Drainage of Abscess		Jan13	04	ACR, SIR				<input checked="" type="checkbox"/>		<input type="checkbox"/>
33222	090	R	May12	5	Relocation of skin pocket for pacemaker or defibrillator		Editorial			5.10	5.10	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
33223	090	R	May12	5	Relocation of skin pocket for pacemaker or defibrillator		Editorial			6.55	6.55	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
33366	000	N	Feb13	51	Transcatheter Aortic Valve Replacement	BB1	Apr13	5	ACC, STS, SCAI	40.00	40.00		<input checked="" type="checkbox"/>	Reaffirm RUC recommendation from April 2012 RUC Meeting	<input type="checkbox"/>
34841	090	N	Feb13	52	Fenestrated Endovascular Repair	CC1	Apr13	6	SVS				<input checked="" type="checkbox"/>	Carrier Price	<input type="checkbox"/>
34842	090	N	Feb13	52	Fenestrated Endovascular Repair	CC2	Apr13	6	SVS				<input checked="" type="checkbox"/>	Carrier Price	<input type="checkbox"/>
34843	090	N	Feb13	52	Fenestrated Endovascular Repair	CC3	Apr13	6	SVS				<input checked="" type="checkbox"/>	Carrier Price	<input type="checkbox"/>

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
34844	090	N	Feb13	52	Fenestrated Endovascular Repair	CC4	Apr13	6	SVS				<input checked="" type="checkbox"/>	Carrier Price	<input type="checkbox"/>
34845	090	N	Feb13	52	Fenestrated Endovascular Repair	CC5	Apr13	6	SVS				<input checked="" type="checkbox"/>	Carrier Price	<input type="checkbox"/>
34846	090	N	Feb13	52	Fenestrated Endovascular Repair	CC6	Apr13	6	SVS				<input checked="" type="checkbox"/>	Carrier Price	<input type="checkbox"/>
34847	090	N	Feb13	52	Fenestrated Endovascular Repair	CC7	Apr13	6	SVS				<input checked="" type="checkbox"/>	Carrier Price	<input type="checkbox"/>
34848	090	N	Feb13	52	Fenestrated Endovascular Repair	CC8	Apr13	6	SVS				<input checked="" type="checkbox"/>	Carrier Price	<input type="checkbox"/>
37204	000	D	Feb13	09	Embolization and Occlusion Procedures	U2	Apr13	8	SVS, SIR, ACR				<input checked="" type="checkbox"/>	Referred to CPT Editorial Panel and deleted	<input type="checkbox"/>
37205	000	D	Feb13	10	Transcatheter Placement of Intravascular Stent		Apr13	9	ACC, ACR, SCAI, SVS, SIR				<input checked="" type="checkbox"/>		<input type="checkbox"/>
37206	ZZZ	D	Feb13	10	Transcatheter Placement of Intravascular Stent		Apr13	9	ACC, ACR, SCAI, SVS, SIR				<input checked="" type="checkbox"/>		<input type="checkbox"/>
37207	000	D	Feb13	10	Transcatheter Placement of Intravascular Stent		Apr13	9	ACC, ACR, SCAI, SVS, SIR				<input checked="" type="checkbox"/>		<input type="checkbox"/>
37208	ZZZ	D	Feb13	10	Transcatheter Placement of Intravascular Stent		Apr13	9	ACC, ACR, SCAI, SVS, SIR				<input checked="" type="checkbox"/>		<input type="checkbox"/>
37210	000	D	Feb13	09	Embolization and Occlusion Procedures		Apr13	8	SVS, SIR, ACR				<input checked="" type="checkbox"/>		<input type="checkbox"/>
37217	090	N	Feb13	11	Retrograde Treatment Open Carotid Stent	Y1	Apr13	7	SVS, AANS, CNS	22.00	22.00		<input checked="" type="checkbox"/>		<input type="checkbox"/>
37236	000	N	Feb13	10	Transcatheter Placement of Intravascular Stent	X1	Apr13	9	ACC, ACR, SCAI, SVS, SIR	9.00	9.00		<input checked="" type="checkbox"/>		<input type="checkbox"/>

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
37237	ZZZ	N	Feb13	10	Transcatheter Placement of Intravascular Stent	X2	Apr13	9	ACC, ACR, SCAI, SVS, SIR	4.25	4.25		<input checked="" type="checkbox"/>		<input type="checkbox"/>
37238	000	N	Feb13	10	Transcatheter Placement of Intravascular Stent	X3	Apr13	9	ACC, ACR, SCAI, SVS, SIR	6.29	6.29		<input checked="" type="checkbox"/>		<input type="checkbox"/>
37239	ZZZ	N	Feb13	10	Transcatheter Placement of Intravascular Stent	X4	Apr13	9	ACC, ACR, SCAI, SVS, SIR	3.34	3.34		<input checked="" type="checkbox"/>		<input type="checkbox"/>
37241	000	N	Feb13	09	Embolization and Occlusion Procedures	W1	Apr13	8	SVS, SIR, ACR	11.50	9.00		<input checked="" type="checkbox"/>		<input type="checkbox"/>
37242	000	N	Feb13	09	Embolization and Occlusion Procedures	W2	Apr13	8	SVS, SIR, ACR	11.98	11.98		<input checked="" type="checkbox"/>		<input type="checkbox"/>
37243	000	N	Feb13	09	Embolization and Occlusion Procedures	W3	Apr13	8	SVS, SIR, ACR	14.00	14.00		<input checked="" type="checkbox"/>		<input type="checkbox"/>
37244	000	N	Feb13	09	Embolization and Occlusion Procedures	W4	Apr13	8	SVS, SIR, ACR	14.00	14.00		<input checked="" type="checkbox"/>		<input type="checkbox"/>
42802	010	D	May12	08	Esophagoscopy		Oct12	10	AGA, ASGE				<input checked="" type="checkbox"/>		<input type="checkbox"/>
43191	000	N	May12	08	Esophagoscopy	C1	Oct12	10	AGA, ASGE	2.78	2.78		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43192	000	N	May12	08	Esophagoscopy	C2	Oct12	10	AGA, ASGE	3.21	3.21		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43193	000	N	May12	08	Esophagoscopy	C3	Oct12	10	AGA, ASGE	3.36	3.36		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43194	000	N	May12	08	Esophagoscopy	C4	Oct12	10	AGA, ASGE	3.99	3.99		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43195	000	N	May12	08	Esophagoscopy	C5	Oct12	10	AGA, ASGE	3.21	3.21		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43196	000	N	May12	08	Esophagoscopy	C6	Oct12	10	AGA, ASGE	3.36	3.36		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43197	000	N	May12	08	Esophagoscopy	C7	Oct12	10	AGA, ASGE	1.59	1.59		<input checked="" type="checkbox"/>		<input type="checkbox"/>

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
43198	000	N	May12	08	Esophagoscopy	C8	Oct12	10	AGA, ASGE	1.89	1.89		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43200	000	R	May12	08	Esophagoscopy	C9	Oct12	10	AGA, ASGE	1.59	1.59	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
43201	000	F	May12	08	Esophagoscopy	C11	Oct12	10	AGA, ASGE	2.09	1.90		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43202	000	F	May12	08	Esophagoscopy	C12	Oct12	10	AGA, ASGE	1.89	1.89	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
43204	000	F	May12	08	Esophagoscopy	C13	Oct12	10	AGA, ASGE	2.89	2.89		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43205	000	F	May12	08	Esophagoscopy	C14	Oct12	10	AGA, ASGE	3.00	3.00		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43206	000	F	May12	08	Esophagoscopy	C10	Oct12	10	AGA, ASGE	2.39	2.39		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43211	000	N	Oct12	14	Esophagoscopy	C25	Jan13	09	AGA, ASGE	4.58	4.58		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43212	000	N	Oct12	14	Esophagoscopy	C26	Jan13	09	AGA, ASGE	3.73	3.73		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43213	000	N	Oct12	14	Esophagoscopy	C27	Jan13	09	AGA, ASGE	5.00	5.00		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43214	000	N	Oct12	14	Esophagoscopy	C28	Jan13	09	AGA, ASGE	3.78	3.78		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43215	000	F	May12	08	Esophagoscopy	C15	Oct12	10	AGA, ASGE	2.60	2.60	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
43216	000	F	May12	08	Esophagoscopy	C16	Oct12	10	AGA, ASGE	2.40	2.40	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
43217	000	F	May12	08	Esophagoscopy	C17	Oct12	10	AGA, ASGE	2.90	2.90	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
43219	000	D	Oct12	14	Esophagoscopy		Jan13	09	AGA, ASGE				<input checked="" type="checkbox"/>		<input type="checkbox"/>
43220	000	F	May12	08	Esophagoscopy	C26	Oct12	10	AGA, ASGE	2.10	2.10	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
43226	000	F	May12	08	Esophagoscopy	C20	Oct12	10	AGA, ASGE	2.34	2.34	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
43227	000	F	May12	08	Esophagoscopy	C21	Oct12	10	AGA, ASGE	3.26	3.26		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43228	000	D	Oct12	14	Esophagoscopy		Jan13	09	AGA, ASGE				<input checked="" type="checkbox"/>		<input type="checkbox"/>

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
43229	000	N	Oct12	14	Esophagoscopy	C29	Jan13	09	AGA, ASGE	3.72	3.72		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43231	000	F	May12	08	Esophagoscopy	C23	Apr13	10	AGA, ASGE	3.19	3.19	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
43232	000	F	May12	08	Esophagoscopy	C24	Apr13	10	AGA, ASGE	3.83	3.83		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43233	000	N	Oct12	08	EGD	I16	Jan13	08	AGA, SAGES, ASGE	4.26	4.45		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43235	000	R	Oct12	08	EGD	I1	Jan13	08	AGA, SAGES, ASGE	2.39	2.26		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43236	000	F	Oct12	08	EGD	I2	Jan13	08	AGA, SAGES, ASGE	2.69	2.57		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43237	000	F	Feb13	12	EGD	I3	Apr13	11	AGA, SAGES, ASGE	3.85	3.85		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43238	000	F	Feb13	12	EGD	I4	Apr13	11	AGA, SAGES, ASGE	4.50	4.50		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43239	000	F	Oct12	08	EGD	I5	Jan13	08	AGA, SAGES, ASGE	2.69	2.56		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43240	000	R	Feb13	12	EGD	I6	Apr13	11	AGA, SAGES, ASGE	7.25	7.25		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43241	000	R	Oct12	08	EGD	I7	Jan13	08	AGA, SAGES, ASGE	2.59	2.59		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43242	000	R	Feb13	12	EGD	I8	Apr13	11	AGA, SAGES, ASGE	5.39	5.39		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43243	000	R	Oct12	08	EGD	I9	Jan13	08	AGA, SAGES, ASGE	4.37	4.37		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43244	000	R	Oct12	08	EGD	I10	Jan13	08	AGA, SAGES, ASGE	4.50	4.50		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43245	000	R	Oct12	08	EGD	I11	Jan13	08	AGA, SAGES, ASGE	3.18	3.18	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
43246	000	F	Feb13	12	EGD	I12	Apr13	11	AGA, SAGES, ASGE	4.32	4.32	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
43247	000	F	Oct12	08	EGD	I13	Jan13	08	AGA, SAGES, ASGE	3.38	3.27		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43248	000	R	Oct12	08	EGD	I14	Jan13	08	AGA, SAGES, ASGE	3.15	3.01		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43249	000	R	Oct12	08	EGD	I15	Jan13	08	AGA, SAGES, ASGE	2.90	2.77		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43250	000	F	Oct12	08	EGD	I17	Jan13	08	AGA, SAGES, ASGE	3.20	3.07		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43251	000	F	Feb13	12	EGD	I18	Apr13	11	AGA, SAGES, ASGE	3.57	3.57		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43252	000	F	Oct12	08	EGD	I19	Jan13	08	AGA, SAGES, ASGE	3.19	3.06		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43253	000	N	Feb13	12	EGD	I20	Apr13	11	AGA, SAGES, ASGE	5.39	5.39		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43254	000	N	Oct12	08	EGD	I21	Jan13	08	AGA, SAGES, ASGE	5.42	5.25		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43255	000	F	Oct12	08	EGD	I22	Jan13	08	AGA, SAGES, ASGE	4.20	4.20		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43256	000	D	Oct12	08	EGD		Jan13	08	AGA, SAGES, ASGE				<input checked="" type="checkbox"/>		<input type="checkbox"/>
43257	000	F	Oct12	08	EGD	I24	Jan13	08	AGA, SAGES, ASGE	4.25	4.25		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43258	000	D	Oct12	08	EGD		Jan13	08	AGA, SAGES, ASGE				<input checked="" type="checkbox"/>		<input type="checkbox"/>
43259	000	R	Feb13	12	EGD	I26	Apr13	11	AGA, SAGES, ASGE	4.74	4.74		<input checked="" type="checkbox"/>		<input type="checkbox"/>

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
43260	000	R	Feb13	13	ERCP	EE1	Apr13	12	AGA, ASGE, ACG	5.95	5.95	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
43261	000	F	Feb13	13	ERCP	EE2	Apr13	12	AGA, ASGE, ACG	6.25	6.25		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43262	000	F	Feb13	13	ERCP	EE3	Apr13	12	AGA, ASGE, ACG	6.60	6.60		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43263	000	R	Feb13	13	ERCP	EE4	Apr13	12	AGA, ASGE, ACG	7.28	7.28	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
43264	000	R	Feb13	13	ERCP	EE5	Apr13	12	AGA, ASGE, ACG	6.73	6.73		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43265	000	R	Feb13	13	ERCP	EE6	Apr13	12	AGA, ASGE, ACG	8.03	8.03		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43266	000	N	Oct12	08	EGD	I23	Jan13	08	AGA, SAGES, ASGE	4.34	4.40		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43267	000	D	Feb13	13	ERCP		Apr13	12	AGA, ASGE, ACG				<input checked="" type="checkbox"/>		<input type="checkbox"/>
43268	000	D	Feb13	13	ERCP		Apr13	12	AGA, ASGE, ACG				<input checked="" type="checkbox"/>		<input type="checkbox"/>
43269	000	D	Feb13	13	ERCP		Apr13	12	AGA, ASGE, ACG				<input checked="" type="checkbox"/>		<input type="checkbox"/>
43270	000	N	Oct12	08	EGD	I25	Jan13	08	AGA, SAGES, ASGE	5.05	4.39		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43271	000	D	Feb13	13	ERCP		Apr13	12	AGA, ASGE, ACG				<input checked="" type="checkbox"/>		<input type="checkbox"/>
43272	000	D	Feb13	13	ERCP		Apr13	12	AGA, ASGE, ACG				<input checked="" type="checkbox"/>		<input type="checkbox"/>
43273	000	R	Feb13	13	ERCP	EE12	Apr13	12	AGA, ASGE, ACG	2.24	2.24	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>



CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
43274	000	N	Feb13	13	ERCP	EE7	Apr13	12	AGA, ASGE, ACG	8.74	8.74		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43275	000	N	Feb13	13	ERCP	EE8	Apr13	12	AGA, ASGE, ACG	6.96	6.96		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43276	000	N	Feb13	13	ERCP	EE9	Apr13	12	AGA, ASGE, ACG	9.10	9.10		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43277	000	N	Feb13	13	ERCP	EE10	Apr13	12	AGA, ASGE, ACG	7.11	7.11		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43278	000	N	Feb13	13	ERCP	EE11	Apr13	12	AGA, ASGE, ACG	8.08	8.08		<input checked="" type="checkbox"/>		<input type="checkbox"/>
43456	000	D	Oct12	08	EGD		Jan13	08	AGA, SAGES, ASGE				<input checked="" type="checkbox"/>		<input type="checkbox"/>
43458	000	D	Oct12	08	EGD		Jan13	08	AGA, SAGES, ASGE				<input checked="" type="checkbox"/>		<input type="checkbox"/>
44901	000	D	Oct12	06	Drainage of Abscess		Jan13	04	ACR, SIR				<input checked="" type="checkbox"/>		<input type="checkbox"/>
47011	000	D	Oct12	06	Drainage of Abscess		Jan13	04	ACR, SIR				<input checked="" type="checkbox"/>		<input type="checkbox"/>
47552	000	R	Feb13	13	Biliary endoscopy		Editorial			6.03	6.03	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
48511	000	D	Oct12	06	Drainage of Abscess		Jan13	04	ACR, SIR				<input checked="" type="checkbox"/>		<input type="checkbox"/>
49021	000	D	Oct12	06	Drainage of Abscess		Jan13	04	ACR, SIR				<input checked="" type="checkbox"/>		<input type="checkbox"/>
49041	000	D	Oct12	06	Drainage of Abscess		Jan13	04	ACR, SIR				<input checked="" type="checkbox"/>		<input type="checkbox"/>
49061	000	D	Oct12	06	Drainage of Abscess		Jan13	04	ACR, SIR				<input checked="" type="checkbox"/>		<input type="checkbox"/>
49405	000	N	Oct12	06	Drainage of Abscess	N2	Jan13	04	ACR, SIR	4.28	4.25		<input checked="" type="checkbox"/>		<input type="checkbox"/>
49406	000	N	Oct12	06	Drainage of Abscess	N3	Jan13	04	ACR, SIR	4.28	4.25		<input checked="" type="checkbox"/>		<input type="checkbox"/>
49407	000	N	Oct12	06	Drainage of Abscess	N4	Jan13	04	ACR, SIR	4.50	4.50		<input checked="" type="checkbox"/>		<input type="checkbox"/>
50021	000	D	Oct12	06	Drainage of Abscess		Jan13	04	ACR, SIR				<input checked="" type="checkbox"/>		<input type="checkbox"/>

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
52332	000	F	Feb13	15	Cystourethroscopy	Z1	Apr13	15	AUA	2.82	2.82	Yes	<input checked="" type="checkbox"/>	Reaffirm RUC recommendation from Sept 2011 meeting	<input type="checkbox"/>
52353	000	F	Feb13	15	Cystourethroscopy	Z2	Apr13	15	AUA	7.50	7.50	Yes	<input checked="" type="checkbox"/>	Reaffirm RUC recommendation from Sept. 2011 meeting	<input type="checkbox"/>
52356	000	N	Feb13	15	Cystourethroscopy	Z3	Apr13	15	AUA	8.00	8.00		<input checked="" type="checkbox"/>		<input type="checkbox"/>
58823	000	D	Oct12	06	Drainage of Abscess		Jan13	04	ACR, SIR				<input checked="" type="checkbox"/>		<input type="checkbox"/>
64612	010	F	Oct12	49	Chemodenervation of Neck Muscles	S1	Jan13	11	AAN, AANEM, AAO-HNS	1.41	1.41	Yes	<input checked="" type="checkbox"/>	Reaffirm RUC recommendation from April 2012 meeting	<input type="checkbox"/>
64613	010	D	Oct12	49	Chemodenervation of Neck Muscles		Jan13	11	AAN, AANEM				<input checked="" type="checkbox"/>		<input type="checkbox"/>
64614	010	D	Oct12	17	Chemodenervation of Extremity and Trunk Muscles		Jan13	10	AAN, AAPMR, AANEM				<input checked="" type="checkbox"/>		<input type="checkbox"/>
64615	010	F	Oct12	17	Chemodenervation of Extremity and Trunk Muscles	R1	Jan13	10	AAN, AAPMR, AANEM	1.85	1.85	Yes	<input checked="" type="checkbox"/>	Reaffirm RUC recommendation from April 2012 meeting	<input type="checkbox"/>
64616	000	N	Oct12	49	Chemodenervation of Neck Muscles	S2	Jan13	11	AAN, AANEM	1.79	1.79		<input checked="" type="checkbox"/>		<input type="checkbox"/>
64617	000	N	Oct12	49	Chemodenervation of Neck Muscles	S3	Jan13	11	AAO-HNS	2.19	2.06		<input checked="" type="checkbox"/>		<input type="checkbox"/>
64642	010	N	Oct12	17	Chemodenervation of Extremity and Trunk Muscles	R2	Jan13	10	AAN, AAPMR, AANEM	1.85	1.65		<input checked="" type="checkbox"/>		<input type="checkbox"/>
64643	ZZZ	N	Oct12	17	Chemodenervation of Extremity and Trunk Muscles	R3	Jan13	10	AAN, AAPMR, AANEM	1.43	1.32		<input checked="" type="checkbox"/>		<input type="checkbox"/>
64644	000	N	Oct12	17	Chemodenervation of Extremity and Trunk Muscles	R4	Jan13	10	AAN, AAPMR, AANEM	2.20	1.82		<input checked="" type="checkbox"/>		<input type="checkbox"/>
64645	ZZZ	N	Oct12	17	Chemodenervation of Extremity and Trunk Muscles	R5	Jan13	10	AAN, AAPMR, AANEM	1.70	1.52		<input checked="" type="checkbox"/>		<input type="checkbox"/>

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
64646	000	N	Oct12	17	Chemodenervation of Extremity and Trunk Muscles	R6	Jan13	10	AAN, AAPMR, AANEM	1.80	1.80		<input checked="" type="checkbox"/>		<input type="checkbox"/>
64647	000	N	Oct12	17	Chemodenervation of Extremity and Trunk Muscles	R7	Jan13	10	AAO, AAN, AAPMR, ASIPP	2.11	2.11		<input checked="" type="checkbox"/>		<input type="checkbox"/>
65778	010	R	Oct12	52	Amniotic Membrane Placement		Editorial			1.19	1.19	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
65779	010	R	Oct12	52	Amniotic Membrane Placement		Editorial			3.92	3.92	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
66183	000	N	Oct12	18	Insertion of Anterior Segment Device	J1	Apr13	14	AAO	13.20	13.20		<input checked="" type="checkbox"/>		<input type="checkbox"/>
69210	000	R	Oct12	19	Removal of Cerumen	L1	Jan13	13	AAFP, AAO-HNS	0.58	0.58		<input checked="" type="checkbox"/>		<input type="checkbox"/>
72040	XXX	R	Feb13	EC-G	X-ray of cervical spine		Editorial			0.22	0.22	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
75894	XXX	F	Oct12	30	Percutaneous Closure Patent Ductus Arteriosus	U3	Jan13	16	ACC, SCAI	1.31	1.31	Yes	<input checked="" type="checkbox"/>	Referred to CPT Editorial Panel; new bundled codes created	<input type="checkbox"/>
75960	XXX	D	Feb13	10\11	Transcatheter Placement of Intravascular Stent		Apr13	7/9	ACC, ACR, SCAI, SVS, SIR				<input checked="" type="checkbox"/>		<input type="checkbox"/>
77031	XXX	D	Oct12	08	Breast Biopsy		Apr13	4	ACR, ACS, ASBS				<input checked="" type="checkbox"/>		<input type="checkbox"/>
77032	XXX	D	Oct12	08	Breast Biopsy		Apr13	4	ACR, ACS, ASBS				<input checked="" type="checkbox"/>		<input type="checkbox"/>
77280	XXX	F	Oct12	22	Respiratory Motion Management Simulation	T1	Jan13	14	ASTRO	0.70	0.70	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
77285	XXX	F	Oct12	22	Respiratory Motion Management Simulation	T2	Jan13	14	ASTRO	1.05	1.05	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
77290	XXX	F	Oct12	22	Respiratory Motion Management Simulation	T3	Jan13	14	ASTRO	1.56	1.56	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
77293	ZZZ	N	Oct12	22	Respiratory Motion Management Simulation	T4	Jan13	14	ASTRO	2.00	2.00		<input checked="" type="checkbox"/>		<input type="checkbox"/>

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
77295	XXX	R	Oct12	22	Respiratory Motion Management Simulation	T5	Jan13	14	ASTRO	4.29	4.29		<input checked="" type="checkbox"/>		<input type="checkbox"/>
81161	XXX	N	May12	16	Molecular Pathology-Tier 1	D1	Oct12	11	CAP	1.85	1.85		<input checked="" type="checkbox"/>		<input type="checkbox"/>
81287	XXX	N	May13	37	Molecular Pathology-Tier 1-MGMT		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
81371	XXX	R	Feb13	28	Molecular Pathology-Tier 1		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
81376	XXX	R	Feb13	28	Molecular Pathology-Tier 1		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
81382	XXX	R	Feb13	28	Molecular Pathology-Tier 1		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
81400	XXX	R	Feb13	30	Molecular Pathology Workgroup-Tier 2		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
81401	XXX	R	Feb13	30	Molecular Pathology Workgroup-Tier 2		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
81402	XXX	R	Feb13	32	Molecular Pathology Workgroup-Tier 2		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
81403	XXX	R	Feb13	30	Molecular Pathology Workgroup-Tier 2		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
81404	XXX	R	Feb13	31	Molecular Pathology Workgroup-Tier 2		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
81405	XXX	R	Feb13	31	Molecular Pathology Workgroup-Tier 2		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
81406	XXX	R	Feb13	31	Molecular Pathology Workgroup-Tier 2		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
81407	XXX	R	Feb13	31	Molecular Pathology Workgroup-Tier 2		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
81408	XXX	R	Feb13	31	Molecular Pathology Workgroup-Tier 2		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
81504	XXX	N	Feb13	39	MAAA		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
81507	XXX	N	Feb13	42	MAAA-Fetal Aneuploidy		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
84112	XXX	R	Feb13	43	PAMG-1		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
87470		R	May13	16	Reverse Transcription		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
87498		R	May13	16	Reverse Transcription		CLFS						<input type="checkbox"/>		<input type="checkbox"/>

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
87521		R	May13	16	Reverse Transcription		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
87522		R	May13	16	Reverse Transcription		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
87535		R	May13	16	Reverse Transcription		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
87536		R	May13	16	Reverse Transcription		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
87538		R	May13	16	Reverse Transcription		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
87539		R	May13	16	Reverse Transcription		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
87661	XXX	N	Oct12	27	Trichomonas Vaginalis		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
88342	XXX	R	May12	21	Immunohistochemistry	B1	Oct12	12	CAP	0.60	0.60		<input checked="" type="checkbox"/>		<input type="checkbox"/>
88343	XXX	N	May12	21	Immunohistochemistry	B2	Oct12	12	CAP	0.24	0.24		<input checked="" type="checkbox"/>		<input type="checkbox"/>
88375	XXX	F	Feb12	23	Optical Endomicroscopy	NN39	Jan13	15	CAP	1.08	1.08		<input checked="" type="checkbox"/>		<input type="checkbox"/>
90673	XXX	N	May13	25	Influenza Vaccine		Vaccine						<input type="checkbox"/>		<input type="checkbox"/>
90685	XXX	N	May12	24	Influenza Vaccine Quadrivalent		Vaccine						<input type="checkbox"/>		<input type="checkbox"/>
90686	XXX	N	May12	24	Influenza Vaccine Quadrivalent		Vaccine						<input type="checkbox"/>		<input type="checkbox"/>
90687	XXX	N	May12	24	Influenza Vaccine Quadrivalent		Vaccine						<input type="checkbox"/>		<input type="checkbox"/>
90688	XXX	N	May12	24	Influenza Vaccine Quadrivalent		Vaccine						<input type="checkbox"/>		<input type="checkbox"/>
91065	000	R	May12	47	Breath Hydrogen Methane Test	H1	Oct12	15	AGA, ASGE				<input checked="" type="checkbox"/>	PE Inputs Recommendations Only	<input type="checkbox"/>
93582	000	N	Oct12	30	Percutaneous Closure Patent Ductus Arteriosus	U1	Jan13	16	ACC, SCAI	14.00	14.00		<input checked="" type="checkbox"/>		<input type="checkbox"/>
93583	000	N	Oct12	31	Percutaneous Alcohol Ablation of Septum	V1	Jan13	17	ACC, SCAI	18.00	14.00		<input checked="" type="checkbox"/>		<input type="checkbox"/>

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
93653	000	R	May13	26	Intracardiac Electrophysiological Ablation Procedure		Editorial			15.00	15.00	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
94667	XXX	F	Feb13	21	Mechanical Chest Wall Oscillations	AA1	Apr13	15	ATS, ACCP			Yes	<input checked="" type="checkbox"/>	PE Inputs Recommendations Only	<input type="checkbox"/>
94668	XXX	F	Feb13	21	Mechanical Chest Wall Oscillations	AA2	Apr13	15	ATS, ACCP			Yes	<input checked="" type="checkbox"/>	PE Inputs Recommendations Only	<input type="checkbox"/>
94669	XXX	N	Feb13	21	Mechanical Chest Wall Oscillations	AA3	Apr13	15	ATS, ACCP				<input checked="" type="checkbox"/>	PE Inputs Recommendations Only	<input type="checkbox"/>
97610	XXX	N	Feb13	54	Ultrasonic Wound Assessment		Apr13	16	APTA(HCP AC), APMA, ASGS				<input checked="" type="checkbox"/>	Carrier Price/Referral to CPT Panel	<input type="checkbox"/>
99170	000	R	May12	22	Anogenital Exam Colposcopy	A1	Oct12	13	AAP				<input checked="" type="checkbox"/>	PE Inputs Recommendations Only	<input type="checkbox"/>
99446	XXX	N	May12	41	Interprofessional Telephone Consultative Services	E1	Oct12	14	AAP, AAN, AACE, ACRh, TES	0.35	0.35		<input checked="" type="checkbox"/>		<input type="checkbox"/>
99447	XXX	N	May12	41	Interprofessional Telephone Consultative Services	E2	Oct12	14	AAP, AAN, AACE, ACRh, TES	0.70	0.70		<input checked="" type="checkbox"/>		<input type="checkbox"/>
99448	XXX	N	May12	41	Interprofessional Telephone Consultative Services	E3	Oct12	14	AAP, AAN, AACE, ACRh, TES	1.05	1.05		<input checked="" type="checkbox"/>		<input type="checkbox"/>
99449	XXX	N	May12	41	Interprofessional Telephone Consultative Services	E4	Oct12	14	AAP, AAN, AACE, ACRh, TES	1.40	1.40		<input checked="" type="checkbox"/>		<input type="checkbox"/>
99481	ZZZ	N	Oct12	38	Total Body and Selective Head Hypothermia	K1	Jan13	18	AAP				<input checked="" type="checkbox"/>	Carrier Price/Referral to CPT Panel	<input type="checkbox"/>
99482	ZZZ	N	Oct12	38	Total Body and Selective Head Hypothermia	K2	Jan13	18	AAP				<input checked="" type="checkbox"/>	Carrier Price/Referral to CPT Panel	<input type="checkbox"/>

## *CPT 2013 HCPAC Recommendations*

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	HCPAC Date	HCPAC Tab	S.S.	Specialty	HCPAC Rec	Same RVU as last year?	MFS?	Comments
92506	XXX	D	Oct12	28	Speech Evaluation		HCPAC	32	ASHA				<input checked="" type="checkbox"/>	HCPAC
92521	XXX	N	Oct12	28	Speech Evaluation	M1	HCPAC	32	ASHA	1.75	1.75		<input checked="" type="checkbox"/>	HCPAC
92522	XXX	N	Oct12	28	Speech Evaluation	M2	HCPAC	32	ASHA	1.5	1.5		<input checked="" type="checkbox"/>	HCPAC
92523	XXX	N	Oct12	28	Speech Evaluation	M3	HCPAC	32	ASHA	3.72	3.36		<input checked="" type="checkbox"/>	HCPAC
92524	XXX	N	Oct12	28	Speech Evaluation	M4	HCPAC	32	ASHA	1.75	1.75		<input checked="" type="checkbox"/>	HCPAC

# Status Report: CMS Requests and Relativity Assessment Issues

**01930** Anesthesia for therapeutic interventional radiological procedures involving the venous/lymphatic system (not to include access to the central circulation); not otherwise specified **Global:** XXX **Issue:** Anesthesia for Interventional Radiology **Screen:** High Volume Growth1 **Complete?** Yes

**Most Recent** **Tab** S **Specialty Developing Recommendation:** ASA

**RUC Meeting:** February 2008

**First Identified:** February 2008

**2012 Est Medicare Utilization:** 21,075

**2007 Work RVU:** 0.00 **2013 Work RVU:** 0.00

**2007 NF PE RVU:** 0 **2013 NF PE RVU:** 0.00

**2007 Fac PE RVU:** 0 **2013 Fac PE RVU:** 0.00

**RUC Recommendation:** Remove from screen

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Remove from Screen

**10022** Fine needle aspiration; with imaging guidance

**Global:** XXX **Issue:** Fine Needle Aspiration

**Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent** **Tab** 38 **Specialty Developing Recommendation:** ACR, SIR, CAP, ACR, ASC

**RUC Meeting:** February 2009

**First Identified:** October 2008

**2012 Est Medicare Utilization:** 178,250

**2007 Work RVU:** 1.27 **2013 Work RVU:** 1.27

**2007 NF PE RVU:** 2.41 **2013 NF PE RVU:** 2.74

**2007 Fac PE RVU:** 0.40 **2013 Fac PE RVU:** 0.49

**RUC Recommendation:** Remove from screen

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Remove from Screen

**10060** Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single

**Global:** 010 **Issue:** Incision and Drainage of Abscess

**Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent** **Tab** 07 **Specialty Developing Recommendation:** APMA

**RUC Meeting:** October 2010

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 503,463

**2007 Work RVU:** 1.19 **2013 Work RVU:** 1.22

**2007 NF PE RVU:** 1.29 **2013 NF PE RVU:** 2.13

**2007 Fac PE RVU:** 0.97 **2013 Fac PE RVU:** 1.53

**RUC Recommendation:** 1.50

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Increase



## Status Report: CMS Requests and Relativity Assessment Issues

**10061** Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple **Global:** 010 **Issue:** Incision and Drainage of Abscess **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** October 2010

**Tab 07** **Specialty Developing Recommendation:** APMA

**First Identified:** October 2009

**2012 Est Medicare Utilization:** 186,531

**2007 Work RVU:** 2.42

**2013 Work RVU:** 2.45

**2007 NF PE RVU:** 1.89

**2013 NF PE RVU:** 3.37

**2007 Fac PE RVU** 1.51

**2013 Fac PE RVU:** 2.58

**RUC Recommendation:** 2.45

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Maintain

**100XX1**

**Global:** **Issue:** Drainage of Abscess

**Screen:** Codes Reported Together 75% or More-Part2

**Complete?** Yes

**Most Recent RUC Meeting:** January 2013

**Tab 04** **Specialty Developing Recommendation:** ACR, SIR

**First Identified:** January 2012

**2012 Est Medicare Utilization:**

**2007 Work RVU:**

**2013 Work RVU:**

**2007 NF PE RVU:**

**2013 NF PE RVU:**

**2007 Fac PE RVU**

**2013 Fac PE RVU:**

**RUC Recommendation:** 3.00

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

October 2012

**Result:** Decrease

**10120** Incision and removal of foreign body, subcutaneous tissues; simple

**Global:** 010 **Issue:**

**Screen:** Harvard Valued - Utilization over 30,000

**Complete?** Yes

**Most Recent RUC Meeting:** September 2011

**Tab 12** **Specialty Developing Recommendation:** APMA, AAFP

**First Identified:** April 2011

**2012 Est Medicare Utilization:** 43,167

**2007 Work RVU:** 1.23

**2013 Work RVU:** 1.22

**2007 NF PE RVU:** 2.12

**2013 NF PE RVU:** 3.21

**2007 Fac PE RVU** 0.97

**2013 Fac PE RVU:** 1.72

**RUC Recommendation:** 1.25

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Maintain

# Status Report: CMS Requests and Relativity Assessment Issues

10180	Incision and drainage, complex, postoperative wound infection			Global:	010	Issue:		Screen:	RUC identified when reviewing comparison codes	Complete?	No
Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:		First Identified:	January 2013	2012 Est Medicare Utilization:	13,203	2007 Work RVU:	2.27	2013 Work RVU:	2.30
								2007 NF PE RVU:	3.06	2013 NF PE RVU:	4.66
								2007 Fac PE RVU	1.94	2013 Fac PE RVU:	2.57
RUC Recommendation:	Review at RAW			CPT Action (if applicable):		Published in CPT Asst:		Result:			
				Referred to CPT Asst	<input type="checkbox"/>						
11040	Deleted from CPT			Global:	000	Issue:	Excision and Debridement	Screen:	Site of Service Anomaly	Complete?	Yes
Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:	APMA, APTA	First Identified:	September 2007	2012 Est Medicare Utilization:		2007 Work RVU:	0.50	2013 Work RVU:	
								2007 NF PE RVU:	0.56	2013 NF PE RVU:	
								2007 Fac PE RVU	0.20	2013 Fac PE RVU:	
RUC Recommendation:	Deleted from CPT			CPT Action (if applicable):		October 2009		Result:	Deleted from CPT		
				Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:					
11041	Deleted from CPT			Global:	000	Issue:	Excision and Debridement	Screen:	Site of Service Anomaly	Complete?	Yes
Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:	APMA, APTA	First Identified:	September 2007	2012 Est Medicare Utilization:		2007 Work RVU:	0.60	2013 Work RVU:	
								2007 NF PE RVU:	0.68	2013 NF PE RVU:	
								2007 Fac PE RVU	0.30	2013 Fac PE RVU:	
RUC Recommendation:	Deleted from CPT			CPT Action (if applicable):		October 2009		Result:	Deleted from CPT		
				Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:					
11042	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less			Global:	000	Issue:	Excision and Debridement	Screen:	Site of Service Anomaly	Complete?	Yes
Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:	APMA, APTA	First Identified:	September 2007	2012 Est Medicare Utilization:	1,383,269	2007 Work RVU:	0.80	2013 Work RVU:	1.01
								2007 NF PE RVU:	0.97	2013 NF PE RVU:	2.39
								2007 Fac PE RVU	0.39	2013 Fac PE RVU:	0.69
RUC Recommendation:	1.12			CPT Action (if applicable):		October 2009		Result:	Increase		
				Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:					

## Status Report: CMS Requests and Relativity Assessment Issues

---

<b>11043</b>	<b>Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less</b>	<b>Global:</b> 000	<b>Issue:</b> Debridement	<b>Screen:</b> Site of Service Anomaly	<b>Complete?</b> Yes
--------------	--	--------------------	---------------------------	--	----------------------

**Most Recent RUC Meeting:** February 2010

**Tab 04 Specialty Developing Recommendation:** APMA, APTA

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 202,552

**2007 Work RVU:** 3.04

**2013 Work RVU:** 2.70

**2007 NF PE RVU:** 3.45

**2013 NF PE RVU:** 3.74

**2007 Fac PE RVU** 2.62

**2013 Fac PE RVU:** 1.49

**Result:** Decrease

**RUC Recommendation:** 3.00

**CPT Action (if applicable):** October 2009

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

---

<b>11044</b>	<b>Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less</b>	<b>Global:</b> 000	<b>Issue:</b> Debridement	<b>Screen:</b> Site of Service Anomaly	<b>Complete?</b> Yes
--------------	--	--------------------	---------------------------	--	----------------------

**Most Recent RUC Meeting:** February 2010

**Tab 04 Specialty Developing Recommendation:** APMA, APTA

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 56,197

**2007 Work RVU:** 4.11

**2013 Work RVU:** 4.10

**2007 NF PE RVU:** 4.58

**2013 NF PE RVU:** 4.66

**2007 Fac PE RVU** 3.73

**2013 Fac PE RVU:** 2.08

**Result:** Increase

**RUC Recommendation:** 4.56

**CPT Action (if applicable):** October 2009

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

---

<b>11045</b>	<b>Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)</b>	<b>Global:</b> ZZZ	<b>Issue:</b> Excision and Debridement	<b>Screen:</b> Site of Service Anomaly	<b>Complete?</b> Yes
--------------	--	--------------------	--	--	----------------------

**Most Recent RUC Meeting:** February 2010

**Tab 04 Specialty Developing Recommendation:** ACS, APMA, APTA

**First Identified:**

**2012 Est Medicare Utilization:** 228,260

**2007 Work RVU:**

**2013 Work RVU:** 0.50

**2007 NF PE RVU:**

**2013 NF PE RVU:** 0.65

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 0.20

**Result:** Increase

**RUC Recommendation:** 0.69

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**11046** Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Debridement **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** February 2010

**Tab** 04

**Specialty Developing Recommendation:** ACS, APMA, APTA

**First Identified:**

**2012 Est Medicare Utilization:** 85,336

**2007 Work RVU:**

**2013 Work RVU:** 1.03

**2007 NF PE RVU:**

**2013 NF PE RVU:** 0.97

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 0.44

**Result:** Decrease

**RUC Recommendation:** 1.29

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**11047** Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Debridement **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** February 2010

**Tab** 04

**Specialty Developing Recommendation:** ACS, APMA, APTA

**First Identified:**

**2012 Est Medicare Utilization:** 20,568

**2007 Work RVU:**

**2013 Work RVU:** 1.80

**2007 NF PE RVU:**

**2013 NF PE RVU:** 1.55

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 0.79

**Result:** Increase

**RUC Recommendation:** 2.00

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**11055** Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion **Global:** 000 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes **Complete?** Yes

**Most Recent RUC Meeting:** January 2012

**Tab** 30

**Specialty Developing Recommendation:**

**First Identified:** November 2011

**2012 Est Medicare Utilization:** 868,700

**2007 Work RVU:** 0.43

**2013 Work RVU:** 0.35

**2007 NF PE RVU:** 0.63

**2013 NF PE RVU:** 1.05

**2007 Fac PE RVU** 0.16

**2013 Fac PE RVU:** 0.09

**Result:** Maintain

**RUC Recommendation:** Maintain

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

<b>11056</b>	<b>Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions</b>	<b>Global:</b> 000	<b>Issue:</b> Trim Skin Lesions	<b>Screen:</b> MPC List / CMS Request to Re-Review Families of Recently Reviewed CPT Codes	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2012	<b>Tab</b> 53 <b>Specialty Developing Recommendation:</b> APMA	<b>First Identified:</b> October 2010	<b>2012 Est Medicare Utilization:</b> 1,854,986	<b>2007 Work RVU:</b> 0.61 <b>2007 NF PE RVU:</b> 0.7 <b>2007 Fac PE RVU Result:</b> Decrease	<b>2013 Work RVU:</b> 0.50 <b>2013 NF PE RVU:</b> 1.20 <b>2013 Fac PE RVU:</b> 0.13
<b>RUC Recommendation:</b> 0.50		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		
<hr/>					
<b>11057</b>	<b>Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); more than 4 lesions</b>	<b>Global:</b> 000	<b>Issue:</b> RAW Review	<b>Screen:</b> CMS Request to Re-Review Families of Recently Reviewed CPT Codes	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2012	<b>Tab</b> 30 <b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> November 2011	<b>2012 Est Medicare Utilization:</b> 363,847	<b>2007 Work RVU:</b> 0.79 <b>2007 NF PE RVU:</b> 0.81 <b>2007 Fac PE RVU Result:</b> Maintain	<b>2013 Work RVU:</b> 0.65 <b>2013 NF PE RVU:</b> 1.25 <b>2013 Fac PE RVU:</b> 0.17
<b>RUC Recommendation:</b> Maintain		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		
<hr/>					
<b>11100</b>	<b>Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion</b>	<b>Global:</b> 000	<b>Issue:</b>	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2011	<b>Tab</b> 41 <b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> October 2010	<b>2012 Est Medicare Utilization:</b> 3,021,942	<b>2007 Work RVU:</b> 0.81 <b>2007 NF PE RVU:</b> 1.41 <b>2007 Fac PE RVU Result:</b> Maintain	<b>2013 Work RVU:</b> 0.81 <b>2013 NF PE RVU:</b> 2.21 <b>2013 Fac PE RVU:</b> 0.52
<b>RUC Recommendation:</b> Reaffirmed RUC recommendation		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

## Status Report: CMS Requests and Relativity Assessment Issues

**11101** Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; each separate/additional lesion (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** **Screen:** Low Value Billed in Multiple Units **Complete?** Yes

**Most Recent RUC Meeting:** February 2011

**Tab** 41

**Specialty Developing Recommendation:**

**First Identified:** October 2010

**2012 Est Medicare Utilization:** 1,321,887

**2007 Work RVU:** 0.41

**2013 Work RVU:** 0.41

**2007 NF PE RVU:** 0.35

**2013 NF PE RVU:** 0.50

**2007 Fac PE RVU** 0.20

**2013 Fac PE RVU:** 0.27

**Result:** Maintain

**RUC Recommendation:** Reaffirmed RUC recommendation

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**11300** Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less

**Global:** 000

**Issue:** Shaving of Epidermal or Dermal Lesions

**Screen:** CMS High Expenditure Procedural Codes

**Complete?** Yes

**Most Recent RUC Meeting:** April 2012

**Tab** 38

**Specialty Developing Recommendation:** AAD

**First Identified:** January 2012

**2012 Est Medicare Utilization:** 90,371

**2007 Work RVU:** 0.51

**2013 Work RVU:** 0.60

**2007 NF PE RVU:** 1.04

**2013 NF PE RVU:** 2.27

**2007 Fac PE RVU** 0.21

**2013 Fac PE RVU:** 0.35

**Result:** Increase

**RUC Recommendation:** 0.60

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**11301** Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm

**Global:** 000

**Issue:** Shaving of Epidermal or Dermal Lesions

**Screen:** CMS High Expenditure Procedural Codes

**Complete?** Yes

**Most Recent RUC Meeting:** April 2012

**Tab** 38

**Specialty Developing Recommendation:** AAD

**First Identified:** January 2012

**2012 Est Medicare Utilization:** 179,738

**2007 Work RVU:** 0.85

**2013 Work RVU:** 0.90

**2007 NF PE RVU:** 1.21

**2013 NF PE RVU:** 2.60

**2007 Fac PE RVU** 0.38

**2013 Fac PE RVU:** 0.56

**Result:** Increase

**RUC Recommendation:** 0.90

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**11302** Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm **Global:** 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

**Most Recent** **Tab** 38 **Specialty Developing** AAD  
**RUC Meeting:** April 2012 **Recommendation:**

**First**  
**Identified:** January 2012

**2012 Est**  
**Medicare**  
**Utilization:** 109,498

**2007 Work RVU:** 1.05 **2013 Work RVU:** 1.05  
**2007 NF PE RVU:** 1.42 **2013 NF PE RVU:** 3.08  
**2007 Fac PE RVU** 0.47 **2013 Fac PE RVU:** 0.66  
**Result:** Increase

**RUC Recommendation:** 1.16

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**11303** Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm **Global:** 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

**Most Recent** **Tab** 38 **Specialty Developing** AAD  
**RUC Meeting:** April 2012 **Recommendation:**

**First**  
**Identified:** January 2012

**2012 Est**  
**Medicare**  
**Utilization:** 16,494

**2007 Work RVU:** 1.24 **2013 Work RVU:** 1.25  
**2007 NF PE RVU:** 1.69 **2013 NF PE RVU:** 3.27  
**2007 Fac PE RVU** 0.53 **2013 Fac PE RVU:** 0.77  
**Result:** Increase

**RUC Recommendation:** 1.25

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**11305** Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less **Global:** 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

**Most Recent** **Tab** 38 **Specialty Developing** AAD  
**RUC Meeting:** April 2012 **Recommendation:**

**First**  
**Identified:** January 2012

**2012 Est**  
**Medicare**  
**Utilization:** 104,075

**2007 Work RVU:** 0.67 **2013 Work RVU:** 0.80  
**2007 NF PE RVU:** 0.91 **2013 NF PE RVU:** 2.09  
**2007 Fac PE RVU** 0.26 **2013 Fac PE RVU:** 0.27  
**Result:** Increase

**RUC Recommendation:** 0.80

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**11306** Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm **Global:** 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

**Most Recent** **Tab** 38 **Specialty Developing** AAD  
**RUC Meeting:** April 2012 **Recommendation:**

**First**  
**Identified:** January 2012

**2012 Est**  
**Medicare**  
**Utilization:** 97,867

**2007 Work RVU:** 0.99 **2013 Work RVU:** 0.96  
**2007 NF PE RVU:** 1.18 **2013 NF PE RVU:** 2.58  
**2007 Fac PE RVU** 0.41 **2013 Fac PE RVU:** 0.44  
**Result:** Increase

**RUC Recommendation:** 1.18

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

# Status Report: CMS Requests and Relativity Assessment Issues

**11307** Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm      **Global:** 000      **Issue:** Shaving of Epidermal or Dermal Lesions      **Screen:** CMS High Expenditure Procedural Codes      **Complete?** Yes

**Most Recent RUC Meeting:** April 2012      **Tab** 38      **Specialty Developing Recommendation:** AAD

**First Identified:** January 2012

**2012 Est Medicare Utilization:** 50,881

**2007 Work RVU:** 1.14      **2013 Work RVU:** 1.20  
**2007 NF PE RVU:** 1.4      **2013 NF PE RVU:** 2.97  
**2007 Fac PE RVU:** 0.49      **2013 Fac PE RVU:** 0.61  
**Result:** Increase

**RUC Recommendation:** 1.20

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**11308** Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm      **Global:** 000      **Issue:** Shaving of Epidermal or Dermal Lesions      **Screen:** CMS High Expenditure Procedural Codes      **Complete?** Yes

**Most Recent RUC Meeting:** April 2012      **Tab** 38      **Specialty Developing Recommendation:** AAD

**First Identified:** January 2012

**2012 Est Medicare Utilization:** 13,865

**2007 Work RVU:** 1.41      **2013 Work RVU:** 1.46  
**2007 NF PE RVU:** 1.53      **2013 NF PE RVU:** 2.97  
**2007 Fac PE RVU:** 0.58      **2013 Fac PE RVU:** 0.58  
**Result:** Increase

**RUC Recommendation:** 1.46

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**11310** Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less      **Global:** 000      **Issue:** Shaving of Epidermal or Dermal Lesions      **Screen:** CMS High Expenditure Procedural Codes      **Complete?** Yes

**Most Recent RUC Meeting:** April 2012      **Tab** 38      **Specialty Developing Recommendation:** AAD

**First Identified:** January 2012

**2012 Est Medicare Utilization:** 82,551

**2007 Work RVU:** 0.73      **2013 Work RVU:** 0.80  
**2007 NF PE RVU:** 1.18      **2013 NF PE RVU:** 2.52  
**2007 Fac PE RVU:** 0.32      **2013 Fac PE RVU:** 0.48  
**Result:** Increase

**RUC Recommendation:** 1.19

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**11311** Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm      **Global:** 000      **Issue:** Shaving of Epidermal or Dermal Lesions      **Screen:** CMS High Expenditure Procedural Codes      **Complete?** Yes

**Most Recent RUC Meeting:** April 2012      **Tab** 38      **Specialty Developing Recommendation:** AAD

**First Identified:** January 2012

**2012 Est Medicare Utilization:** 116,903

**2007 Work RVU:** 1.05      **2013 Work RVU:** 1.10  
**2007 NF PE RVU:** 1.34      **2013 NF PE RVU:** 2.09  
**2007 Fac PE RVU:** 0.49      **2013 Fac PE RVU:** 0.69  
**Result:** Increase

**RUC Recommendation:** 1.43

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**



# Status Report: CMS Requests and Relativity Assessment Issues

**11312** Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm      **Global:** 000      **Issue:** Shaving of Epidermal or Dermal Lesions      **Screen:** CMS High Expenditure Procedural Codes      **Complete?** Yes

**Most Recent**      **Tab** 38      **Specialty Developing**      AAD  
**RUC Meeting:** April 2012      **Recommendation:**

**First**  
**Identified:** January 2012

**2012 Est**  
**Medicare**  
**Utilization:** 52,227

**2007 Work RVU:** 1.20      **2013 Work RVU:** 1.30  
**2007 NF PE RVU:** 1.55      **2013 NF PE RVU:** 3.36  
**2007 Fac PE RVU** 0.56      **2013 Fac PE RVU:** 0.82  
**Result:** Increase

**RUC Recommendation:** 1.80

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**11313** Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm      **Global:** 000      **Issue:** Shaving of Epidermal or Dermal Lesions      **Screen:** CMS High Expenditure Procedural Codes      **Complete?** Yes

**Most Recent**      **Tab** 38      **Specialty Developing**      AAD  
**RUC Meeting:** April 2012      **Recommendation:**

**First**  
**Identified:** January 2012

**2012 Est**  
**Medicare**  
**Utilization:** 6,377

**2007 Work RVU:** 1.62      **2013 Work RVU:** 1.68  
**2007 NF PE RVU:** 1.9      **2013 NF PE RVU:** 3.66  
**2007 Fac PE RVU** 0.73      **2013 Fac PE RVU:** 1.04  
**Result:** Increase

**RUC Recommendation:** 2.00

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**11719** Trimming of nondystrophic nails, any number      **Global:** 000      **Issue:** Debridement of Nail      **Screen:** Low Value-High Volume      **Complete?** Yes

**Most Recent**      **Tab** 32      **Specialty Developing**      APMA  
**RUC Meeting:** January 2012      **Recommendation:**

**First**  
**Identified:** October 2010

**2012 Est**  
**Medicare**  
**Utilization:** 1,509,009

**2007 Work RVU:** 0.17      **2013 Work RVU:** 0.17  
**2007 NF PE RVU:** 0.28      **2013 NF PE RVU:** 0.16  
**2007 Fac PE RVU** 0.07      **2013 Fac PE RVU:** 0.04  
**Result:** Maintain

**RUC Recommendation:** 0.17

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**11720** Debridement of nail(s) by any method(s); 1 to 5      **Global:** 000      **Issue:** Debridement of Nail      **Screen:** MPC List      **Complete?** Yes

**Most Recent**      **Tab** 53      **Specialty Developing**      APMA  
**RUC Meeting:** September 2011      **Recommendation:**

**First**  
**Identified:**

**2012 Est**  
**Medicare**  
**Utilization:** 2,267,725

**2007 Work RVU:** 0.32      **2013 Work RVU:** 0.32  
**2007 NF PE RVU:** 0.37      **2013 NF PE RVU:** 0.61  
**2007 Fac PE RVU** 0.11      **2013 Fac PE RVU:** 0.08  
**Result:** Maintain

**RUC Recommendation:** 0.32 (Interim)

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

# Status Report: CMS Requests and Relativity Assessment Issues

## 11721 Debridement of nail(s) by any method(s); 6 or more

Global: 000

Issue: Debridement of Nail

Screen: MPC List

Complete? Yes

Most Recent Tab 53 Specialty Developing APMA  
RUC Meeting: September 2011 Recommendation:

First Identified: October 2010

2012 Est Medicare Utilization: 7,284,510

2007 Work RVU: 0.54

2013 Work RVU: 0.54

2007 NF PE RVU: 0.47

2013 NF PE RVU: 0.74

2007 Fac PE RVU 0.20

2013 Fac PE RVU: 0.14

Result: Maintain

RUC Recommendation: 0.54 (Interim)

CPT Action (if applicable):

Referred to CPT Asst ☐

Published in CPT Asst:

## 11900 Injection, intralesional; up to and including 7 lesions

Global: 000

Issue: Skin Injection Services

Screen: Harvard Valued - Utilization over 100,000

Complete? Yes

Most Recent Tab 31 Specialty Developing AAD  
RUC Meeting: April 2010 Recommendation:

First Identified: October 2009

2012 Est Medicare Utilization: 174,084

2007 Work RVU: 0.52

2013 Work RVU: 0.52

2007 NF PE RVU: 0.72

2013 NF PE RVU: 1.08

2007 Fac PE RVU 0.22

2013 Fac PE RVU: 0.34

Result: Maintain

RUC Recommendation: 0.52

CPT Action (if applicable):

Referred to CPT Asst ☐

Published in CPT Asst:

## 11901 Injection, intralesional; more than 7 lesions

Global: 000

Issue: Skin Injection Services

Screen: Harvard Valued - Utilization over 100,000

Complete? Yes

Most Recent Tab 31 Specialty Developing AAD  
RUC Meeting: April 2010 Recommendation:

First Identified: February 2010

2012 Est Medicare Utilization: 57,374

2007 Work RVU: 0.80

2013 Work RVU: 0.80

2007 NF PE RVU: 0.75

2013 NF PE RVU: 1.17

2007 Fac PE RVU 0.37

2013 Fac PE RVU: 0.53

Result: Maintain

RUC Recommendation: 0.80

CPT Action (if applicable):

Referred to CPT Asst ☐

Published in CPT Asst:

## 11980 Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)

Global: 000

Issue: RAW

Screen: High Volume Growth2

Complete? No

Most Recent Tab Specialty Developing  
RUC Meeting: Recommendation:

First Identified: April 2013

2012 Est Medicare Utilization: 22,910

2007 Work RVU: 1.48

2013 Work RVU: 1.48

2007 NF PE RVU: 1.1

2013 NF PE RVU: 1.34

2007 Fac PE RVU 0.55

2013 Fac PE RVU: 0.64

Result:

RUC Recommendation: Review Action Plan

CPT Action (if applicable):

Referred to CPT Asst ☐

Published in CPT Asst:

# Status Report: CMS Requests and Relativity Assessment Issues

## 11981 Insertion, non-biodegradable drug delivery implant

Global: XXX

Issue: Drug Implant

Screen: High Volume Growth1

Complete? Yes

Most Recent Tab 57 Specialty Developing AUA  
RUC Meeting: April 2008 Recommendation:

First Identified: June 2008

2012 Est Medicare Utilization: 12,094

2007 Work RVU: 1.48 2013 Work RVU: 1.48  
2007 NF PE RVU: 1.76 2013 NF PE RVU: 2.35  
2007 Fac PE RVU 0.66 2013 Fac PE RVU: 0.65  
Result: Remove from Screen

RUC Recommendation: Remove from screen

CPT Action (if applicable):  
Referred to CPT Asst ☐

Published in CPT Asst:

## 11982 Removal, non-biodegradable drug delivery implant

Global: XXX

Issue: Drug Implant

Screen: High Volume Growth1

Complete? Yes

Most Recent Tab 57 Specialty Developing AUA  
RUC Meeting: April 2008 Recommendation:

First Identified: February 2008

2012 Est Medicare Utilization: 3,298

2007 Work RVU: 1.78 2013 Work RVU: 1.78  
2007 NF PE RVU: 1.97 2013 NF PE RVU: 2.57  
2007 Fac PE RVU 0.81 2013 Fac PE RVU: 0.81  
Result: Remove from Screen

RUC Recommendation: Remove from screen

CPT Action (if applicable):  
Referred to CPT Asst ☐

Published in CPT Asst:

## 11983 Removal with reinsertion, non-biodegradable drug delivery implant

Global: XXX

Issue: Drug Implant

Screen: High Volume Growth1

Complete? Yes

Most Recent Tab 57 Specialty Developing AUA  
RUC Meeting: April 2008 Recommendation:

First Identified: June 2008

2012 Est Medicare Utilization: 3,946

2007 Work RVU: 3.30 2013 Work RVU: 3.30  
2007 NF PE RVU: 2.38 2013 NF PE RVU: 2.60  
2007 Fac PE RVU 1.44 2013 Fac PE RVU: 1.24  
Result: Remove from Screen

RUC Recommendation: Remove from screen

CPT Action (if applicable):  
Referred to CPT Asst ☐

Published in CPT Asst:

## 12001 Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less

Global: 000

Issue: Repair of Superficial Wounds

Screen: Harvard Valued - Utilization over 100,000

Complete? Yes

Most Recent Tab 32 Specialty Developing ACEP, AAFP  
RUC Meeting: April 2010 Recommendation:

First Identified: October 2009

2012 Est Medicare Utilization: 184,203

2007 Work RVU: 1.72 2013 Work RVU: 0.84  
2007 NF PE RVU: 1.92 2013 NF PE RVU: 1.74  
2007 Fac PE RVU 0.76 2013 Fac PE RVU: 0.34  
Result: Decrease

RUC Recommendation: 0.84

CPT Action (if applicable):  
Referred to CPT Asst ☐

Published in CPT Asst:

# Status Report: CMS Requests and Relativity Assessment Issues

**12002** Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm **Global:** 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab 32 Specialty Developing Recommendation:** ACEP, AAFP

**First Identified:** October 2009

**2012 Est Medicare Utilization:** 142,525

**2007 Work RVU:** 1.88  
**2007 NF PE RVU:** 1.98  
**2007 Fac PE RVU:** 0.89

**2013 Work RVU:** 1.14  
**2013 NF PE RVU:** 1.96  
**2013 Fac PE RVU:** 0.42

**RUC Recommendation:** 1.14

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**12004** Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 7.6 cm to 12.5 cm **Global:** 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab 32 Specialty Developing Recommendation:** ACEP, AAFP

**First Identified:**

**2012 Est Medicare Utilization:** 21,528

**2007 Work RVU:** 2.26  
**2007 NF PE RVU:** 2.26  
**2007 Fac PE RVU:** 0.99

**2013 Work RVU:** 1.44  
**2013 NF PE RVU:** 2.18  
**2013 Fac PE RVU:** 0.50

**RUC Recommendation:** 1.44

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**12005** Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 12.6 cm to 20.0 cm **Global:** 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab 32 Specialty Developing Recommendation:** ACEP, AAFP

**First Identified:**

**2012 Est Medicare Utilization:** 5,647

**2007 Work RVU:** 2.88  
**2007 NF PE RVU:** 2.75  
**2007 Fac PE RVU:** 1.17

**2013 Work RVU:** 1.97  
**2013 NF PE RVU:** 2.69  
**2013 Fac PE RVU:** 0.64

**RUC Recommendation:** 1.97

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**12006** Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 20.1 cm to 30.0 cm **Global:** 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab 32 Specialty Developing Recommendation:** ACEP, AAFP

**First Identified:**

**2012 Est Medicare Utilization:** 1,075

**2007 Work RVU:** 3.68  
**2007 NF PE RVU:** 3.3  
**2007 Fac PE RVU:** 1.46

**2013 Work RVU:** 2.39  
**2013 NF PE RVU:** 3.23  
**2013 Fac PE RVU:** 0.78

**RUC Recommendation:** 2.39

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

# Status Report: CMS Requests and Relativity Assessment Issues

**12007** Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); over 30.0 cm **Global:** 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab 32 Specialty Developing Recommendation:** ACEP, AAFP

**First Identified:**

**2012 Est Medicare Utilization:** 369

**2007 Work RVU:** 4.13

**2013 Work RVU:** 2.90

**2007 NF PE RVU:** 3.71

**2013 NF PE RVU:** 3.46

**2007 Fac PE RVU:** 1.73

**2013 Fac PE RVU:** 1.09

**Result:** Decrease

**RUC Recommendation:** 2.90

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**12011** Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less **Global:** 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab 32 Specialty Developing Recommendation:** ACEP, AAFP

**First Identified:**

**2012 Est Medicare Utilization:** 88,665

**2007 Work RVU:** 1.78

**2013 Work RVU:** 1.07

**2007 NF PE RVU:** 2.07

**2013 NF PE RVU:** 2.06

**2007 Fac PE RVU:** 0.78

**2013 Fac PE RVU:** 0.40

**Result:** Decrease

**RUC Recommendation:** 1.07

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**12013** Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm **Global:** 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab 32 Specialty Developing Recommendation:** ACEP, AAFP

**First Identified:**

**2012 Est Medicare Utilization:** 50,258

**2007 Work RVU:** 2.01

**2013 Work RVU:** 1.22

**2007 NF PE RVU:** 2.22

**2013 NF PE RVU:** 2.21

**2007 Fac PE RVU:** 0.92

**2013 Fac PE RVU:** 0.42

**Result:** Decrease

**RUC Recommendation:** 1.22

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**12014** Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm **Global:** 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab 32 Specialty Developing Recommendation:** ACEP, AAFP

**First Identified:**

**2012 Est Medicare Utilization:** 6,516

**2007 Work RVU:** 2.48

**2013 Work RVU:** 1.57

**2007 NF PE RVU:** 2.5

**2013 NF PE RVU:** 2.41

**2007 Fac PE RVU:** 1.04

**2013 Fac PE RVU:** 0.51

**Result:** Decrease

**RUC Recommendation:** 1.57

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

# Status Report: CMS Requests and Relativity Assessment Issues

**12015** Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm **Global:** 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab 32 Specialty Developing Recommendation:** ACEP, AAFP

**First Identified:**

**2012 Est Medicare Utilization:** 3,249

**2007 Work RVU:** 3.21  
**2007 NF PE RVU:** 3.04  
**2007 Fac PE RVU:** 1.22

**2013 Work RVU:** 1.98  
**2013 NF PE RVU:** 2.86  
**2013 Fac PE RVU:** 0.61

**RUC Recommendation:** 1.98

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**12016** Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm

**Global:** 000

**Issue:** Repair of Superficial Wounds

**Screen:** Harvard Valued - Utilization over 100,000

**Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab 32 Specialty Developing Recommendation:** ACEP, AAFP

**First Identified:**

**2012 Est Medicare Utilization:** 489

**2007 Work RVU:** 3.94  
**2007 NF PE RVU:** 3.45  
**2007 Fac PE RVU:** 1.47

**2013 Work RVU:** 2.68  
**2013 NF PE RVU:** 3.28  
**2013 Fac PE RVU:** 0.80

**RUC Recommendation:** 2.68

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**12017** Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm

**Global:** 000

**Issue:** Repair of Superficial Wounds

**Screen:** Harvard Valued - Utilization over 100,000

**Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab 32 Specialty Developing Recommendation:** ACEP, AAFP

**First Identified:**

**2012 Est Medicare Utilization:** 75

**2007 Work RVU:** 4.72  
**2007 NF PE RVU:** NA  
**2007 Fac PE RVU:** 1.79

**2013 Work RVU:** 3.18  
**2013 NF PE RVU:** NA  
**2013 Fac PE RVU:** 0.78

**RUC Recommendation:** 3.18

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**12018** Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm

**Global:** 000

**Issue:** Repair of Superficial Wounds

**Screen:** Harvard Valued - Utilization over 100,000

**Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab 32 Specialty Developing Recommendation:** ACEP, AAFP

**First Identified:**

**2012 Est Medicare Utilization:** 30

**2007 Work RVU:** 5.54  
**2007 NF PE RVU:** NA  
**2007 Fac PE RVU:** 2.19

**2013 Work RVU:** 3.61  
**2013 NF PE RVU:** NA  
**2013 Fac PE RVU:** 1.74

**RUC Recommendation:** 3.61

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

## Status Report: CMS Requests and Relativity Assessment Issues

<b>12031</b>	Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less	<b>Global:</b> 010	<b>Issue:</b> Repair of Intermediate Wounds	<b>Screen:</b> Harvard Valued - Utilization over 100,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2010	<b>Tab 22</b>	<b>Specialty Developing Recommendation:</b> AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 58,015	<b>2007 Work RVU:</b> 2.17 <b>2007 NF PE RVU:</b> 2.69 <b>2007 Fac PE RVU:</b> 1.17 <b>2013 Work RVU:</b> 2.00 <b>2013 NF PE RVU:</b> 4.86 <b>2013 Fac PE RVU:</b> 2.28
<b>RUC Recommendation:</b> 2.00			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b> Decrease
<b>12032</b>	Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.6 cm to 7.5 cm	<b>Global:</b> 010	<b>Issue:</b> Repair of Intermediate Wounds	<b>Screen:</b> Harvard Valued - Utilization over 100,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2010	<b>Tab 22</b>	<b>Specialty Developing Recommendation:</b> AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA	<b>First Identified:</b> October 2009	<b>2012 Est Medicare Utilization:</b> 217,348	<b>2007 Work RVU:</b> 2.49 <b>2007 NF PE RVU:</b> 4.19 <b>2007 Fac PE RVU:</b> 1.92 <b>2013 Work RVU:</b> 2.52 <b>2013 NF PE RVU:</b> 6.27 <b>2013 Fac PE RVU:</b> 2.95
<b>RUC Recommendation:</b> 2.52			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b> Maintain
<b>12034</b>	Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 7.6 cm to 12.5 cm	<b>Global:</b> 010	<b>Issue:</b> Repair of Intermediate Wounds	<b>Screen:</b> Harvard Valued - Utilization over 100,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2010	<b>Tab 22</b>	<b>Specialty Developing Recommendation:</b> AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 21,643	<b>2007 Work RVU:</b> 2.94 <b>2007 NF PE RVU:</b> 3.54 <b>2007 Fac PE RVU:</b> 1.59 <b>2013 Work RVU:</b> 2.97 <b>2013 NF PE RVU:</b> 5.92 <b>2013 Fac PE RVU:</b> 2.70
<b>RUC Recommendation:</b> 2.97			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b> Maintain



## Status Report: CMS Requests and Relativity Assessment Issues

<b>12035</b>	Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 12.6 cm to 20.0 cm	<b>Global:</b> 010	<b>Issue:</b> Repair of Intermediate Wounds	<b>Screen:</b> Harvard Valued - Utilization over 100,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2010	<b>Tab 22</b>	<b>Specialty Developing Recommendation:</b> AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 4,985	<b>2007 Work RVU:</b> 3.44 <b>2007 NF PE RVU:</b> 5.21 <b>2007 Fac PE RVU:</b> 2.14 <b>2013 Work RVU:</b> 3.50 <b>2013 NF PE RVU:</b> 7.54 <b>2013 Fac PE RVU:</b> 3.09
<b>RUC Recommendation:</b> 3.60			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b> Increase
<b>12036</b>	Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 20.1 cm to 30.0 cm	<b>Global:</b> 010	<b>Issue:</b> Repair of Intermediate Wounds	<b>Screen:</b> Harvard Valued - Utilization over 100,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2010	<b>Tab 22</b>	<b>Specialty Developing Recommendation:</b> AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 1,024	<b>2007 Work RVU:</b> 4.06 <b>2007 NF PE RVU:</b> 5.51 <b>2007 Fac PE RVU:</b> 2.47 <b>2013 Work RVU:</b> 4.23 <b>2013 NF PE RVU:</b> 7.70 <b>2013 Fac PE RVU:</b> 3.31
<b>RUC Recommendation:</b> 4.50			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b> Increase
<b>12037</b>	Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); over 30.0 cm	<b>Global:</b> 010	<b>Issue:</b> Repair of Intermediate Wounds	<b>Screen:</b> Harvard Valued - Utilization over 100,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2010	<b>Tab 22</b>	<b>Specialty Developing Recommendation:</b> AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 634	<b>2007 Work RVU:</b> 4.68 <b>2007 NF PE RVU:</b> 6.05 <b>2007 Fac PE RVU:</b> 2.88 <b>2013 Work RVU:</b> 5.00 <b>2013 NF PE RVU:</b> 8.05 <b>2013 Fac PE RVU:</b> 3.68
<b>RUC Recommendation:</b> 5.25			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b> Increase



## Status Report: CMS Requests and Relativity Assessment Issues

12041	Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.5 cm or less		Global: 010	Issue: Repair of Intermediate Wounds	Screen: Harvard Valued - Utilization over 100,000	Complete?	Yes													
Most Recent RUC Meeting:	October 2010	Tab 22	Specialty Developing Recommendation:	AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA	First Identified:	February 2010	2012 Est Medicare Utilization:	19,126	2007 Work RVU:	2.39	2013 Work RVU:	2.10	2007 NF PE RVU:	2.87	2013 NF PE RVU:	4.87	2007 Fac PE RVU	1.29	2013 Fac PE RVU:	2.26
RUC Recommendation:				2.10		CPT Action (if applicable): Referred to CPT Asst				<input type="checkbox"/>		Published in CPT Asst:				Result: Decrease				
12042	Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.6 cm to 7.5 cm		Global: 010	Issue: Repair of Intermediate Wounds	Screen: Harvard Valued - Utilization over 100,000	Complete?	Yes													
Most Recent RUC Meeting:	October 2010	Tab 22	Specialty Developing Recommendation:	AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA	First Identified:	February 2010	2012 Est Medicare Utilization:	45,434	2007 Work RVU:	2.76	2013 Work RVU:	2.79	2007 NF PE RVU:	3.57	2013 NF PE RVU:	5.47	2007 Fac PE RVU	1.63	2013 Fac PE RVU:	2.78
RUC Recommendation:				2.79		CPT Action (if applicable): Referred to CPT Asst				<input type="checkbox"/>		Published in CPT Asst:				Result: Maintain				
12044	Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 7.6 cm to 12.5 cm		Global: 010	Issue: Repair of Intermediate Wounds	Screen: Harvard Valued - Utilization over 100,000	Complete?	Yes													
Most Recent RUC Meeting:	October 2010	Tab 22	Specialty Developing Recommendation:	AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA	First Identified:	February 2010	2012 Est Medicare Utilization:	2,081	2007 Work RVU:	3.16	2013 Work RVU:	3.19	2007 NF PE RVU:	3.74	2013 NF PE RVU:	7.13	2007 Fac PE RVU	1.69	2013 Fac PE RVU:	2.69
RUC Recommendation:				3.19		CPT Action (if applicable): Referred to CPT Asst				<input type="checkbox"/>		Published in CPT Asst:				Result: Maintain				

## Status Report: CMS Requests and Relativity Assessment Issues

12045	Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 12.6 cm to 20.0 cm			Global: 010	Issue: Repair of Intermediate Wounds	Screen: Harvard Valued - Utilization over 100,000	Complete?	Yes	
Most Recent RUC Meeting:	October 2010	Tab 22	Specialty Developing Recommendation:	AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA	First Identified: February 2010	2012 Est Medicare Utilization: 379	2007 Work RVU: 3.65 2007 NF PE RVU: 5.21 2007 Fac PE RVU 2.23	2013 Work RVU: 3.75 2013 NF PE RVU: 7.72 2013 Fac PE RVU: 3.73	
RUC Recommendation: 3.90					CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:		Result: Increase
12046	Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 20.1 cm to 30.0 cm			Global: 010	Issue: Repair of Intermediate Wounds	Screen: Harvard Valued - Utilization over 100,000	Complete?	Yes	
Most Recent RUC Meeting:	October 2010	Tab 22	Specialty Developing Recommendation:	AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA	First Identified: February 2010	2012 Est Medicare Utilization: 72	2007 Work RVU: 4.26 2007 NF PE RVU: 6.28 2007 Fac PE RVU 2.64	2013 Work RVU: 4.30 2013 NF PE RVU: 11.00 2013 Fac PE RVU: 5.00	
RUC Recommendation: 4.60					CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:		Result: Increase
12047	Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; over 30.0 cm			Global: 010	Issue: Repair of Intermediate Wounds	Screen: Harvard Valued - Utilization over 100,000	Complete?	Yes	
Most Recent RUC Meeting:	October 2010	Tab 22	Specialty Developing Recommendation:	AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA	First Identified: February 2010	2012 Est Medicare Utilization: 34	2007 Work RVU: 4.66 2007 NF PE RVU: 6.3 2007 Fac PE RVU 2.95	2013 Work RVU: 4.95 2013 NF PE RVU: 11.79 2013 Fac PE RVU: 5.35	
RUC Recommendation: 5.50					CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:		Result: Increase

## Status Report: CMS Requests and Relativity Assessment Issues

**12051** Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less **Global:** 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** October 2010

**Tab** 22

**Specialty Developing Recommendation:**

AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 59,142

**2007 Work RVU:** 2.49

**2013 Work RVU:** 2.33

**2007 NF PE RVU:** 3.48

**2013 NF PE RVU:** 5.10

**2007 Fac PE RVU** 1.57

**2013 Fac PE RVU:** 2.45

**RUC Recommendation:** 2.33

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**12052** Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm **Global:** 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab** 45

**Specialty Developing Recommendation:**

AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 78,692

**2007 Work RVU:** 2.81

**2013 Work RVU:** 2.87

**2007 NF PE RVU:** 3.64

**2013 NF PE RVU:** 5.54

**2007 Fac PE RVU** 1.72

**2013 Fac PE RVU:** 2.79

**RUC Recommendation:** Remove from screen

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Remove from Screen

**12053** Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm **Global:** 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** October 2010

**Tab** 22

**Specialty Developing Recommendation:**

AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 9,289

**2007 Work RVU:** 3.14

**2013 Work RVU:** 3.17

**2007 NF PE RVU:** 3.77

**2013 NF PE RVU:** 6.76

**2007 Fac PE RVU** 1.68

**2013 Fac PE RVU:** 2.81

**RUC Recommendation:** 3.17

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Maintain

## Status Report: CMS Requests and Relativity Assessment Issues

12054	Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm		Global: 010	Issue: Repair of Intermediate Wounds	Screen: Harvard Valued - Utilization over 100,000	Complete?	Yes					
Most Recent RUC Meeting:	October 2010	Tab 22	Specialty Developing Recommendation:	AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA	First Identified:	February 2010	2012 Est Medicare Utilization:	3,077	2007 Work RVU:	3.47	2013 Work RVU:	3.50
									2007 NF PE RVU:	4.02	2013 NF PE RVU:	7.04
									2007 Fac PE RVU	1.74	2013 Fac PE RVU:	2.74
RUC Recommendation:	3.50				CPT Action (if applicable): Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:		Result:	Maintain		
12055	Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm		Global: 010	Issue: Repair of Intermediate Wounds	Screen: Harvard Valued - Utilization over 100,000	Complete?	Yes					
Most Recent RUC Meeting:	October 2010	Tab 22	Specialty Developing Recommendation:	AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA	First Identified:	February 2010	2012 Est Medicare Utilization:	396	2007 Work RVU:	4.44	2013 Work RVU:	4.50
									2007 NF PE RVU:	4.87	2013 NF PE RVU:	8.99
									2007 Fac PE RVU	2.13	2013 Fac PE RVU:	3.73
RUC Recommendation:	4.65				CPT Action (if applicable): Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:		Result:	Increase		
12056	Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm		Global: 010	Issue: Repair of Intermediate Wounds	Screen: Harvard Valued - Utilization over 100,000	Complete?	Yes					
Most Recent RUC Meeting:	October 2010	Tab 22	Specialty Developing Recommendation:	AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA	First Identified:	February 2010	2012 Est Medicare Utilization:	61	2007 Work RVU:	5.25	2013 Work RVU:	5.30
									2007 NF PE RVU:	6.62	2013 NF PE RVU:	10.46
									2007 Fac PE RVU	2.89	2013 Fac PE RVU:	5.25
RUC Recommendation:	5.50				CPT Action (if applicable): Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:		Result:	Increase		

## Status Report: CMS Requests and Relativity Assessment Issues

**12057** Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm **Global:** 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** October 2010

**Tab** 22

**Specialty Developing Recommendation:**

AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 118

**2007 Work RVU:** 5.97

**2013 Work RVU:** 6.00

**2007 NF PE RVU:** 6.47

**2013 NF PE RVU:** 9.82

**2007 Fac PE RVU:** 3.53

**2013 Fac PE RVU:** 4.41

**RUC Recommendation:** 6.28

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Increase

**13100** Repair, complex, trunk; 1.1 cm to 2.5 cm

**Global:** 010

**Issue:** Complex Wound Repair

**Screen:** CMS Request

**Complete?** Yes

**Most Recent RUC Meeting:** April 2012

**Tab** 37

**Specialty Developing Recommendation:**

AAD, AAO-HNS, ASPS

**First Identified:**

**2012 Est Medicare Utilization:** 5,404

**2007 Work RVU:** 3.14

**2013 Work RVU:** 3.00

**2007 NF PE RVU:** 4.15

**2013 NF PE RVU:** 6.58

**2007 Fac PE RVU:** 2.35

**2013 Fac PE RVU:** 2.66

**RUC Recommendation:** 3.00

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**13101** Repair, complex, trunk; 2.6 cm to 7.5 cm

**Global:** 010

**Issue:** Complex Wound Repair

**Screen:** CMS Request

**Complete?** Yes

**Most Recent RUC Meeting:** April 2012

**Tab** 37

**Specialty Developing Recommendation:**

AAD, AAO-HNS, ASPS

**First Identified:**

**2012 Est Medicare Utilization:** 68,383

**2007 Work RVU:** 3.93

**2013 Work RVU:** 3.50

**2007 NF PE RVU:** 4.99

**2013 NF PE RVU:** 7.90

**2007 Fac PE RVU:** 2.77

**2013 Fac PE RVU:** 3.56

**RUC Recommendation:** 3.50

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**13102** Repair, complex, trunk; each additional 5 cm or less (List separately in addition to code for primary procedure)

**Global:** ZZZ

**Issue:** Complex Wound Repair

**Screen:** CMS Request

**Complete?** Yes

**Most Recent RUC Meeting:** April 2012

**Tab** 37

**Specialty Developing Recommendation:**

AAD, AAO-HNS, ASPS

**First Identified:**

**2012 Est Medicare Utilization:** 18,796

**2007 Work RVU:** 1.24

**2013 Work RVU:** 1.24

**2007 NF PE RVU:** 1.22

**2013 NF PE RVU:** 2.19

**2007 Fac PE RVU:** 0.57

**2013 Fac PE RVU:** 0.73

**RUC Recommendation:** 1.24

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Maintain

# Status Report: CMS Requests and Relativity Assessment Issues

**13120** Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm

**Global:** 010

**Issue:** Complex Wound Repair

**Screen:** CMS Fastest Growing

**Complete?** Yes

**Most Recent RUC Meeting:** April 2012

**Tab** 37

**Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS

**First Identified:** October 2008

**2012 Est Medicare Utilization:** 8,696

**2007 Work RVU:** 3.32

**2013 Work RVU:** 3.23

**2007 NF PE RVU:** 4.26

**2013 NF PE RVU:** 6.80

**2007 Fac PE RVU:** 2.41

**2013 Fac PE RVU:** 3.34

**RUC Recommendation:** 3.23

**CPT Action (if applicable):**

**Referred to CPT Asst** ☒

**Published in CPT Asst:** May 2011

**Result:** Decrease

**13121** Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm

**Global:** 010

**Issue:** Complex Wound Repair

**Screen:** CMS Fastest Growing

**Complete?** Yes

**Most Recent RUC Meeting:** April 2012

**Tab** 37

**Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS

**First Identified:** October 2008

**2012 Est Medicare Utilization:** 117,058

**2007 Work RVU:** 4.36

**2013 Work RVU:** 4.00

**2007 NF PE RVU:** 5.32

**2013 NF PE RVU:** 8.24

**2007 Fac PE RVU:** 3.02

**2013 Fac PE RVU:** 3.36

**RUC Recommendation:** 4.00

**CPT Action (if applicable):**

**Referred to CPT Asst** ☒

**Published in CPT Asst:** May 2011

**Result:** Decrease

**13122** Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)

**Global:** ZZZ

**Issue:** Complex Wound Repair

**Screen:** CMS Fastest Growing

**Complete?** Yes

**Most Recent RUC Meeting:** April 2012

**Tab** 37

**Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS

**First Identified:** October 2008

**2012 Est Medicare Utilization:** 18,633

**2007 Work RVU:** 1.44

**2013 Work RVU:** 1.44

**2007 NF PE RVU:** 1.48

**2013 NF PE RVU:** 2.31

**2007 Fac PE RVU:** 0.63

**2013 Fac PE RVU:** 0.84

**RUC Recommendation:** 1.44

**CPT Action (if applicable):**

**Referred to CPT Asst** ☒

**Published in CPT Asst:** May 2011

**Result:** Maintain

**13131** Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm

**Global:** 010

**Issue:** Complex Wound Repair

**Screen:** Harvard Valued - Utilization over 30,000

**Complete?** Yes

**Most Recent RUC Meeting:** April 2012

**Tab** 37

**Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS

**First Identified:** April 2011

**2012 Est Medicare Utilization:** 37,216

**2007 Work RVU:** 3.80

**2013 Work RVU:** 3.73

**2007 NF PE RVU:** 4.53

**2013 NF PE RVU:** 7.28

**2007 Fac PE RVU:** 2.74

**2013 Fac PE RVU:** 3.16

**RUC Recommendation:** 3.73

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

# Status Report: CMS Requests and Relativity Assessment Issues

**13132** Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm      **Global:** 010      **Issue:** Complex Wound Repair      **Screen:** CMS Request      **Complete?** Yes

**Most Recent RUC Meeting:** April 2012      **Tab** 37      **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS      **First Identified:** September 2011      **2012 Est Medicare Utilization:** 216,113      **2007 Work RVU:** 6.48      **2013 Work RVU:** 4.78  
**2007 NF PE RVU:** 6.42      **2013 NF PE RVU:** 8.80  
**2007 Fac PE RVU:** 4.38      **2013 Fac PE RVU:** 3.88  
**RUC Recommendation:** 4.78      **CPT Action (if applicable):**  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

**13133** Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (List separately in addition to code for primary procedure)      **Global:** ZZZ      **Issue:** Complex Wound Repair      **Screen:** CMS Request      **Complete?** Yes

**Most Recent RUC Meeting:** April 2012      **Tab** 37      **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS      **First Identified:** September 2011      **2012 Est Medicare Utilization:** 12,317      **2007 Work RVU:** 2.19      **2013 Work RVU:** 2.19  
**2007 NF PE RVU:** 1.72      **2013 NF PE RVU:** 2.78  
**2007 Fac PE RVU:** 1.02      **2013 Fac PE RVU:** 1.35  
**RUC Recommendation:** 2.19      **CPT Action (if applicable):**  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

**13150** Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less      **Global:** 010      **Issue:** Complex Wound Repair      **Screen:** CMS Request      **Complete?** Yes

**Most Recent RUC Meeting:** April 2012      **Tab** 37      **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS      **First Identified:** September 2011      **2012 Est Medicare Utilization:** 2,431      **2007 Work RVU:** 3.82      **2013 Work RVU:** 3.58  
**2007 NF PE RVU:** 4.83      **2013 NF PE RVU:** 7.09  
**2007 Fac PE RVU:** 2.76      **2013 Fac PE RVU:** 2.48  
**RUC Recommendation:** Deleted from CPT      **CPT Action (if applicable):** October 2012  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

**13151** Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm      **Global:** 010      **Issue:** Complex Wound Repair      **Screen:** CMS Request      **Complete?** Yes

**Most Recent RUC Meeting:** April 2012      **Tab** 37      **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS      **First Identified:** September 2011      **2012 Est Medicare Utilization:** 32,836      **2007 Work RVU:** 4.46      **2013 Work RVU:** 4.34  
**2007 NF PE RVU:** 4.99      **2013 NF PE RVU:** 7.66  
**2007 Fac PE RVU:** 3.17      **2013 Fac PE RVU:** 3.58  
**RUC Recommendation:** 4.34      **CPT Action (if applicable):**  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

# Status Report: CMS Requests and Relativity Assessment Issues

<b>13152</b>	Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm	<b>Global:</b> 010	<b>Issue:</b> Complex Wound Repair	<b>Screen:</b> Harvard Valued - Utilization over 30,000 / Harvard-Valued with Annual Allowed Charges over \$10 million	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2012	<b>Tab</b> 37	<b>Specialty Developing Recommendation:</b> AAD, AAO-HNS, ASPS	<b>First Identified:</b> April 2011	<b>2012 Est Medicare Utilization:</b> 47,216	<b>2007 Work RVU:</b> 6.34 <b>2007 NF PE RVU:</b> 6.42 <b>2007 Fac PE RVU:</b> 4.03 <b>Result:</b> Decrease
<b>RUC Recommendation:</b> 5.34			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 4.90 <b>2013 NF PE RVU:</b> 8.73 <b>2013 Fac PE RVU:</b> 3.93
<b>13153</b>	Repair, complex, eyelids, nose, ears and/or lips; each additional 5 cm or less (List separately in addition to code for primary procedure)	<b>Global:</b> ZZZ	<b>Issue:</b> Complex Wound Repair	<b>Screen:</b> CMS Request	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2012	<b>Tab</b> 37	<b>Specialty Developing Recommendation:</b> AAD, AAO-HNS, ASPS	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 1,096	<b>2007 Work RVU:</b> 2.38 <b>2007 NF PE RVU:</b> 1.96 <b>2007 Fac PE RVU:</b> 1.11 <b>Result:</b> Maintain
<b>RUC Recommendation:</b> 2.38			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 2.38 <b>2013 NF PE RVU:</b> 3.01 <b>2013 Fac PE RVU:</b> 1.42
<b>14000</b>	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less	<b>Global:</b> 090	<b>Issue:</b> Skin Tissue Rearrangement	<b>Screen:</b> Site of Service Anomaly	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2008	<b>Tab</b> 9	<b>Specialty Developing Recommendation:</b> ACS, AAD, ASPS	<b>First Identified:</b> April 2008	<b>2012 Est Medicare Utilization:</b> 9,938	<b>2007 Work RVU:</b> 6.83 <b>2007 NF PE RVU:</b> 8.14 <b>2007 Fac PE RVU:</b> 5.63 <b>Result:</b> Decrease
<b>RUC Recommendation:</b> 6.19			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 6.37 <b>2013 NF PE RVU:</b> 11.26 <b>2013 Fac PE RVU:</b> 7.65



# Status Report: CMS Requests and Relativity Assessment Issues

<b>14001</b>	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm	<b>Global:</b> 090	<b>Issue:</b> Skin Tissue Rearrangement	<b>Screen:</b> Site of Service Anomaly	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2008	<b>Tab</b> 9	<b>Specialty Developing Recommendation:</b> ACS, AAD, ASPS	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 8,745	<b>2007 Work RVU:</b> 9.60 <b>2007 NF PE RVU:</b> 9.86 <b>2007 Fac PE RVU:</b> 7.22 <b>Result:</b> Decrease
<b>RUC Recommendation:</b> 8.58			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 8.78 <b>2013 NF PE RVU:</b> 13.69 <b>2013 Fac PE RVU:</b> 9.31
<b>14020</b>	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less	<b>Global:</b> 090	<b>Issue:</b> Skin Tissue Rearrangement	<b>Screen:</b> Site of Service Anomaly	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2008	<b>Tab</b> 9	<b>Specialty Developing Recommendation:</b> AAD, ASPS	<b>First Identified:</b> April 2008	<b>2012 Est Medicare Utilization:</b> 22,057	<b>2007 Work RVU:</b> 7.66 <b>2007 NF PE RVU:</b> 8.98 <b>2007 Fac PE RVU:</b> 6.64 <b>Result:</b> Decrease
<b>RUC Recommendation:</b> 7.02			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 7.22 <b>2013 NF PE RVU:</b> 12.55 <b>2013 Fac PE RVU:</b> 8.69
<b>14021</b>	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm	<b>Global:</b> 090	<b>Issue:</b> Skin Tissue Rearrangement	<b>Screen:</b> Site of Service Anomaly / CMS Fastest Growing	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2008	<b>Tab</b> 9	<b>Specialty Developing Recommendation:</b> AAD, ASPS	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 17,129	<b>2007 Work RVU:</b> 11.18 <b>2007 NF PE RVU:</b> 10.63 <b>2007 Fac PE RVU:</b> 8.41 <b>Result:</b> Decrease
<b>RUC Recommendation:</b> 9.52			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 9.72 <b>2013 NF PE RVU:</b> 14.86 <b>2013 Fac PE RVU:</b> 10.31
<b>14040</b>	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less	<b>Global:</b> 090	<b>Issue:</b> Skin Tissue Rearrangement	<b>Screen:</b> Site of Service Anomaly	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2008	<b>Tab</b> 9	<b>Specialty Developing Recommendation:</b> AAD, ASPS, AAO-HNS	<b>First Identified:</b> April 2008	<b>2012 Est Medicare Utilization:</b> 77,310	<b>2007 Work RVU:</b> 8.44 <b>2007 NF PE RVU:</b> 9.17 <b>2007 Fac PE RVU:</b> 7.17 <b>Result:</b> Maintain
<b>RUC Recommendation:</b> 8.44			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 8.60 <b>2013 NF PE RVU:</b> 12.97 <b>2013 Fac PE RVU:</b> 9.11

# Status Report: CMS Requests and Relativity Assessment Issues

**14041** Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm **Global:** 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** October 2008

**Tab** 9

**Specialty Developing Recommendation:** AAD, ASPS, AAO-HNS

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 40,665

**2007 Work RVU:** 12.67

**2013 Work RVU:** 10.83

**2007 NF PE RVU:** 11.37

**2013 NF PE RVU:** 15.77

**2007 Fac PE RVU** 8.88

**2013 Fac PE RVU:** 10.85

**Result:** Decrease

**RUC Recommendation:** 10.63

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**14060** Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less **Global:** 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** October 2008

**Tab** 9

**Specialty Developing Recommendation:** AAD, ASPS, AAO-HNS

**First Identified:** April 2008

**2012 Est Medicare Utilization:** 96,804

**2007 Work RVU:** 9.07

**2013 Work RVU:** 9.23

**2007 NF PE RVU:** 9.02

**2013 NF PE RVU:** 12.61

**2007 Fac PE RVU** 7.39

**2013 Fac PE RVU:** 9.58

**Result:** Maintain

**RUC Recommendation:** 9.07

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**14061** Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10.1 sq cm to 30.0 sq cm **Global:** 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** October 2008

**Tab** 9

**Specialty Developing Recommendation:** AAD, ASPS, AAO-HNS

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 26,538

**2007 Work RVU:** 13.67

**2013 Work RVU:** 11.48

**2007 NF PE RVU:** 12.45

**2013 NF PE RVU:** 17.14

**2007 Fac PE RVU** 9.72

**2013 Fac PE RVU:** 11.71

**Result:** Decrease

**RUC Recommendation:** 11.25

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**14300** Deleted from CPT **Global:** 090 **Issue:** Adjacent Tissue Transfer **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

**Most Recent RUC Meeting:** April 2009

**Tab** 04

**Specialty Developing Recommendation:** ACS, AAD, ASPS, AAO-HNS

**First Identified:** September 2007

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 13.26

**2013 Work RVU:**

**2007 NF PE RVU:** 11.77

**2013 NF PE RVU:**

**2007 Fac PE RVU** 9.28

**2013 Fac PE RVU:**

**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**14301** Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm      **Global:** 090      **Issue:** Adjacent Tissue Transfer      **Screen:** Site of Service Anomaly / CMS Fastest Growing      **Complete?** Yes

**Most Recent RUC Meeting:** April 2009

**Tab** 04

**Specialty Developing Recommendation:** ACS, AAO-HNS, ASPS

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 25,130

**2007 Work RVU:**

**2013 Work RVU:** 12.65

**2007 NF PE RVU:**

**2013 NF PE RVU:** 17.49

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 11.65

**RUC Recommendation:** 12.47

**CPT Action (if applicable):** February 2009

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**14302** Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)      **Global:** ZZZ      **Issue:** Adjacent Tissue Transfer      **Screen:** Site of Service Anomaly / CMS Fastest Growing      **Complete?** Yes

**Most Recent RUC Meeting:** April 2009

**Tab** 04

**Specialty Developing Recommendation:** ACS, AAO-HNS, ASPS

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 16,907

**2007 Work RVU:**

**2013 Work RVU:** 3.73

**2007 NF PE RVU:**

**2013 NF PE RVU:** 2.12

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 2.12

**RUC Recommendation:** 3.73

**CPT Action (if applicable):** February 2009

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**15120** Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)      **Global:** 090      **Issue:** Autograft      **Screen:** Site of Service Anomaly      **Complete?** Yes

**Most Recent RUC Meeting:** September 2007

**Tab** 16

**Specialty Developing Recommendation:** AAO-HNS, ASPS

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 10,624

**2007 Work RVU:** 10.96

**2013 Work RVU:** 10.15

**2007 NF PE RVU:** 10.87

**2013 NF PE RVU:** 13.58

**2007 Fac PE RVU** 7.71

**2013 Fac PE RVU:** 8.93

**RUC Recommendation:** Remove from screen

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Remove from Screen

## Status Report: CMS Requests and Relativity Assessment Issues

**15170** Acellular dermal replacement, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children **Global:** 090 **Issue:** Acellular Dermal Replacement **Screen:** Different Performing Specialty from Survey **Complete?** Yes

**Most Recent RUC Meeting:** February 2010

**Tab** 31

**Specialty Developing Recommendation:** APMA, ASPS

**First Identified:** February 2010

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 5.99

**2013 Work RVU:**

**2007 NF PE RVU:** 3.79

**2013 NF PE RVU:**

**2007 Fac PE RVU:** 2.37

**2013 Fac PE RVU:**

**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**15171** Acellular dermal replacement, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Acellular Dermal Replacement **Screen:** Different Performing Specialty from Survey **Complete?** Yes

**Most Recent RUC Meeting:** February 2010

**Tab** 31

**Specialty Developing Recommendation:** APMA, ASPS

**First Identified:** February 2010

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 1.55

**2013 Work RVU:**

**2007 NF PE RVU:** 0.68

**2013 NF PE RVU:**

**2007 Fac PE RVU:** 0.60

**2013 Fac PE RVU:**

**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**15175** Acellular dermal replacement, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children **Global:** 090 **Issue:** Acellular Dermal Replacement **Screen:** Different Performing Specialty from Survey **Complete?** Yes

**Most Recent RUC Meeting:** February 2010

**Tab** 31

**Specialty Developing Recommendation:** APMA, ASPS

**First Identified:** October 2009

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 7.99

**2013 Work RVU:**

**2007 NF PE RVU:** 5.4

**2013 NF PE RVU:**

**2007 Fac PE RVU:** 3.96

**2013 Fac PE RVU:**

**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**15176** Acellular dermal replacement, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Acellular Dermal Replacement **Screen:** Different Performing Specialty from Survey **Complete?** Yes

**Most Recent RUC Meeting:** February 2010 **Tab** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2012 Est Medicare Utilization:** **2007 Work RVU:** 2.45 **2013 Work RVU:** **2007 NF PE RVU:** 1.1 **2013 NF PE RVU:** **2007 Fac PE RVU** 0.95 **2013 Fac PE RVU:** **Result:** Deleted from CPT **RUC Recommendation:** Deleted from CPT **CPT Action (if applicable):** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

**15220** Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; 20 sq cm or less **Global:** 090 **Issue:** Skin Graft **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

**Most Recent RUC Meeting:** September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAO-HNS, ASPS **First Identified:** September 2007 **2012 Est Medicare Utilization:** 8,215 **2007 Work RVU:** 7.95 **2013 Work RVU:** 8.09 **2007 NF PE RVU:** 9.5 **2013 NF PE RVU:** 13.73 **2007 Fac PE RVU** 6.69 **2013 Fac PE RVU:** 9.02 **Result:** PE Only **RUC Recommendation:** Reduce 99238 to 0.5 **CPT Action (if applicable):** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

**15271** Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area **Global:** 000 **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

**Most Recent RUC Meeting:** April 2011 **Tab** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2012 Est Medicare Utilization:** 62,469 **2007 Work RVU:** **2013 Work RVU:** 1.50 **2007 NF PE RVU:** **2013 NF PE RVU:** 2.28 **2007 Fac PE RVU** **2013 Fac PE RVU:** 0.80 **Result:** Decrease **RUC Recommendation:** 1.50 **CPT Action (if applicable):** February 2011 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

<b>15272</b>	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	<b>Global:</b> ZZZ	<b>Issue:</b> Chronic Wound Dermal Substitute	<b>Screen:</b> Different Performing Specialty from Survey	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2011	<b>Tab</b> 04 <b>Specialty Developing Recommendation:</b> ACS, APMA, ASPS	<b>First Identified:</b> April 2011	<b>2012 Est Medicare Utilization:</b> 10,845	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease	<b>2013 Work RVU:</b> 0.33 <b>2013 NF PE RVU:</b> 0.38 <b>2013 Fac PE RVU:</b> 0.13
<b>RUC Recommendation:</b> 0.59		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b> February 2011		
<hr/>					
<b>15273</b>	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	<b>Global:</b> 000	<b>Issue:</b> Chronic Wound Dermal Substitute	<b>Screen:</b> Different Performing Specialty from Survey	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2011	<b>Tab</b> 04 <b>Specialty Developing Recommendation:</b> ACS, APMA, ASPS	<b>First Identified:</b> April 2011	<b>2012 Est Medicare Utilization:</b> 4,974	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease	<b>2013 Work RVU:</b> 3.50 <b>2013 NF PE RVU:</b> 3.95 <b>2013 Fac PE RVU:</b> 1.61
<b>RUC Recommendation:</b> 3.50		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b> February 2011		
<hr/>					
<b>15274</b>	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	<b>Global:</b> ZZZ	<b>Issue:</b> Chronic Wound Dermal Substitute	<b>Screen:</b> Different Performing Specialty from Survey	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2011	<b>Tab</b> 04 <b>Specialty Developing Recommendation:</b> ACS, APMA, ASPS	<b>First Identified:</b> April 2011	<b>2012 Est Medicare Utilization:</b> 18,172	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease	<b>2013 Work RVU:</b> 0.80 <b>2013 NF PE RVU:</b> 0.92 <b>2013 Fac PE RVU:</b> 0.32
<b>RUC Recommendation:</b> 0.80		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b> February 2011		

## Status Report: CMS Requests and Relativity Assessment Issues

**15275** Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area **Global:** 000 **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

**Most Recent RUC Meeting:** April 2011

**Tab** 04

**Specialty Developing Recommendation:** ACS, APMA, ASPS

**First Identified:** April 2011

**2012 Est Medicare Utilization:** 81,965

**2007 Work RVU:**

**2013 Work RVU:** 1.83

**2007 NF PE RVU:**

**2013 NF PE RVU:** 2.41

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 0.94

**RUC Recommendation:** 1.83

**CPT Action (if applicable):** February 2011  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Decrease

**15276** Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

**Most Recent RUC Meeting:** April 2011

**Tab** 04

**Specialty Developing Recommendation:** ACS, APMA, ASPS

**First Identified:** April 2011

**2012 Est Medicare Utilization:** 5,667

**2007 Work RVU:**

**2013 Work RVU:** 0.50

**2007 NF PE RVU:**

**2013 NF PE RVU:** 0.45

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 0.20

**RUC Recommendation:** 0.59

**CPT Action (if applicable):** February 2011  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Decrease

**15277** Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children **Global:** 000 **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

**Most Recent RUC Meeting:** April 2011

**Tab** 04

**Specialty Developing Recommendation:** ACS, APMA, ASPS

**First Identified:** April 2011

**2012 Est Medicare Utilization:** 1,618

**2007 Work RVU:**

**2013 Work RVU:** 4.00

**2007 NF PE RVU:**

**2013 NF PE RVU:** 4.22

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 1.81

**RUC Recommendation:** 4.00

**CPT Action (if applicable):** February 2011  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Decrease

## Status Report: CMS Requests and Relativity Assessment Issues

**15278** Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

**Global:** ZZZ

**Issue:** Chronic Wound Dermal Substitute

**Screen:** Different Performing Specialty from Survey

**Complete?** Yes

**Most Recent RUC Meeting:** April 2011

**Tab** 04

**Specialty Developing Recommendation:**

ACS, APMA, ASPS

**First Identified:** April 2011

**2012 Est Medicare Utilization:** 2,360

**2007 Work RVU:**

**2013 Work RVU:** 1.00

**2007 NF PE RVU:**

**2013 NF PE RVU:** 1.06

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 0.41

**RUC Recommendation:** 1.00

**CPT Action (if applicable):** February 2011

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**15320** Deleted from CPT

**Global:** 090

**Issue:** Skin Allograft

**Screen:** Different Performing Specialty from Survey

**Complete?** Yes

**Most Recent RUC Meeting:** February 2010

**Tab** 31

**Specialty Developing Recommendation:**

APMA, ASPS

**First Identified:** October 2009

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 5.36

**2013 Work RVU:**

**2007 NF PE RVU:** 3.66

**2013 NF PE RVU:**

**2007 Fac PE RVU** 2.49

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2010

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Deleted from CPT

**15321** Deleted from CPT

**Global:** ZZZ

**Issue:** Skin Allograft

**Screen:** Different Performing Specialty from Survey

**Complete?** Yes

**Most Recent RUC Meeting:** February 2010

**Tab** 31

**Specialty Developing Recommendation:**

APMA, ASPS

**First Identified:** February 2010

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 1.50

**2013 Work RVU:**

**2007 NF PE RVU:** 0.69

**2013 NF PE RVU:**

**2007 Fac PE RVU** 0.57

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Deleted from CPT



## Status Report: CMS Requests and Relativity Assessment Issues

**15330** Acellular dermal allograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children **Global:** 090 **Issue:** Allograft **Screen:** High IWPOT **Complete?** Yes

**Most Recent** **Tab** S **Specialty Developing Recommendation:** ASPS  
**RUC Meeting:** February 2008

**First Identified:** February 2008

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 3.99

**2013 Work RVU:**

**2007 NF PE RVU:** 3.18

**2013 NF PE RVU:**

**2007 Fac PE RVU** 2.15

**2013 Fac PE RVU:**

**RUC Recommendation:** Remove from screen

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Remove from Screen

**15331 Deleted from CPT**

**Global:** ZZZ

**Issue:** Acellular Dermal Allograft

**Screen:** Different Performing Specialty from Survey

**Complete?** Yes

**Most Recent** **Tab** 31 **Specialty Developing Recommendation:** AAO-HNS, APMA, ASPS  
**RUC Meeting:** February 2010

**First Identified:** February 2010

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 1.00

**2013 Work RVU:**

**2007 NF PE RVU:** 0.46

**2013 NF PE RVU:**

**2007 Fac PE RVU** 0.39

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Deleted from CPT

**15335 Deleted from CPT**

**Global:** 090

**Issue:** Acellular Dermal Allograft

**Screen:** Different Performing Specialty from Survey

**Complete?** Yes

**Most Recent** **Tab** 31 **Specialty Developing Recommendation:** AAO-HNS, APMA, ASPS  
**RUC Meeting:** February 2010

**First Identified:** October 2009

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 4.50

**2013 Work RVU:**

**2007 NF PE RVU:** 3.46

**2013 NF PE RVU:**

**2007 Fac PE RVU** 2.35

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

October 2010

**Result:** Deleted from CPT

**15336 Deleted from CPT**

**Global:** ZZZ

**Issue:** Acellular Dermal Allograft

**Screen:** Different Performing Specialty from Survey

**Complete?** Yes

**Most Recent** **Tab** 31 **Specialty Developing Recommendation:** AAO-HNS, APMA, ASPS  
**RUC Meeting:** February 2010

**First Identified:** February 2010

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 1.43

**2013 Work RVU:**

**2007 NF PE RVU:** 0.7

**2013 NF PE RVU:**

**2007 Fac PE RVU** 0.55

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

February 2011

**Result:** Deleted from CPT

# Status Report: CMS Requests and Relativity Assessment Issues

**15360 Deleted from CPT** **Global:** 090 **Issue:** Tissue Cultured Allogeneic Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

**Most Recent RUC Meeting:** February 2010 **Tab** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2012 Est Medicare Utilization:** **2007 Work RVU:** 3.93 **2013 Work RVU:** **2007 NF PE RVU:** 4.47 **2013 NF PE RVU:** **2007 Fac PE RVU:** 3.13 **2013 Fac PE RVU:** **RUC Recommendation:** Deleted from CPT **CPT Action (if applicable):** February 2011 **Result:** Deleted from CPT **Referred to CPT Asst** ☐ **Published in CPT Asst:**

**15361 Deleted from CPT** **Global:** ZZZ **Issue:** Tissue Cultured Allogeneic Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

**Most Recent RUC Meeting:** February 2010 **Tab** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2012 Est Medicare Utilization:** **2007 Work RVU:** 1.15 **2013 Work RVU:** **2007 NF PE RVU:** 0.58 **2013 NF PE RVU:** **2007 Fac PE RVU:** 0.44 **2013 Fac PE RVU:** **RUC Recommendation:** Deleted from CPT **CPT Action (if applicable):** February 2011 **Result:** Deleted from CPT **Referred to CPT Asst** ☐ **Published in CPT Asst:**

**15365 Deleted from CPT** **Global:** 090 **Issue:** Tissue Cultured Allogeneic Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

**Most Recent RUC Meeting:** February 2010 **Tab** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** October 2009 **2012 Est Medicare Utilization:** **2007 Work RVU:** 4.21 **2013 Work RVU:** **2007 NF PE RVU:** 4.5 **2013 NF PE RVU:** **2007 Fac PE RVU:** 3.2 **2013 Fac PE RVU:** **RUC Recommendation:** Deleted from CPT **CPT Action (if applicable):** October 2010 **Result:** Deleted from CPT **Referred to CPT Asst** ☐ **Published in CPT Asst:**

**15366 Deleted from CPT** **Global:** ZZZ **Issue:** Tissue Cultured Allogeneic Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

**Most Recent RUC Meeting:** February 2010 **Tab** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2012 Est Medicare Utilization:** **2007 Work RVU:** 1.45 **2013 Work RVU:** **2007 NF PE RVU:** 0.7 **2013 NF PE RVU:** **2007 Fac PE RVU:** 0.56 **2013 Fac PE RVU:** **RUC Recommendation:** Deleted from CPT **CPT Action (if applicable):** February 2011 **Result:** Deleted from CPT **Referred to CPT Asst** ☐ **Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

### 15400 Deleted from CPT

Global: 090

Issue: Xenograft

Screen: Site of Service Anomaly

Complete? Yes

Most Recent  
RUC Meeting: September 2007

Tab 16

Specialty Developing  
Recommendation: APMA, AAO-  
HNS, ASPS

First  
Identified: September 2007

2012 Est  
Medicare  
Utilization:

2007 Work RVU: 4.38

2013 Work RVU:

2007 NF PE RVU: 4.25

2013 NF PE RVU:

2007 Fac PE RVU 3.95

2013 Fac PE RVU:

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

CPT Action (if applicable):

Referred to CPT Asst ☐

Published in CPT Asst:

### 15401 Deleted from CPT

Global: ZZZ

Issue: Xenograft

Screen: High Volume Growth1

Complete? Yes

Most Recent  
RUC Meeting: February 2008

Tab S

Specialty Developing  
Recommendation: ACS, ASPS

First  
Identified: February 2008

2012 Est  
Medicare  
Utilization:

2007 Work RVU: 1.00

2013 Work RVU:

2007 NF PE RVU: 1.67

2013 NF PE RVU:

2007 Fac PE RVU 0.42

2013 Fac PE RVU:

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

CPT Action (if applicable):

Referred to CPT Asst ☐

Published in CPT Asst:

### 15420 Deleted from CPT

Global: 090

Issue: Xenograft Skin

Screen: Different Performing  
Specialty from Survey

Complete? Yes

Most Recent  
RUC Meeting: February 2010

Tab 31

Specialty Developing  
Recommendation: APMA,  
ASPS, AAD

First  
Identified: October 2009

2012 Est  
Medicare  
Utilization:

2007 Work RVU: 4.89

2013 Work RVU:

2007 NF PE RVU: 4.86

2013 NF PE RVU:

2007 Fac PE RVU 3.83

2013 Fac PE RVU:

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

CPT Action (if applicable):

Referred to CPT Asst ☐

October 2010

Published in CPT Asst:

### 15421 Deleted from CPT

Global: ZZZ

Issue: Xenograft Skin

Screen: Different Performing  
Specialty from Survey

Complete? Yes

Most Recent  
RUC Meeting: February 2010

Tab 31

Specialty Developing  
Recommendation: APMA,  
ASPS, AAD

First  
Identified: February 2010

2012 Est  
Medicare  
Utilization:

2007 Work RVU: 1.50

2013 Work RVU:

2007 NF PE RVU: 1.29

2013 NF PE RVU:

2007 Fac PE RVU 0.60

2013 Fac PE RVU:

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

CPT Action (if applicable):

Referred to CPT Asst ☐

February 2011

Published in CPT Asst:

# Status Report: CMS Requests and Relativity Assessment Issues

**15570** Formation of direct or tubed pedicle, with or without transfer; trunk **Global:** 090 **Issue:** Skin Pedicle Flaps **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent** **Tab** 10 **Specialty Developing** ACS, ASPS, **First** **2012 Est** **2007 Work RVU:** 10.00 **2013 Work RVU:** 10.21  
**RUC Meeting:** October 2008 **Recommendation:** AAO-HNS **Identified:** September 2007 **Medicare** **2007 NF PE RVU:** 11.09 **2013 NF PE RVU:** 15.21  
**Utilization:** 417 **2007 Fac PE RVU:** 6.71 **2013 Fac PE RVU:** 9.85  
**RUC Recommendation:** 10.00 **CPT Action (if applicable):** **Result:** Maintain  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**15572** Formation of direct or tubed pedicle, with or without transfer; scalp, arms, or legs **Global:** 090 **Issue:** Skin Pedicle Flaps **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent** **Tab** 10 **Specialty Developing** ACS, ASPS, **First** **2012 Est** **2007 Work RVU:** 9.94 **2013 Work RVU:** 10.12  
**RUC Meeting:** October 2008 **Recommendation:** AAO-HNS **Identified:** April 2008 **Medicare** **2007 NF PE RVU:** 9.59 **2013 NF PE RVU:** 14.40  
**Utilization:** 620 **2007 Fac PE RVU:** 6.53 **2013 Fac PE RVU:** 10.18  
**RUC Recommendation:** 9.94 **CPT Action (if applicable):** **Result:** Maintain  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**15574** Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet **Global:** 090 **Issue:** Skin Pedicle Flaps **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent** **Tab** 10 **Specialty Developing** ASPS, AAO- **First** **2012 Est** **2007 Work RVU:** 10.52 **2013 Work RVU:** 10.70  
**RUC Meeting:** October 2008 **Recommendation:** HNS **Identified:** September 2007 **Medicare** **2007 NF PE RVU:** 10.64 **2013 NF PE RVU:** 14.85  
**Utilization:** 2,150 **2007 Fac PE RVU:** 7.6 **2013 Fac PE RVU:** 10.43  
**RUC Recommendation:** 10.52 **CPT Action (if applicable):** **Result:** Maintain  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**15576** Formation of direct or tubed pedicle, with or without transfer; eyelids, nose, ears, lips, or intraoral **Global:** 090 **Issue:** Skin Pedicle Flaps **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent** **Tab** 10 **Specialty Developing** ASPS, AAO- **First** **2012 Est** **2007 Work RVU:** 9.24 **2013 Work RVU:** 9.37  
**RUC Meeting:** October 2008 **Recommendation:** HNS **Identified:** September 2007 **Medicare** **2007 NF PE RVU:** 9.74 **2013 NF PE RVU:** 13.43  
**Utilization:** 4,062 **2007 Fac PE RVU:** 6.81 **2013 Fac PE RVU:** 9.34  
**RUC Recommendation:** 9.24 **CPT Action (if applicable):** **Result:** Maintain  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

# Status Report: CMS Requests and Relativity Assessment Issues

**15732** Muscle, myocutaneous, or fasciocutaneous flap; head and neck (eg, temporalis, masseter muscle, sternocleidomastoid, levator scapulae) **Global:** 090 **Issue:** Muscle - Skin Graft **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** October 2010

**Tab** 16 **Specialty Developing Recommendation:** ASPS, AAO-HNS

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 13,393

**2007 Work RVU:** 19.70

**2013 Work RVU:** 16.38

**2007 NF PE RVU:** 17.27

**2013 NF PE RVU:** 19.55

**2007 Fac PE RVU** 12.01

**2013 Fac PE RVU:** 14.66

**Result:** Decrease

**RUC Recommendation:** 19.83

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**15740** Flap; island pedicle requiring identification and dissection of an anatomically named axial vessel

**Global:** 090

**Issue:** Dermatology and Plastic Surgery Procedures

**Screen:** Site of Service Anomaly / CMS Fastest Growing

**Complete?** Yes

**Most Recent RUC Meeting:** April 2008

**Tab** 28 **Specialty Developing Recommendation:** AAD, ASPS

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 2,742

**2007 Work RVU:** 11.57

**2013 Work RVU:** 11.80

**2007 NF PE RVU:** 11.01

**2013 NF PE RVU:** 16.84

**2007 Fac PE RVU** 8.58

**2013 Fac PE RVU:** 11.95

**Result:** Maintain

**RUC Recommendation:** 11.57

**CPT Action (if applicable):**

February 2009 & February 2012

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**15777** Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (eg, breast, trunk) (List separately in addition to code for primary procedure)

**Global:** ZZZ

**Issue:** Chronic Wound Dermal Substitute

**Screen:** Different Performing Specialty from Survey

**Complete?** Yes

**Most Recent RUC Meeting:** April 2011

**Tab** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS

**First Identified:** April 2011

**2012 Est Medicare Utilization:** 8,630

**2007 Work RVU:**

**2013 Work RVU:** 3.65

**2007 NF PE RVU:**

**2013 NF PE RVU:** 1.48

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 1.48

**Result:** Decrease

**RUC Recommendation:** 3.65

**CPT Action (if applicable):**

February 2011

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

# Status Report: CMS Requests and Relativity Assessment Issues

<b>15823</b>	<b>Blepharoplasty, upper eyelid; with excessive skin weighting down lid</b>	<b>Global:</b> 090	<b>Issue:</b> Upper Eyelid Blepharoplasty	<b>Screen:</b> Harvard Valued - Utilization over 100,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab</b> 33	<b>Specialty Developing Recommendation:</b> AAO	<b>First Identified:</b> October 2009	<b>2012 Est Medicare Utilization:</b> 102,448	<b>2007 Work RVU:</b> 8.12 <b>2007 NF PE RVU:</b> 7.8 <b>2007 Fac PE RVU:</b> 6.41 <b>Result:</b> Decrease
<b>RUC Recommendation:</b> 6.81			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 6.81 <b>2013 NF PE RVU:</b> 10.72 <b>2013 Fac PE RVU:</b> 8.78

<b>16020</b>	<b>Dressings and/or debridement of partial-thickness burns, initial or subsequent; small (less than 5% total body surface area)</b>	<b>Global:</b> 000	<b>Issue:</b> Dressings/ Debridement of Partial-Thickness Burns	<b>Screen:</b> Different Performing Specialty from Survey	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2010	<b>Tab</b> 08	<b>Specialty Developing Recommendation:</b> ASPS, AAFP, AAPMR, ACS, AAP	<b>First Identified:</b> October 2009	<b>2012 Est Medicare Utilization:</b> 17,387	<b>2007 Work RVU:</b> 0.80 <b>2007 NF PE RVU:</b> 1.25 <b>2007 Fac PE RVU:</b> 0.58 <b>Result:</b> Maintain
<b>RUC Recommendation:</b> 0.80			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 0.71 <b>2013 NF PE RVU:</b> 1.64 <b>2013 Fac PE RVU:</b> 0.81

<b>16025</b>	<b>Dressings and/or debridement of partial-thickness burns, initial or subsequent; medium (eg, whole face or whole extremity, or 5% to 10% total body surface area)</b>	<b>Global:</b> 000	<b>Issue:</b> Dressings/ Debridement of Partial-Thickness Burns	<b>Screen:</b> Different Performing Specialty from Survey	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2010	<b>Tab</b> 08	<b>Specialty Developing Recommendation:</b> ASPS, AAFP, AAPMR, ACS, AAP	<b>First Identified:</b> October 2009	<b>2012 Est Medicare Utilization:</b> 2,386	<b>2007 Work RVU:</b> 1.85 <b>2007 NF PE RVU:</b> 1.72 <b>2007 Fac PE RVU:</b> 0.94 <b>Result:</b> Maintain
<b>RUC Recommendation:</b> 1.85			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 1.74 <b>2013 NF PE RVU:</b> 2.38 <b>2013 Fac PE RVU:</b> 1.29

## Status Report: CMS Requests and Relativity Assessment Issues

**16030** Dressings and/or debridement of partial-thickness burns, initial or subsequent; large (eg, more than 1 extremity, or greater than 10% total body surface area) **Global:** 000 **Issue:** Dressings/ Debridement of Partial-Thickness Burns **Screen:** Different Performing Specialty from Survey **Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab** 45

**Specialty Developing Recommendation:**

ACEP, ASPS, AAFP, AAPMR, ACS, AAP

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 1,151

**2007 Work RVU:** 2.08

**2013 Work RVU:** 2.08

**2007 NF PE RVU:** 2.12

**2013 NF PE RVU:** 3.05

**2007 Fac PE RVU:** 1.08

**2013 Fac PE RVU:** 1.51

**RUC Recommendation:** CPT Assistant article published.

**CPT Action (if applicable):**

**Referred to CPT Asst** ☒

**Published in CPT Asst:** Oct 2012

**Result:** Maintain

**17000** Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion

**Global:** 010

**Issue:** Destruction of Premalignant Lesions

**Screen:** MPC List

**Complete?** Yes

**Most Recent RUC Meeting:** April 2013

**Tab** 17

**Specialty Developing Recommendation:**

**First Identified:** October 2010

**2012 Est Medicare Utilization:** 5,171,887

**2007 Work RVU:** 0.62

**2013 Work RVU:** 0.65

**2007 NF PE RVU:** 1.08

**2013 NF PE RVU:** 1.72

**2007 Fac PE RVU:** 0.59

**2013 Fac PE RVU:** 0.95

**RUC Recommendation:** 0.61

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**17003** Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); second through 14 lesions, each (List separately in addition to code for first lesion)

**Global:** ZZZ

**Issue:** Destruction of Premalignant Lesions

**Screen:** Low Value-Billed in Multiple Units / CMS High Expenditure Procedural Codes

**Complete?** Yes

**Most Recent RUC Meeting:** April 2013

**Tab** 17

**Specialty Developing Recommendation:**

**First Identified:** October 2010

**2012 Est Medicare Utilization:** 16,326,192

**2007 Work RVU:** 0.07

**2013 Work RVU:** 0.07

**2007 NF PE RVU:** 0.11

**2013 NF PE RVU:** 0.12

**2007 Fac PE RVU:** 0.06

**2013 Fac PE RVU:** 0.05

**RUC Recommendation:** 0.04

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

# Status Report: CMS Requests and Relativity Assessment Issues

**17004** Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions **Global:** 010 **Issue:** Destruction of Premalignant Lesions **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

**Most Recent RUC Meeting:** April 2013

**Tab 17** **Specialty Developing Recommendation:**

**First Identified:** September 2011

**2012 Est Medicare Utilization:** 785,488

**2007 Work RVU:** 1.82  
**2007 NF PE RVU:** 2.33  
**2007 Fac PE RVU:** 1.54  
**Result:** Decrease

**2013 Work RVU:** 1.85  
**2013 NF PE RVU:** 2.96  
**2013 Fac PE RVU:** 1.76

**RUC Recommendation:** 1.37

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**17106** Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm **Global:** 090 **Issue:** Destruction of Skin Lesions **Screen:** High IWPUT **Complete?** Yes

**Most Recent RUC Meeting:** October 2008

**Tab 11** **Specialty Developing Recommendation:** AAD

**First Identified:** February 2008

**2012 Est Medicare Utilization:** 2,517

**2007 Work RVU:** 4.62  
**2007 NF PE RVU:** 4.63  
**2007 Fac PE RVU:** 3.33  
**Result:** Decrease

**2013 Work RVU:** 3.69  
**2013 NF PE RVU:** 5.87  
**2013 Fac PE RVU:** 3.91

**RUC Recommendation:** 3.61

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**17107** Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm **Global:** 090 **Issue:** Destruction of Skin Lesions **Screen:** High IWPUT **Complete?** Yes

**Most Recent RUC Meeting:** October 2008

**Tab 11** **Specialty Developing Recommendation:** AAD

**First Identified:** February 2008

**2012 Est Medicare Utilization:** 1,242

**2007 Work RVU:** 9.19  
**2007 NF PE RVU:** 7.24  
**2007 Fac PE RVU:** 5.41  
**Result:** Decrease

**2013 Work RVU:** 4.79  
**2013 NF PE RVU:** 7.61  
**2013 Fac PE RVU:** 4.98

**RUC Recommendation:** 4.68

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**17108** Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm **Global:** 090 **Issue:** Destruction of Skin Lesions **Screen:** High IWPUT **Complete?** Yes

**Most Recent RUC Meeting:** October 2008

**Tab 11** **Specialty Developing Recommendation:** AAD

**First Identified:** February 2008

**2012 Est Medicare Utilization:** 2,700

**2007 Work RVU:** 13.22  
**2007 NF PE RVU:** 9.34  
**2007 Fac PE RVU:** 7.49  
**Result:** Decrease

**2013 Work RVU:** 7.49  
**2013 NF PE RVU:** 10.35  
**2013 Fac PE RVU:** 6.88

**RUC Recommendation:** 6.37

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**



## Status Report: CMS Requests and Relativity Assessment Issues

**17110** Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions **Global:** 010 **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** No

**Most Recent RUC Meeting:** **Tab** **Specialty Developing Recommendation:** **First Identified:** April 2013 **2012 Est Medicare Utilization:** 1,689,777 **2007 Work RVU:** 0.67 **2013 Work RVU:** 0.70 **2007 NF PE RVU:** 1.66 **2013 NF PE RVU:** 2.58 **2007 Fac PE RVU:** 0.74 **2013 Fac PE RVU:** 1.32 **RUC Recommendation:** Review Action Plan **CPT Action (if applicable):** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

**17111** Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions **Global:** 010 **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** No

**Most Recent RUC Meeting:** **Tab** **Specialty Developing Recommendation:** **First Identified:** April 2013 **2012 Est Medicare Utilization:** 86,759 **2007 Work RVU:** 0.94 **2013 Work RVU:** 0.97 **2007 NF PE RVU:** 1.83 **2013 NF PE RVU:** 2.89 **2007 Fac PE RVU:** 0.89 **2013 Fac PE RVU:** 1.48 **RUC Recommendation:** Review Action Plan **CPT Action (if applicable):** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

**17261** Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 0.6 to 1.0 cm **Global:** 010 **Issue:** Destruction of Malignant Lesion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** October 2010 **Tab** 26 **Specialty Developing Recommendation:** AAD, AAFP **First Identified:** October 2009 **2012 Est Medicare Utilization:** 138,030 **2007 Work RVU:** 1.19 **2013 Work RVU:** 1.22 **2007 NF PE RVU:** 1.84 **2013 NF PE RVU:** 2.94 **2007 Fac PE RVU:** 0.90 **2013 Fac PE RVU:** 1.34 **RUC Recommendation:** 1.22 **CPT Action (if applicable):** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Maintain

## Status Report: CMS Requests and Relativity Assessment Issues

**17262** Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 1.1 to 2.0 cm **Global:** 010 **Issue:** Destruction of Malignant Lesion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** October 2010

**Tab 26 Specialty Developing Recommendation:** AAD, AAFP

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 223,935

**2007 Work RVU:** 1.60

**2013 Work RVU:** 1.63

**2007 NF PE RVU:** 2.13

**2013 NF PE RVU:** 3.40

**2007 Fac PE RVU** 1.09

**2013 Fac PE RVU:** 1.61

**Result:** Maintain

**RUC Recommendation:** 1.63

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**17271** Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm **Global:** 010 **Issue:** Destruction of Malignant Lesion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** October 2010

**Tab 26 Specialty Developing Recommendation:** AAD, AAFP

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 57,411

**2007 Work RVU:** 1.51

**2013 Work RVU:** 1.54

**2007 NF PE RVU:** 2

**2013 NF PE RVU:** 3.15

**2007 Fac PE RVU** 1.05

**2013 Fac PE RVU:** 1.55

**Result:** Maintain

**RUC Recommendation:** 1.54

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**17272** Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm **Global:** 010 **Issue:** Destruction of Malignant Lesion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** October 2010

**Tab 26 Specialty Developing Recommendation:** AAD, AAFP

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 75,985

**2007 Work RVU:** 1.79

**2013 Work RVU:** 1.82

**2007 NF PE RVU:** 2.24

**2013 NF PE RVU:** 3.51

**2007 Fac PE RVU** 1.18

**2013 Fac PE RVU:** 1.73

**Result:** Maintain

**RUC Recommendation:** 1.82

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

<b>17281</b>	<b>Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm</b>	<b>Global:</b> 010	<b>Issue:</b> Destruction of Malignant Lesion	<b>Screen:</b> Harvard Valued - Utilization over 100,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2010	<b>Tab</b> 26 <b>Specialty Developing Recommendation:</b> AAD, AAFP	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 123,321	<b>2007 Work RVU:</b> 1.74 <b>2007 NF PE RVU:</b> 2.12 <b>2007 Fac PE RVU:</b> 1.16 <b>Result:</b> Maintain	<b>2013 Work RVU:</b> 1.77 <b>2013 NF PE RVU:</b> 3.31 <b>2013 Fac PE RVU:</b> 1.70
<b>RUC Recommendation:</b> 1.77	<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>		
<b>17282</b>	<b>Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm</b>	<b>Global:</b> 010	<b>Issue:</b> Destruction of Malignant Lesion	<b>Screen:</b> Harvard Valued - Utilization over 100,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2010	<b>Tab</b> 26 <b>Specialty Developing Recommendation:</b> AAD, AAFP	<b>First Identified:</b> October 2009	<b>2012 Est Medicare Utilization:</b> 107,991	<b>2007 Work RVU:</b> 2.06 <b>2007 NF PE RVU:</b> 2.41 <b>2007 Fac PE RVU:</b> 1.31 <b>Result:</b> Maintain	<b>2013 Work RVU:</b> 2.09 <b>2013 NF PE RVU:</b> 3.73 <b>2013 Fac PE RVU:</b> 1.90
<b>RUC Recommendation:</b> 2.09	<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>		
<b>17311</b>	<b>Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks</b>	<b>Global:</b> 000	<b>Issue:</b> Mohs Surgery	<b>Screen:</b> CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 18 <b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 586,965	<b>2007 Work RVU:</b> 6.20 <b>2007 NF PE RVU:</b> 10.79 <b>2007 Fac PE RVU:</b> 3.16 <b>Result:</b> Maintain	<b>2013 Work RVU:</b> 6.20 <b>2013 NF PE RVU:</b> 12.46 <b>2013 Fac PE RVU:</b> 4.09
<b>RUC Recommendation:</b> 6.20	<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>		

## Status Report: CMS Requests and Relativity Assessment Issues

17312	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Mohs Surgery	Screen: CMS High Expenditure Procedural Codes	Complete? Yes
Most Recent RUC Meeting: April 2013	Tab 18 Specialty Developing Recommendation:	First Identified: September 2011	2012 Est Medicare Utilization: 437,085	2007 Work RVU: 3.30 2007 NF PE RVU: 6.92 2007 Fac PE RVU 1.68 Result: Maintain	2013 Work RVU: 3.30 2013 NF PE RVU: 7.94 2013 Fac PE RVU: 2.17
RUC Recommendation: 3.30			CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	
17313	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; first stage, up to 5 tissue blocks	Global: 000	Issue: Mohs Surgery	Screen: CMS High Expenditure Procedural Codes	Complete? Yes
Most Recent RUC Meeting: April 2013	Tab 18 Specialty Developing Recommendation:	First Identified: January 2012	2012 Est Medicare Utilization: 83,002	2007 Work RVU: 5.56 2007 NF PE RVU: 9.95 2007 Fac PE RVU 2.83 Result: Maintain	2013 Work RVU: 5.56 2013 NF PE RVU: 11.48 2013 Fac PE RVU: 3.67
RUC Recommendation: 5.56			CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	
17314	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Mohs Surgery	Screen: CMS High Expenditure Procedural Codes	Complete? Yes
Most Recent RUC Meeting: April 2013	Tab 18 Specialty Developing Recommendation:	First Identified: January 2012	2012 Est Medicare Utilization: 43,845	2007 Work RVU: 3.06 2007 NF PE RVU: 6.41 2007 Fac PE RVU 1.55 Result: Maintain	2013 Work RVU: 3.06 2013 NF PE RVU: 7.36 2013 Fac PE RVU: 2.02
RUC Recommendation: 3.06			CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	

# Status Report: CMS Requests and Relativity Assessment Issues

**17315** Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), each additional block after the first 5 tissue blocks, any stage (List separately in addition to code for primary procedure)

**Global:** ZZZ **Issue:** Mohs Surgery **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

**Most Recent RUC Meeting:** April 2013 **Tab 18** **Specialty Developing Recommendation:**

**First Identified:** January 2012 **2012 Est Medicare Utilization:** 22,393

**2007 Work RVU:** 0.87 **2013 Work RVU:** 0.87  
**2007 NF PE RVU:** 1.15 **2013 NF PE RVU:** 1.34  
**2007 Fac PE RVU:** 0.44 **2013 Fac PE RVU:** 0.57  
**Result:** Maintain

**RUC Recommendation:** 0.87

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**19020** Mastotomy with exploration or drainage of abscess, deep

**Global:** 090 **Issue:** Mastotomy **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** September 2007 **Tab 16** **Specialty Developing Recommendation:** ACS

**First Identified:** September 2007 **2012 Est Medicare Utilization:** 2,071

**2007 Work RVU:** 3.74 **2013 Work RVU:** 3.83  
**2007 NF PE RVU:** 6.39 **2013 NF PE RVU:** 9.77  
**2007 Fac PE RVU:** 2.76 **2013 Fac PE RVU:** 4.54  
**Result:** PE Only

**RUC Recommendation:** Reduce 99238 to 0.5, remove hospital visits

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**19102** Biopsy of breast; percutaneous, needle core, using imaging guidance

**Global:** 000 **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

**Most Recent RUC Meeting:** April 2013 **Tab 04** **Specialty Developing Recommendation:**

**First Identified:** January 2012 **2012 Est Medicare Utilization:** 59,667

**2007 Work RVU:** 2.00 **2013 Work RVU:** 2.00  
**2007 NF PE RVU:** 3.68 **2013 NF PE RVU:** 4.17  
**2007 Fac PE RVU:** 0.64 **2013 Fac PE RVU:** 0.73  
**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2012  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

---

<b>19103</b>	<b>Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance</b>	<b>Global:</b> 000	<b>Issue:</b> Breast Biopsy	<b>Screen:</b> Codes Reported Together 75% or More-Part2	<b>Complete?</b> Yes
--------------	--	--------------------	-----------------------------	--	----------------------

<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 04	<b>Specialty Developing Recommendation:</b>
--	---------------	---

<b>First Identified:</b> January 2012	<b>2012 Est Medicare Utilization:</b> 119,202
---------------------------------------	---

<b>2007 Work RVU:</b> 3.69	<b>2013 Work RVU:</b> 3.69
<b>2007 NF PE RVU:</b> 11.01	<b>2013 NF PE RVU:</b> 12.45
<b>2007 Fac PE RVU:</b> 1.18	<b>2013 Fac PE RVU:</b> 1.36

**RUC Recommendation:** Deleted from CPT

<b>CPT Action (if applicable):</b> October 2012
<b>Referred to CPT Asst</b> <input type="checkbox"/> <b>Published in CPT Asst:</b>

**Result:** Deleted from CPT

---

**191XX1**

<b>Global:</b> 000	<b>Issue:</b> Breast Biopsy	<b>Screen:</b> Codes Reported Together 75% or More-Part2	<b>Complete?</b> Yes
--------------------	-----------------------------	--	----------------------

<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 04	<b>Specialty Developing Recommendation:</b>
--	---------------	---

<b>First Identified:</b> January 2012	<b>2012 Est Medicare Utilization:</b>
<b>CPT Action (if applicable):</b> October 2012	
<b>Referred to CPT Asst</b> <input type="checkbox"/> <b>Published in CPT Asst:</b>	

<b>2007 Work RVU:</b>	<b>2013 Work RVU:</b>
<b>2007 NF PE RVU:</b>	<b>2013 NF PE RVU:</b>
<b>2007 Fac PE RVU</b>	<b>2013 Fac PE RVU:</b>
<b>Result:</b> Decrease	

**RUC Recommendation:** 3.29

---

**191XX2**

<b>Global:</b> ZZZ	<b>Issue:</b> Breast Biopsy	<b>Screen:</b> Codes Reported Together 75% or More-Part2	<b>Complete?</b> Yes
--------------------	-----------------------------	--	----------------------

<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 04	<b>Specialty Developing Recommendation:</b>
--	---------------	---

<b>First Identified:</b> January 2012	<b>2012 Est Medicare Utilization:</b>
<b>CPT Action (if applicable):</b> October 2012	
<b>Referred to CPT Asst</b> <input type="checkbox"/> <b>Published in CPT Asst:</b>	

<b>2007 Work RVU:</b>	<b>2013 Work RVU:</b>
<b>2007 NF PE RVU:</b>	<b>2013 NF PE RVU:</b>
<b>2007 Fac PE RVU</b>	<b>2013 Fac PE RVU:</b>
<b>Result:</b> Decrease	

**RUC Recommendation:** 1.65

## Status Report: CMS Requests and Relativity Assessment Issues

191XX3

Global: 000

Issue: Breast Biopsy

Screen: Codes Reported  
Together 75% or More-  
Part2

Complete? Yes

Most Recent  
RUC Meeting: April 2013

Tab 04

Specialty Developing  
Recommendation:

First  
Identified: January 2012

2012 Est  
Medicare  
Utilization:

2007 Work RVU:

2013 Work RVU:

2007 NF PE RVU:

2013 NF PE RVU:

2007 Fac PE RVU

2013 Fac PE RVU:

RUC Recommendation: 3.10

CPT Action (if applicable): October 2012

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Decrease

191XX4

Global: ZZZ

Issue: Breast Biopsy

Screen: Codes Reported  
Together 75% or More-  
Part2

Complete? Yes

Most Recent  
RUC Meeting: April 2013

Tab 04

Specialty Developing  
Recommendation:

First  
Identified: January 2012

2012 Est  
Medicare  
Utilization:

2007 Work RVU:

2013 Work RVU:

2007 NF PE RVU:

2013 NF PE RVU:

2007 Fac PE RVU

2013 Fac PE RVU:

RUC Recommendation: 1.55

CPT Action (if applicable): October 2012

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Decrease

191XX5

Global: 000

Issue: Breast Biopsy

Screen: Codes Reported  
Together 75% or More-  
Part2

Complete? Yes

Most Recent  
RUC Meeting: April 2013

Tab 04

Specialty Developing  
Recommendation:

First  
Identified: January 2012

2012 Est  
Medicare  
Utilization:

2007 Work RVU:

2013 Work RVU:

2007 NF PE RVU:

2013 NF PE RVU:

2007 Fac PE RVU

2013 Fac PE RVU:

RUC Recommendation: 3.64

CPT Action (if applicable): October 2012

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Decrease

## Status Report: CMS Requests and Relativity Assessment Issues

191XX6

Global: ZZZ Issue: Breast Biopsy

Screen: Codes Reported  
Together 75% or More-  
Part2

Complete? Yes

Most Recent  
RUC Meeting: April 2013

Tab 04

Specialty Developing  
Recommendation:

First  
Identified: January 2012

2012 Est  
Medicare  
Utilization:

2007 Work RVU:

2013 Work RVU:

2007 NF PE RVU:

2013 NF PE RVU:

2007 Fac PE RVU

2013 Fac PE RVU:

RUC Recommendation: 1.82

CPT Action (if applicable):  
Referred to CPT Asst ☐ Published in CPT Asst:

October 2012

Result: Decrease

19290 Preoperative placement of needle localization wire, breast;

Global: 000 Issue: Breast Biopsy

Screen: Codes Reported  
Together 75% or More-  
Part2

Complete? Yes

Most Recent  
RUC Meeting: April 2013

Tab 04

Specialty Developing  
Recommendation:

First  
Identified: January 2012

2012 Est  
Medicare  
Utilization: 53,055

2007 Work RVU: 1.27

2013 Work RVU: 1.27

2007 NF PE RVU: 2.81

2013 NF PE RVU: 3.31

2007 Fac PE RVU 0.41

2013 Fac PE RVU: 0.46

RUC Recommendation: Deleted from CPT

CPT Action (if applicable):  
Referred to CPT Asst ☐ Published in CPT Asst:

October 2012

Result: Deleted from CPT

19291 Preoperative placement of needle localization wire, breast; each additional  
lesion (List separately in addition to code for primary procedure)

Global: ZZZ Issue: Breast Biopsy

Screen: Codes Reported  
Together 75% or More-  
Part2

Complete? Yes

Most Recent  
RUC Meeting: April 2013

Tab 04

Specialty Developing  
Recommendation:

First  
Identified: January 2012

2012 Est  
Medicare  
Utilization: 4,318

2007 Work RVU: 0.63

2013 Work RVU: 0.63

2007 NF PE RVU: 1.17

2013 NF PE RVU: 1.33

2007 Fac PE RVU 0.20

2013 Fac PE RVU: 0.23

RUC Recommendation: Deleted from CPT

CPT Action (if applicable):  
Referred to CPT Asst ☐ Published in CPT Asst:

October 2012

Result: Deleted from CPT



# Status Report: CMS Requests and Relativity Assessment Issues

<b>19295</b>	Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)	<b>Global:</b> ZZZ	<b>Issue:</b> Breast Biopsy	<b>Screen:</b> CMS Fastest Growing / Codes Reported Together 75% or More-Part2	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 04 <b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> October 2008	<b>2012 Est Medicare Utilization:</b> 155,707	<b>2007 Work RVU:</b> 0.00 <b>2007 NF PE RVU:</b> 2.57 <b>2007 Fac PE RVU:</b> 2.02 <b>Result:</b> Deleted from CPT	<b>2013 Work RVU:</b> 0.00 <b>2013 NF PE RVU:</b> 2.80 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Deleted from CPT		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	October 2012 <b>Published in CPT Asst:</b>		
<hr/>					
<b>1929XX1</b>		<b>Global:</b> 000	<b>Issue:</b> Breast Biopsy	<b>Screen:</b> Codes Reported Together 75% or More-Part2	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 04 <b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> January 2012	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU:</b> <b>Result:</b> Decrease	<b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>
<b>RUC Recommendation:</b> 2.00		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	October 2012 <b>Published in CPT Asst:</b>		
<hr/>					
<b>1929XX2</b>		<b>Global:</b> ZZZ	<b>Issue:</b> Breast Biopsy	<b>Screen:</b> Codes Reported Together 75% or More-Part2	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 04 <b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> January 2012	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU:</b> <b>Result:</b> Decrease	<b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>
<b>RUC Recommendation:</b> 1.00		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	October 2012 <b>Published in CPT Asst:</b>		

# Status Report: CMS Requests and Relativity Assessment Issues

<b>I929XX3</b>		<b>Global:</b> 000		<b>Issue:</b> Breast Biopsy	<b>Screen:</b> Codes Reported Together 75% or More-Part2	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 04	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> January 2012	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b>	<b>2013 Work RVU:</b>
<b>RUC Recommendation:</b> 2.00			<b>CPT Action (if applicable):</b>	October 2012	<b>2007 NF PE RVU:</b>	<b>2013 NF PE RVU:</b>
			<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2007 Fac PE RVU</b>	<b>2013 Fac PE RVU:</b>
					<b>Result:</b> Decrease	

<b>I929XX4</b>		<b>Global:</b> ZZZ		<b>Issue:</b> Breast Biopsy	<b>Screen:</b> Codes Reported Together 75% or More-Part2	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 04	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> January 2012	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b>	<b>2013 Work RVU:</b>
<b>RUC Recommendation:</b> 1.00			<b>CPT Action (if applicable):</b>	October 2012	<b>2007 NF PE RVU:</b>	<b>2013 NF PE RVU:</b>
			<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2007 Fac PE RVU</b>	<b>2013 Fac PE RVU:</b>
					<b>Result:</b> Decrease	

<b>I929XX5</b>		<b>Global:</b> 000		<b>Issue:</b> Breast Biopsy	<b>Screen:</b> Codes Reported Together 75% or More-Part2	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 04	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> January 2012	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b>	<b>2013 Work RVU:</b>
<b>RUC Recommendation:</b> 1.70			<b>CPT Action (if applicable):</b>	October 2012	<b>2007 NF PE RVU:</b>	<b>2013 NF PE RVU:</b>
			<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2007 Fac PE RVU</b>	<b>2013 Fac PE RVU:</b>
					<b>Result:</b> Decrease	

# Status Report: CMS Requests and Relativity Assessment Issues

<b>I929XX6</b>		<b>Global:</b> ZZZ		<b>Issue:</b> Breast Biopsy	<b>Screen:</b> Codes Reported Together 75% or More-Part2	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 04	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> January 2012	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b>	<b>2013 Work RVU:</b>
<b>RUC Recommendation:</b> 0.85			<b>CPT Action (if applicable):</b>	October 2012	<b>2007 NF PE RVU:</b>	<b>2013 NF PE RVU:</b>
			<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2007 Fac PE RVU</b>	<b>2013 Fac PE RVU:</b>
					<b>Result:</b> Decrease	

<b>I929XX7</b>		<b>Global:</b> 000		<b>Issue:</b> Breast Biopsy	<b>Screen:</b> Codes Reported Together 75% or More-Part2	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 04	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> January 2012	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b>	<b>2013 Work RVU:</b>
<b>RUC Recommendation:</b> 3.02			<b>CPT Action (if applicable):</b>	October 2012	<b>2007 NF PE RVU:</b>	<b>2013 NF PE RVU:</b>
			<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2007 Fac PE RVU</b>	<b>2013 Fac PE RVU:</b>
					<b>Result:</b> Decrease	

<b>I929XX8</b>		<b>Global:</b> ZZZ		<b>Issue:</b> Breast Biopsy	<b>Screen:</b> Codes Reported Together 75% or More-Part2	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 04	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> January 2012	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b>	<b>2013 Work RVU:</b>
<b>RUC Recommendation:</b> 1.51			<b>CPT Action (if applicable):</b>	October 2012	<b>2007 NF PE RVU:</b>	<b>2013 NF PE RVU:</b>
			<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2007 Fac PE RVU</b>	<b>2013 Fac PE RVU:</b>
					<b>Result:</b> Decrease	

# Status Report: CMS Requests and Relativity Assessment Issues

19318    Reduction mammoplasty			Global: 090		Issue: Mammoplasty		Screen: Site of Service Anomaly (99238-Only)		Complete? Yes			
Most Recent RUC Meeting: September 2007		Tab 16	Specialty Developing Recommendation: ASPS		First Identified: September 2007		2012 Est Medicare Utilization: 7,074		2007 Work RVU: 15.91		2013 Work RVU: 16.03	
									2007 NF PE RVU: NA		2013 NF PE RVU: NA	
									2007 Fac PE RVU 10.94		2013 Fac PE RVU: 13.93	
RUC Recommendation: Reduce 99238 to 0.5			CPT Action (if applicable):					Result: PE Only				
			Referred to CPT Asst		<input type="checkbox"/>		Published in CPT Asst:					

19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction			Global: 090	Issue: Insertion of Breast Prosthesis	Screen: CMS Request	Complete? Yes
Most Recent RUC Meeting: October 2009	Tab 10	Specialty Developing Recommendation: ASPS	First Identified:	2012 Est Medicare Utilization: 3,205	2007 Work RVU: 6.32	2013 Work RVU: 13.99	
					2007 NF PE RVU: NA	2013 NF PE RVU: NA	
					2007 Fac PE RVU 3.07	2013 Fac PE RVU: 13.42	
RUC Recommendation: 13.99			CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Decrease		

19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion			Global: 090	Issue: Breast Reconstruction	Screen: Site of Service Anomaly	Complete? Yes
Most Recent RUC Meeting:	February 2010	Tab 20	Specialty Developing Recommendation: ASPS	First Identified: September 2007	2012 Est Medicare Utilization: 6,854	2007 Work RVU: 20.57	2013 Work RVU: 18.50
						2007 NF PE RVU: NA	2013 NF PE RVU: NA
						2007 Fac PE RVU 15.69	2013 Fac PE RVU: 23.37
RUC Recommendation:	18.50			CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>	October 2009	Published in CPT Asst:	Result: Decrease

20000	Deleted from CPT			Global: 010	Issue: Incision of Abscess	Screen: Site of Service Anomaly (99238-Only)	Complete? Yes
Most Recent RUC Meeting:	September 2007	Tab 16	Specialty Developing Recommendation: APMA, AAOS	First Identified: September 2007	2012 Est Medicare Utilization:	2007 Work RVU: 2.14	2013 Work RVU:
						2007 NF PE RVU: 2.71	2013 NF PE RVU:
						2007 Fac PE RVU 1.68	2013 Fac PE RVU:
RUC Recommendation:	Deleted from CPT			CPT Action (if applicable):	June 2009	Result: Deleted from CPT	
				Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

# Status Report: CMS Requests and Relativity Assessment Issues

**20005** Incision and drainage of soft tissue abscess, subfascial (ie, involves the soft tissue below the deep fascia) **Global:** 010 **Issue:** Incision of Deep Abscess **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** September 2007 **Tab** 16 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2012 Est Medicare Utilization:** 5,183 **2007 Work RVU:** 3.55 **2013 Work RVU:** 3.58 **2007 NF PE RVU:** 3.54 **2013 NF PE RVU:** 5.14 **2007 Fac PE RVU:** 2.2 **2013 Fac PE RVU:** 2.81 **RUC Recommendation:** 3.55 **CPT Action (if applicable):** June 2009 **Result:** Maintain **Referred to CPT Asst** ☐ **Published in CPT Asst:**

**20525** Removal of foreign body in muscle or tendon sheath; deep or complicated **Global:** 010 **Issue:** Removal of Foreign Body **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

**Most Recent RUC Meeting:** September 2007 **Tab** 16 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2012 Est Medicare Utilization:** 1,917 **2007 Work RVU:** 3.51 **2013 Work RVU:** 3.54 **2007 NF PE RVU:** 8.62 **2013 NF PE RVU:** 10.49 **2007 Fac PE RVU:** 2.52 **2013 Fac PE RVU:** 3.24 **RUC Recommendation:** Reduce 99238 to 0.5 **CPT Action (if applicable):** **Result:** PE Only **Referred to CPT Asst** ☐ **Published in CPT Asst:**

**20550** Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia") **Global:** 000 **Issue:** Tendon Injections **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent RUC Meeting:** April 2009 **Tab** 38 **Specialty Developing Recommendation:** APMA, AAPM, AAOS **First Identified:** October 2008 **2012 Est Medicare Utilization:** 786,251 **2007 Work RVU:** 0.75 **2013 Work RVU:** 0.75 **2007 NF PE RVU:** 0.69 **2013 NF PE RVU:** 0.89 **2007 Fac PE RVU:** 0.25 **2013 Fac PE RVU:** 0.38 **RUC Recommendation:** Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen **Referred to CPT Asst** ☐ **Published in CPT Asst:**

**20551** Injection(s); single tendon origin/insertion **Global:** 000 **Issue:** RAW **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent RUC Meeting:** September 2011 **Tab** 51 **Specialty Developing Recommendation:** APMA, AAPM, AAOS **First Identified:** October 2008 **2012 Est Medicare Utilization:** 129,004 **2007 Work RVU:** 0.75 **2013 Work RVU:** 0.75 **2007 NF PE RVU:** 0.67 **2013 NF PE RVU:** 0.95 **2007 Fac PE RVU:** 0.32 **2013 Fac PE RVU:** 0.42 **RUC Recommendation:** Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen **Referred to CPT Asst** ☐ **Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

<b>20600</b>	<b>Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes)</b>	<b>Global:</b> 000	<b>Issue:</b> Arthrocentesis	<b>Screen:</b> Harvard Valued - Utilization over 100,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2010	<b>Tab</b> 09	<b>Specialty Developing Recommendation:</b> AAOS, ACRh, APMA, ASSH, AOFAS	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 414,148	<b>2007 Work RVU:</b> 0.66 <b>2007 NF PE RVU:</b> 0.66 <b>2007 Fac PE RVU:</b> 0.34 <b>2013 Work RVU:</b> 0.66 <b>2013 NF PE RVU:</b> 0.66 <b>2013 Fac PE RVU:</b> 0.30
<b>RUC Recommendation:</b> 0.66 and new PE inputs	<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>		<b>Result:</b> Maintain
<b>20605</b>	<b>Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)</b>	<b>Global:</b> 000	<b>Issue:</b> Arthrocentesis	<b>Screen:</b> Harvard Valued - Utilization over 100,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2010	<b>Tab</b> 09	<b>Specialty Developing Recommendation:</b> AAOS, ACRh, APMA, ASSH, AOFAS	<b>First Identified:</b> October 2009	<b>2012 Est Medicare Utilization:</b> 519,694	<b>2007 Work RVU:</b> 0.68 <b>2007 NF PE RVU:</b> 0.76 <b>2007 Fac PE RVU:</b> 0.35 <b>2013 Work RVU:</b> 0.98 <b>2013 NF PE RVU:</b> 0.83 <b>2013 Fac PE RVU:</b> 0.45
<b>RUC Recommendation:</b> 0.68 and new PE inputs	<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>		<b>Result:</b> Maintain
<b>20610</b>	<b>Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)</b>	<b>Global:</b> 000	<b>Issue:</b> Arthrocentesis	<b>Screen:</b> Harvard Valued - Utilization over 100,000 / MPC List / CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2012	<b>Tab</b> 39	<b>Specialty Developing Recommendation:</b> AAOS	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 6,634,755	<b>2007 Work RVU:</b> 0.79 <b>2007 NF PE RVU:</b> 0.98 <b>2007 Fac PE RVU:</b> 0.42 <b>2013 Work RVU:</b> 0.79 <b>2013 NF PE RVU:</b> 0.87 <b>2013 Fac PE RVU:</b> 0.44
<b>RUC Recommendation:</b> 0.79 and new PE inputs	<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>		<b>Result:</b> Maintain

# Status Report: CMS Requests and Relativity Assessment Issues

## 20694 Removal, under anesthesia, of external fixation system

Global: 090

Issue: External Fixation

Screen: Site of Service Anomaly (99238-Only)

Complete? Yes

Most Recent RUC Meeting: September 2007

Tab 16

Specialty Developing Recommendation: AAOS

First Identified: September 2007

2012 Est Medicare Utilization: 5,193

2007 Work RVU: 4.20

2013 Work RVU: 4.28

2007 NF PE RVU: 6.69

2013 NF PE RVU: 7.72

2007 Fac PE RVU: 3.92

2013 Fac PE RVU: 5.04

Result: PE Only

RUC Recommendation: Reduce 99238 to 0.5

CPT Action (if applicable):

Referred to CPT Asst ☐

Published in CPT Asst:

## 20900 Bone graft, any donor area; minor or small (eg, dowel or button)

Global: 000

Issue: Bone Graft Procedures

Screen: Site of Service Anomaly

Complete? Yes

Most Recent RUC Meeting: April 2008

Tab 29

Specialty Developing Recommendation: AOFAS, AAOS

First Identified: September 2007

2012 Est Medicare Utilization: 3,272

2007 Work RVU: 5.77

2013 Work RVU: 3.00

2007 NF PE RVU: 8.65

2013 NF PE RVU: 9.27

2007 Fac PE RVU: 5.5

2013 Fac PE RVU: 2.71

Result: Decrease

RUC Recommendation: 3.00

CPT Action (if applicable):

Referred to CPT Asst ☐

Published in CPT Asst:

## 20902 Bone graft, any donor area; major or large

Global: 000

Issue: Bone Graft Procedures

Screen: Site of Service Anomaly

Complete? Yes

Most Recent RUC Meeting: April 2008

Tab 29

Specialty Developing Recommendation: AOFAS, AAOS

First Identified: April 2008

2012 Est Medicare Utilization: 4,101

2007 Work RVU: 7.98

2013 Work RVU: 4.58

2007 NF PE RVU: NA

2013 NF PE RVU: NA

2007 Fac PE RVU: 6.63

2013 Fac PE RVU: 3.64

Result: Decrease

RUC Recommendation: 4.58

CPT Action (if applicable):

Referred to CPT Asst ☐

Published in CPT Asst:

## 20926 Tissue grafts, other (eg, paratenon, fat, dermis)

Global: 090

Issue: Tissue Grafts

Screen: CMS Fastest Growing

Complete? Yes

Most Recent RUC Meeting: February 2010

Tab 31

Specialty Developing Recommendation: AAOS, AAO-HNS, AANS

First Identified: October 2008

2012 Est Medicare Utilization: 12,185

2007 Work RVU: 5.70

2013 Work RVU: 5.79

2007 NF PE RVU: NA

2013 NF PE RVU: NA

2007 Fac PE RVU: 4.67

2013 Fac PE RVU: 6.20

Result: Remove from Screen

RUC Recommendation: Remove from screen

CPT Action (if applicable):

Referred to CPT Asst ☐

Published in CPT Asst:

## Status Report: CMS Requests and Relativity Assessment Issues

<b>21015</b>	<b>Radical resection of tumor (eg, malignant neoplasm), soft tissue of face or scalp; less than 2 cm</b>			<b>Global:</b> 090	<b>Issue:</b> Radical Resection of Soft Tissue Tumor	<b>Screen:</b> Site of Service Anomaly	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2009	<b>Tab</b> 6	<b>Specialty Developing Recommendation:</b>	ACS, AAOS, AAO-HNS, ASPS	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 1,430	<b>2007 Work RVU:</b> 5.59 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 4.85 <b>Result:</b> Increase	<b>2013 Work RVU:</b> 9.89 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 9.39
<b>RUC Recommendation:</b> 9.71				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	June 2008 <b>Published in CPT Asst:</b>		
<hr/>							
<b>21025</b>	<b>Excision of bone (eg, for osteomyelitis or bone abscess); mandible</b>			<b>Global:</b> 090	<b>Issue:</b> Excision of Bone – Mandible	<b>Screen:</b> Site of Service Anomaly	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2010	<b>Tab</b> 61	<b>Specialty Developing Recommendation:</b>	AAOMS	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 1,378	<b>2007 Work RVU:</b> 11.07 <b>2007 NF PE RVU:</b> 12.32 <b>2007 Fac PE RVU:</b> 9.21 <b>Result:</b> Decrease	<b>2013 Work RVU:</b> 10.03 <b>2013 NF PE RVU:</b> 15.23 <b>2013 Fac PE RVU:</b> 10.93
<b>RUC Recommendation:</b> 10.03				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		
<hr/>							
<b>21557</b>	<b>Radical resection of tumor (eg, malignant neoplasm), soft tissue of neck or anterior thorax; less than 5 cm</b>			<b>Global:</b> 090	<b>Issue:</b> Radical Resection of Soft Tissue Tumor	<b>Screen:</b> Site of Service Anomaly	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2009	<b>Tab</b> 6	<b>Specialty Developing Recommendation:</b>	ACS, AAOS	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 1,095	<b>2007 Work RVU:</b> 8.91 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 5.13 <b>Result:</b> Decrease	<b>2013 Work RVU:</b> 14.75 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 11.02
<b>RUC Recommendation:</b> 14.57				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	June 2008 <b>Published in CPT Asst:</b>		
<hr/>							
<b>21935</b>	<b>Radical resection of tumor (eg, malignant neoplasm), soft tissue of back or flank; less than 5 cm</b>			<b>Global:</b> 090	<b>Issue:</b> Radical Resection of Soft Tissue Tumor	<b>Screen:</b> Site of Service Anomaly	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2009	<b>Tab</b> 6	<b>Specialty Developing Recommendation:</b>	ACS, AAOS	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 651	<b>2007 Work RVU:</b> 18.38 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 9.37 <b>Result:</b> Decrease	<b>2013 Work RVU:</b> 15.72 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 11.69
<b>RUC Recommendation:</b> 15.54				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	June 2008 <b>Published in CPT Asst:</b>		



## Status Report: CMS Requests and Relativity Assessment Issues

<b>22214</b>	<b>Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar</b>	<b>Global:</b> 090	<b>Issue:</b> RAW	<b>Screen:</b> CMS Fastest Growing	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> September 2011	<b>Tab</b> 51	<b>Specialty Developing Recommendation:</b> AAOS, NASS, AANS/CNS	<b>First Identified:</b> October 2008	<b>2012 Est Medicare Utilization:</b> 2,670	<b>2007 Work RVU:</b> 20.77 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU</b> 13.53 <b>2013 Work RVU:</b> 21.02 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 17.86
<b>RUC Recommendation:</b> Review September 2014			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b>
<b>22520</b>	<b>Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; thoracic</b>	<b>Global:</b> 010	<b>Issue:</b> Moderate Sedation PE Inputs	<b>Screen:</b> CMS Request - Practice Expense Review / Codes Reported Together 75% or More-Part2	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> February 2009	<b>Tab</b> 33	<b>Specialty Developing Recommendation:</b> ACR, NASS, ASNR, SIR, ASIPP, AANS/CNS	<b>First Identified:</b> February 2009	<b>2012 Est Medicare Utilization:</b> 7,448	<b>2007 Work RVU:</b> 9.17 <b>2007 NF PE RVU:</b> 56.83 <b>2007 Fac PE RVU</b> 4.84 <b>2013 Work RVU:</b> 9.22 <b>2013 NF PE RVU:</b> 58.41 <b>2013 Fac PE RVU:</b> 4.60
<b>RUC Recommendation:</b> Refer to CPT to bundle.			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b>
<b>22521</b>	<b>Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; lumbar</b>	<b>Global:</b> 010	<b>Issue:</b> Moderate Sedation PE Inputs	<b>Screen:</b> Site of Service Anomaly (99238-Only); CMS Request - PE Inputs / Codes Reported Together 75% or More-Part2	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> February 2009	<b>Tab</b> 33	<b>Specialty Developing Recommendation:</b> ACR, ASNR, NASS, SIR	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 7,644	<b>2007 Work RVU:</b> 8.60 <b>2007 NF PE RVU:</b> 52.87 <b>2007 Fac PE RVU</b> 4.69 <b>2013 Work RVU:</b> 8.65 <b>2013 NF PE RVU:</b> 59.10 <b>2013 Fac PE RVU:</b> 4.55
<b>RUC Recommendation:</b> Refer to CPT to bundle.			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b>

## Status Report: CMS Requests and Relativity Assessment Issues

<b>22523</b>	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic	<b>Global:</b> 010	<b>Issue:</b> Kyphoplasty	<b>Screen:</b> CMS Request: PE Review	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> September 2011	<b>Tab</b> 47 <b>Specialty Developing Recommendation:</b> ACR, SIR	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 22,557	<b>2007 Work RVU:</b> 9.21 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU Result:</b> PE Only	<b>2013 Work RVU:</b> 9.04 <b>2013 NF PE RVU:</b> 224.14 <b>2013 Fac PE RVU:</b> 5.82
<b>RUC Recommendation:</b> New PE inputs		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		
<b>22524</b>	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); lumbar	<b>Global:</b> 010	<b>Issue:</b> Kyphoplasty	<b>Screen:</b> CMS Request: PE Review	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> September 2011	<b>Tab</b> 47 <b>Specialty Developing Recommendation:</b> ACR, SIR	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 25,978	<b>2007 Work RVU:</b> 8.81 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU Result:</b> PE Only	<b>2013 Work RVU:</b> 8.54 <b>2013 NF PE RVU:</b> 223.34 <b>2013 Fac PE RVU:</b> 5.59
<b>RUC Recommendation:</b> New PE inputs		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		
<b>22525</b>	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)	<b>Global:</b> ZZZ	<b>Issue:</b> Kyphoplasty	<b>Screen:</b> CMS Request: PE Review	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> September 2011	<b>Tab</b> 47 <b>Specialty Developing Recommendation:</b> ACR, SIR	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 12,099	<b>2007 Work RVU:</b> 4.47 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU Result:</b> PE Only	<b>2013 Work RVU:</b> 4.47 <b>2013 NF PE RVU:</b> 139.24 <b>2013 Fac PE RVU:</b> 2.13
<b>RUC Recommendation:</b> New PE inputs		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

## Status Report: CMS Requests and Relativity Assessment Issues

<b>22533</b>	<b>Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar</b>	<b>Global:</b> 090	<b>Issue:</b> Arthrodesis	<b>Screen:</b> CMS Fastest Growing	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> September 2011	<b>Tab</b> 51	<b>Specialty Developing Recommendation:</b> AAOS, NASS, AANS/CNS	<b>First Identified:</b> October 2008	<b>2012 Est Medicare Utilization:</b> 1,143	<b>2007 Work RVU:</b> 24.61 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 13.57 <b>2013 Work RVU:</b> 24.79 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 18.58
<b>RUC Recommendation:</b> Remove from screen. CPT Assistant article published.			<b>CPT Action (if applicable):</b>		<b>Result:</b> Remove from Screen
			<b>Referred to CPT Asst</b> <input checked="" type="checkbox"/>	<b>Published in CPT Asst:</b> Oct 2009	

<b>22551</b>	<b>Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophyctomy and decompression of spinal cord and/or nerve roots; cervical below C2</b>	<b>Global:</b> 090	<b>Issue:</b> Arthrodesis	<b>Screen:</b> Codes Reported Together 95% or More	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2010	<b>Tab</b> 05	<b>Specialty Developing Recommendation:</b> NASS, AANS/CNS, AAOS	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 32,046	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU:</b> <b>2013 Work RVU:</b> 25.00 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 18.38
<b>RUC Recommendation:</b> 24.50			<b>CPT Action (if applicable):</b> October 2009		<b>Result:</b> Decrease
			<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	

<b>22552</b>	<b>Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophyctomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for separate procedure)</b>	<b>Global:</b> ZZZ	<b>Issue:</b> Arthrodesis	<b>Screen:</b> Codes Reported Together 95% or More	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2010	<b>Tab</b> 05	<b>Specialty Developing Recommendation:</b> NASS, AANS/CNS, AAOS	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 25,900	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU:</b> <b>2013 Work RVU:</b> 6.50 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 3.35
<b>RUC Recommendation:</b> 6.50			<b>CPT Action (if applicable):</b> October 2009		<b>Result:</b> Maintain
			<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	

## Status Report: CMS Requests and Relativity Assessment Issues

---

<b>22554</b>	<b>Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2</b>	<b>Global:</b> 090	<b>Issue:</b> Arthrodesis	<b>Screen:</b> Codes Reported Together 95% or More	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2010	<b>Tab</b> 5	<b>Specialty Developing Recommendation:</b> NASS, AANS/CNS	<b>First Identified:</b> February 2008	<b>2012 Est Medicare Utilization:</b> 6,882	<b>2007 Work RVU:</b> 17.54 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 11.97 <b>2013 Work RVU:</b> 17.69 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 14.64
<b>RUC Recommendation:</b> 4.04			<b>CPT Action (if applicable):</b> October 2009	<b>Published in CPT Asst:</b>	<b>Result:</b> Maintain
			<b>Referred to CPT Asst</b> <input type="checkbox"/>		

---

<b>22558</b>	<b>Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar</b>	<b>Global:</b> 090	<b>Issue:</b> RAW	<b>Screen:</b> High Volume Growth2	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> April 2013	<b>2012 Est Medicare Utilization:</b> 11,564	<b>2007 Work RVU:</b> 23.33 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 12.86 <b>2013 Work RVU:</b> 23.53 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 16.56
<b>RUC Recommendation:</b> Review Action Plan			<b>CPT Action (if applicable):</b>	<b>Published in CPT Asst:</b>	<b>Result:</b>
			<b>Referred to CPT Asst</b> <input type="checkbox"/>		

---

<b>22585</b>	<b>Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)</b>	<b>Global:</b> ZZZ	<b>Issue:</b> Arthrodesis	<b>Screen:</b> Codes Reported Together 95% or More	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2010	<b>Tab</b> 05	<b>Specialty Developing Recommendation:</b> NASS, AANS/CNS	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 14,640	<b>2007 Work RVU:</b> 5.52 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 2.62 <b>2013 Work RVU:</b> 5.52 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 2.77
<b>RUC Recommendation:</b> Remove from screen			<b>CPT Action (if applicable):</b> October 2009	<b>Published in CPT Asst:</b>	<b>Result:</b> Maintain
			<b>Referred to CPT Asst</b> <input type="checkbox"/>		

---

# Status Report: CMS Requests and Relativity Assessment Issues

<b>22612</b>	<b>Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)</b>	<b>Global:</b> 090	<b>Issue:</b> Lumbar Arthrodesis	<b>Screen:</b> Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> January 2013	<b>Tab</b> 30	<b>Specialty Developing Recommendation:</b> AANS/CNS, AAOS, NASS	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 45,871	<b>2007 Work RVU:</b> 23.38 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 13.83 <b>2013 Work RVU:</b> 23.53 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 17.60 <b>Result:</b> Maintain
<b>RUC Recommendation:</b> Review 3/4 2012 utilization data at the RAW in January 2013. The specialty societies ability to survey will change as surgeons are able to understand correct coding. 23.53		<b>CPT Action (if applicable):</b> October 2010			
		<b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	

<b>22614</b>	<b>Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)</b>	<b>Global:</b> ZZZ	<b>Issue:</b> Lumbar Arthrodesis	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2011	<b>Tab</b> 04	<b>Specialty Developing Recommendation:</b> AANS/CNS, AAOS, NASS	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 96,941	<b>2007 Work RVU:</b> 6.43 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 3.15 <b>2013 Work RVU:</b> 6.43 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 3.34 <b>Result:</b> Decrease
<b>RUC Recommendation:</b> 6.43		<b>CPT Action (if applicable):</b>			
		<b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	

<b>22630</b>	<b>Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar</b>	<b>Global:</b> 090	<b>Issue:</b> Lumbar Arthrodesis	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2011	<b>Tab</b> 04	<b>Specialty Developing Recommendation:</b> AANS/CNS, AAOS, NASS	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 8,018	<b>2007 Work RVU:</b> 21.89 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 13.39 <b>2013 Work RVU:</b> 22.09 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 17.57 <b>Result:</b> Maintain
<b>RUC Recommendation:</b> 22.09		<b>CPT Action (if applicable):</b> October 2010			
		<b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	

## Status Report: CMS Requests and Relativity Assessment Issues

22632	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure)				Global: ZZZ	Issue: Lumbar Arthrodesis	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes		
Most Recent RUC Meeting:	February 2011	Tab 04	Specialty Developing Recommendation:	AANS/CNS, AAOS, NASS	First Identified:	February 2010	2012 Est Medicare Utilization:	3,113	2007 Work RVU: 5.22	2013 Work RVU: 5.22
							2007 NF PE RVU:	NA	2013 NF PE RVU:	NA
							2007 Fac PE RVU	2.51	2013 Fac PE RVU:	2.71
RUC Recommendation:	5.22				CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:			
22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar				Global: 090	Issue: Lumbar Arthrodesis	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes		
Most Recent RUC Meeting:	February 2011	Tab 04	Specialty Developing Recommendation:	AANS/CNS, AAOS, NASS	First Identified:	February 2010	2012 Est Medicare Utilization:	26,166	2007 Work RVU:	2013 Work RVU: 27.75
									2007 NF PE RVU:	2013 NF PE RVU: NA
							2007 Fac PE RVU		2013 Fac PE RVU:	19.45
RUC Recommendation:	27.75				CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:			
22634	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; each additional interspace and segment (List separately in addition to code for primary procedure)				Global: ZZZ	Issue: Lumbar Arthrodesis	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes		
Most Recent RUC Meeting:	February 2011	Tab 04	Specialty Developing Recommendation:	AANS/CNS, AAOS, NASS	First Identified:	February 2010	2012 Est Medicare Utilization:	10,565	2007 Work RVU:	2013 Work RVU: 8.16
									2007 NF PE RVU:	2013 NF PE RVU: NA
							2007 Fac PE RVU		2013 Fac PE RVU:	4.23
RUC Recommendation:	8.16				CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:			

## Status Report: CMS Requests and Relativity Assessment Issues

**22843** Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Spine Fixation Device **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent RUC Meeting:** February 2009

**Tab** 38

**Specialty Developing Recommendation:** AAOS, NASS, AANS

**First Identified:** October 2008

**2012 Est Medicare Utilization:** 4,952

**2007 Work RVU:** 13.44

**2013 Work RVU:** 13.44

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU:** 6.28

**2013 Fac PE RVU:** 7.02

**Result:** Remove from Screen

**RUC Recommendation:** Remove from screen

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**22849** Reinsertion of spinal fixation device

**Global:** 090

**Issue:** Spinal Fixation

**Screen:** CMS Fastest Growing

**Complete?** No

**Most Recent RUC Meeting:** September 2011

**Tab** 51

**Specialty Developing Recommendation:** AAOS, NASS, AANS/CNS

**First Identified:** October 2008

**2012 Est Medicare Utilization:** 4,083

**2007 Work RVU:** 19.08

**2013 Work RVU:** 19.17

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU:** 11.39

**2013 Fac PE RVU:** 14.30

**Result:**

**RUC Recommendation:** Review September 2014

**CPT Action (if applicable):**

June 2010

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**22851** Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), methylmethacrylate) to vertebral defect or interspace (List separately in addition to code for primary procedure)

**Global:** ZZZ

**Issue:** Intervertebral Device

**Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes

**Complete?** No

**Most Recent RUC Meeting:** January 2012

**Tab** 30

**Specialty Developing Recommendation:** NASS, AANS

**First Identified:** October 2008

**2012 Est Medicare Utilization:** 108,366

**2007 Work RVU:** 6.70

**2013 Work RVU:** 6.70

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU:** 3.18

**2013 Fac PE RVU:** 3.47

**Result:**

**RUC Recommendation:** Review utilization October 2014.

**CPT Action (if applicable):**

October 2009

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

# Status Report: CMS Requests and Relativity Assessment Issues

**22900** Excision, tumor, soft tissue of abdominal wall, subfascial (eg, intramuscular); less than 5 cm **Global:** 090 **Issue:** Subfascial Excision of Soft Tissue Tumor **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** February 2009 **Tab** 5 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2012 Est Medicare Utilization:** 1,104 **2007 Work RVU:** 6.14 **2013 Work RVU:** 8.32 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 3.3 **2013 Fac PE RVU:** 6.69 **RUC Recommendation:** 8.21 **CPT Action (if applicable):** June 2008 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Increase

**23076** Excision, tumor, soft tissue of shoulder area, subfascial (eg, intramuscular); less than 5 cm **Global:** 090 **Issue:** Subfascial Excision of Soft Tissue Tumor **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** February 2009 **Tab** 5 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2012 Est Medicare Utilization:** 817 **2007 Work RVU:** 7.77 **2013 Work RVU:** 7.41 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 5.5 **2013 Fac PE RVU:** 7.11 **RUC Recommendation:** 7.28 **CPT Action (if applicable):** June 2008 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Decrease

**23120** Claviculectomy; partial **Global:** 090 **Issue:** Claviculectomy **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** April 2008 **Tab** 30 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2012 Est Medicare Utilization:** 11,596 **2007 Work RVU:** 7.23 **2013 Work RVU:** 7.39 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 6.22 **2013 Fac PE RVU:** 8.62 **RUC Recommendation:** 7.23 **CPT Action (if applicable):** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Maintain

**23130** Acromioplasty or acromionectomy, partial, with or without coracoacromial ligament release **Global:** 090 **Issue:** Removal of Bone **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

**Most Recent RUC Meeting:** September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2012 Est Medicare Utilization:** 4,980 **2007 Work RVU:** 7.63 **2013 Work RVU:** 7.77 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 6.88 **2013 Fac PE RVU:** 8.84 **RUC Recommendation:** Reduce 99238 to 0.5 **CPT Action (if applicable):** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** PE Only



# Status Report: CMS Requests and Relativity Assessment Issues

<b>23350</b>	Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography	<b>Global:</b> 000	<b>Issue:</b> Injection for Shoulder X-Ray	<b>Screen:</b> Harvard Valued - Utilization over 30,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> September 2011	<b>Tab</b> 13	<b>Specialty Developing Recommendation:</b> ACR, AAOS	<b>First Identified:</b> April 2011	<b>2012 Est Medicare Utilization:</b> 35,847	<b>2007 Work RVU:</b> 1.00 <b>2007 NF PE RVU:</b> 3.23 <b>2007 Fac PE RVU:</b> 0.32 <b>Result:</b> Maintain
<b>RUC Recommendation:</b> 1.00			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 1.00 <b>2013 NF PE RVU:</b> 2.74 <b>2013 Fac PE RVU:</b> 0.38
<hr/>					
<b>23405</b>	Tenotomy, shoulder area; single tendon	<b>Global:</b> 090	<b>Issue:</b> Tenotomy	<b>Screen:</b> Site of Service Anomaly (99238-Only)	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> September 2007	<b>Tab</b> 16	<b>Specialty Developing Recommendation:</b> AAOS	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 2,789	<b>2007 Work RVU:</b> 8.43 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 6.69 <b>Result:</b> PE Only
<b>RUC Recommendation:</b> Reduce 99238 to 0.5			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 8.54 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 8.45
<hr/>					
<b>23410</b>	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute	<b>Global:</b> 090	<b>Issue:</b> Rotator Cuff	<b>Screen:</b> Site of Service Anomaly	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2008	<b>Tab</b> 12	<b>Specialty Developing Recommendation:</b> AAOS	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 4,853	<b>2007 Work RVU:</b> 12.63 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 9.02 <b>Result:</b> Decrease
<b>RUC Recommendation:</b> 11.23			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 11.39 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 10.81
<hr/>					
<b>23412</b>	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic	<b>Global:</b> 090	<b>Issue:</b> Rotator Cuff	<b>Screen:</b> Site of Service Anomaly	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2008	<b>Tab</b> 12	<b>Specialty Developing Recommendation:</b> AAOS	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 20,682	<b>2007 Work RVU:</b> 13.55 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 9.49 <b>Result:</b> Decrease
<b>RUC Recommendation:</b> 11.77			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 11.93 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 11.09

## Status Report: CMS Requests and Relativity Assessment Issues

### 23415 Coracoacromial ligament release, with or without acromioplasty

Global: 090

Issue: Shoulder Ligament Release

Screen: Site of Service Anomaly

Complete? Yes

Most Recent Tab 62 Specialty Developing AAOS  
RUC Meeting: October 2010 Recommendation:

First Identified: September 2007

2012 Est  
Medicare  
Utilization: 1,045

2007 Work RVU: 10.09

2013 Work RVU: 9.23

2007 NF PE RVU: NA

2013 NF PE RVU: NA

2007 Fac PE RVU 7.65

2013 Fac PE RVU: 9.66

Result: Decrease

RUC Recommendation: 9.23

CPT Action (if applicable):

Referred to CPT Asst ☐

Published in CPT Asst:

### 23420 Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)

Global: 090

Issue: Rotator Cuff

Screen: Site of Service Anomaly

Complete? Yes

Most Recent Tab 12 Specialty Developing AAOS  
RUC Meeting: February 2008 Recommendation:

First Identified: September 2007

2012 Est  
Medicare  
Utilization: 7,753

2007 Work RVU: 14.75

2013 Work RVU: 13.54

2007 NF PE RVU: NA

2013 NF PE RVU: NA

2007 Fac PE RVU 10.59

2013 Fac PE RVU: 12.61

Result: Decrease

RUC Recommendation: 13.35

CPT Action (if applicable):

Referred to CPT Asst ☐

Published in CPT Asst:

### 23430 Tenodesis of long tendon of biceps

Global: 090

Issue: Tenodesis

Screen: CMS Fastest Growing,  
Site of Service Anomaly  
(99238-Only)

Complete? Yes

Most Recent Tab 12 Specialty Developing AAOS  
RUC Meeting: October 2009 Recommendation:

First Identified: September 2007

2012 Est  
Medicare  
Utilization: 12,336

2007 Work RVU: 10.05

2013 Work RVU: 10.17

2007 NF PE RVU: NA

2013 NF PE RVU: NA

2007 Fac PE RVU 7.78

2013 Fac PE RVU: 10.14

Result: Maintain

RUC Recommendation: 10.17

CPT Action (if applicable):

Referred to CPT Asst ☐

Published in CPT Asst:

### 23440 Resection or transplantation of long tendon of biceps

Global: 090

Issue: Tendon Transfer

Screen: Site of Service Anomaly  
(99238-Only)

Complete? Yes

Most Recent Tab 16 Specialty Developing AAOS  
RUC Meeting: September 2007 Recommendation:

First Identified: September 2007

2012 Est  
Medicare  
Utilization: 2,101

2007 Work RVU: 10.53

2013 Work RVU: 10.64

2007 NF PE RVU: NA

2013 NF PE RVU: NA

2007 Fac PE RVU 7.91

2013 Fac PE RVU: 9.73

Result: PE Only

RUC Recommendation: Reduce 99238 to 0.5

CPT Action (if applicable):

Referred to CPT Asst ☐

Published in CPT Asst:

## Status Report: CMS Requests and Relativity Assessment Issues

**23472** Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder)) **Global:** 090 **Issue:** Arthroplasty **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent** **Tab** 26 **Specialty Developing** AAOS  
**RUC Meeting:** October 2008 **Recommendation:**

**First Identified:** October 2008

**2012 Est Medicare Utilization:** 33,386

**2007 Work RVU:** 22.47 **2013 Work RVU:** 22.13

**2007 NF PE RVU:** NA **2013 NF PE RVU:** NA

**2007 Fac PE RVU** 13.89 **2013 Fac PE RVU:** 16.89

**RUC Recommendation:** Remove from screen

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Remove from Screen

**23600** Closed treatment of proximal humeral (surgical or anatomical neck) fracture; without manipulation

**Global:** 090

**Issue:** Treatment of Humerus Fracture

**Screen:** Harvard Valued - Utilization over 30,000

**Complete?** Yes

**Most Recent** **Tab** 14 **Specialty Developing** AAOS  
**RUC Meeting:** September 2011 **Recommendation:**

**First Identified:** April 2011

**2012 Est Medicare Utilization:** 36,365

**2007 Work RVU:** 3.00 **2013 Work RVU:** 3.00

**2007 NF PE RVU:** 4.43 **2013 NF PE RVU:** 6.30

**2007 Fac PE RVU** 3.58 **2013 Fac PE RVU:** 5.71

**RUC Recommendation:** 3.00

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**25116** Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); extensors, with or without transposition of dorsal retinaculum

**Global:** 090

**Issue:** Forearm Excision

**Screen:** Site of Service Anomaly

**Complete?** Yes

**Most Recent** **Tab** 63 **Specialty Developing** ASSH, AAOS, ASPS  
**RUC Meeting:** October 2010 **Recommendation:**

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 1,019

**2007 Work RVU:** 7.38 **2013 Work RVU:** 7.56

**2007 NF PE RVU:** NA **2013 NF PE RVU:** NA

**2007 Fac PE RVU** 12.13 **2013 Fac PE RVU:** 8.94

**RUC Recommendation:** 7.56

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Maintain

# Status Report: CMS Requests and Relativity Assessment Issues

## 25210 Carpectomy; 1 bone

Global: 090

Issue: Carpectomy

Screen: Site of Service Anomaly  
(99238-Only)

Complete? Yes

Most Recent  
RUC Meeting: September 2007

Tab 16

Specialty Developing  
Recommendation: AAOS

First  
Identified: September 2007

2012 Est  
Medicare  
Utilization: 2,038

2007 Work RVU: 6.01

2013 Work RVU: 6.12

2007 NF PE RVU: NA

2013 NF PE RVU: NA

2007 Fac PE RVU 6.49

2013 Fac PE RVU: 7.29

Result: PE Only

RUC Recommendation: Reduce 99238 to 0.5

CPT Action (if applicable):

Referred to CPT Asst ☐

Published in CPT Asst:

## 25260 Repair, tendon or muscle, flexor, forearm and/or wrist; primary, single, each tendon or muscle

Global: 090

Issue: Tendon Repair

Screen: Site of Service Anomaly  
(99238-Only)

Complete? Yes

Most Recent  
RUC Meeting: September 2007

Tab 16

Specialty Developing  
Recommendation: AAOS

First  
Identified: September 2007

2012 Est  
Medicare  
Utilization: 1,094

2007 Work RVU: 7.89

2013 Work RVU: 8.04

2007 NF PE RVU: NA

2013 NF PE RVU: NA

2007 Fac PE RVU 12.30

2013 Fac PE RVU: 9.21

Result: PE Only

RUC Recommendation: Reduce 99238 to 0.5

CPT Action (if applicable):

Referred to CPT Asst ☐

Published in CPT Asst:

## 25280 Lengthening or shortening of flexor or extensor tendon, forearm and/or wrist, single, each tendon

Global: 090

Issue: Tendon Repair

Screen: Site of Service Anomaly  
(99238-Only)

Complete? Yes

Most Recent  
RUC Meeting: September 2007

Tab 16

Specialty Developing  
Recommendation: AAOS

First  
Identified: September 2007

2012 Est  
Medicare  
Utilization: 1,370

2007 Work RVU: 7.28

2013 Work RVU: 7.39

2007 NF PE RVU: NA

2013 NF PE RVU: NA

2007 Fac PE RVU 11.6

2013 Fac PE RVU: 8.04

Result: PE Only

RUC Recommendation: Reduce 99238 to 0.5

CPT Action (if applicable):

Referred to CPT Asst ☐

Published in CPT Asst:

## 25310 Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon

Global: 090

Issue: Forearm Repair

Screen: Site of Service Anomaly

Complete? Yes

Most Recent  
RUC Meeting: February 2008

Tab 15

Specialty Developing  
Recommendation: ASSH, AAOS

First  
Identified: September 2007

2012 Est  
Medicare  
Utilization: 7,379

2007 Work RVU: 8.26

2013 Work RVU: 8.08

2007 NF PE RVU: NA

2013 NF PE RVU: NA

2007 Fac PE RVU 11.99

2013 Fac PE RVU: 8.84

Result: Decrease

RUC Recommendation: 7.94

CPT Action (if applicable):

Referred to CPT Asst ☐

Published in CPT Asst:

# Status Report: CMS Requests and Relativity Assessment Issues

<b>26080</b>	<b>Arthrotomy, with exploration, drainage, or removal of loose or foreign body; interphalangeal joint, each</b>	<b>Global:</b> 090	<b>Issue:</b> RAW	<b>Screen:</b> Site of Service Anomaly	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b> 27 <b>Specialty Developing Recommendation:</b> ASSH, AAOS	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 1,795	<b>2007 Work RVU:</b> 4.36 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 4.73 <b>Result:</b>	<b>2013 Work RVU:</b> 4.47 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 6.36
<b>RUC Recommendation:</b> Re-review October 2014.	<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input checked="" type="checkbox"/>	<b>Published in CPT Asst:</b> Published Sept 201			
<b>26356</b>	<b>Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); primary, without free graft, each tendon</b>	<b>Global:</b> 090	<b>Issue:</b> Tendon Repair	<b>Screen:</b> Site of Service Anomaly (99238-Only)	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> September 2007	<b>Tab</b> 16 <b>Specialty Developing Recommendation:</b> AAOS	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 1,171	<b>2007 Work RVU:</b> 10.22 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 17.22 <b>Result:</b> PE Only	<b>2013 Work RVU:</b> 10.62 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 19.96
<b>RUC Recommendation:</b> Reduce 99238 to 0.5	<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>			
<b>26480</b>	<b>Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; without free graft, each tendon</b>	<b>Global:</b> 090	<b>Issue:</b> Tendon Transfer	<b>Screen:</b> CMS Fastest Growing	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2009	<b>Tab</b> 26 <b>Specialty Developing Recommendation:</b> AAOS, ASSH	<b>First Identified:</b> October 2008	<b>2012 Est Medicare Utilization:</b> 6,640	<b>2007 Work RVU:</b> 6.76 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 13.68 <b>Result:</b> Maintain	<b>2013 Work RVU:</b> 6.90 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 14.24
<b>RUC Recommendation:</b> 6.76	<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>			
<b>27048</b>	<b>Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); less than 5 cm</b>	<b>Global:</b> 090	<b>Issue:</b> Excision of Subfascial Soft Tissue Tumor Codes	<b>Screen:</b> Site of Service Anomaly	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2009	<b>Tab</b> 05 <b>Specialty Developing Recommendation:</b> ACS, AAOS	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 479	<b>2007 Work RVU:</b> 6.44 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 4.76 <b>Result:</b> Increase	<b>2013 Work RVU:</b> 8.85 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 7.46
<b>RUC Recommendation:</b> 8.74	<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b> June 2008			

## Status Report: CMS Requests and Relativity Assessment Issues

**27062** Excision; trochanteric bursa or calcification **Global:** 090 **Issue:** Trochanteric Bursa Excision **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent**  
**RUC Meeting:** April 2008 **Tab** 32 **Specialty Developing Recommendation:** AAOS

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 1,418

**2007 Work RVU:** 5.66

**2013 Work RVU:** 5.75

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 5.05

**2013 Fac PE RVU:** 6.72

**Result:** Maintain

**RUC Recommendation:** 5.66

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**27096** Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed **Global:** 000 **Issue:** Injection for Sacroiliac Joint **Screen:** Different Performing Specialty from Survey **Complete?** Yes

**Most Recent**  
**RUC Meeting:** April 2011 **Tab** 06 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, ASIPP, ISIS, NASS

**First Identified:** October 2009

**2012 Est Medicare Utilization:** 355,837

**2007 Work RVU:** 1.40

**2013 Work RVU:** 1.48

**2007 NF PE RVU:** 3.88

**2013 NF PE RVU:** 3.41

**2007 Fac PE RVU** 0.33

**2013 Fac PE RVU:** 0.92

**RUC Recommendation:** 1.48

**CPT Action (if applicable):**

February 2011

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**27130** Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft **Global:** 090 **Issue:** Arthroplasty **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

**Most Recent**  
**RUC Meeting:** January 2013 **Tab** 20 **Specialty Developing Recommendation:** AAOS, AAHKS

**First Identified:** September 2011

**2012 Est Medicare Utilization:** 123,762

**2007 Work RVU:** 21.61

**2013 Work RVU:** 21.79

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 12.96

**2013 Fac PE RVU:** 16.67

**RUC Recommendation:** 21.79

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

## Status Report: CMS Requests and Relativity Assessment Issues

<b>27236</b>	Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement	<b>Global:</b> 090	<b>Issue:</b> Open Treatment of Femoral Fracture	<b>Screen:</b> CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b> 16 <b>Specialty Developing Recommendation:</b> AAOS	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 62,772	<b>2007 Work RVU:</b> 17.43 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 10.85 <b>Result:</b> Maintain	<b>2013 Work RVU:</b> 17.61 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 14.44
<b>RUC Recommendation:</b> 17.61		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		
<hr/>					
<b>27244</b>	Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with plate/screw type implant, with or without cerclage	<b>Global:</b> 090	<b>Issue:</b> Treat Thigh Fracture	<b>Screen:</b> High IWP/UT	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2008	<b>Tab</b> 12 <b>Specialty Developing Recommendation:</b> AAOS	<b>First Identified:</b> April 2008	<b>2012 Est Medicare Utilization:</b> 17,374	<b>2007 Work RVU:</b> 17.08 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 10.91 <b>Result:</b> Increase	<b>2013 Work RVU:</b> 18.18 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 14.76
<b>RUC Recommendation:</b> 18.00		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		
<hr/>					
<b>27245</b>	Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with intramedullary implant, with or without interlocking screws and/or cerclage	<b>Global:</b> 090	<b>Issue:</b> Treat Thigh Fracture	<b>Screen:</b> High IWP/UT / CMS Fastest Growing	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2008	<b>Tab</b> 12 <b>Specialty Developing Recommendation:</b> AAOS	<b>First Identified:</b> February 2008	<b>2012 Est Medicare Utilization:</b> 74,014	<b>2007 Work RVU:</b> 21.09 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 13.19 <b>Result:</b> Decrease	<b>2013 Work RVU:</b> 18.18 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 14.77
<b>RUC Recommendation:</b> 18.00		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		
<hr/>					
<b>27250</b>	Closed treatment of hip dislocation, traumatic; without anesthesia	<b>Global:</b> 000	<b>Issue:</b> Closed Treatment of Hip Dislocation	<b>Screen:</b> Site of Service Anomaly	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2008	<b>Tab</b> 18 <b>Specialty Developing Recommendation:</b> ACEP	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 2,914	<b>2007 Work RVU:</b> 7.21 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 4.54 <b>Result:</b> Decrease	<b>2013 Work RVU:</b> 3.82 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 0.88
<b>RUC Recommendation:</b> 3.82		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

# Status Report: CMS Requests and Relativity Assessment Issues

**27324** Biopsy, soft tissue of thigh or knee area; deep (subfascial or intramuscular) **Global:** 090 **Issue:** Soft Tissue Biopsy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

**Most Recent RUC Meeting:** September 2007 **Tab** 16 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2012 Est Medicare Utilization:** 881 **2007 Work RVU:** 4.95 **2013 Work RVU:** 5.04 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 4.1 **2013 Fac PE RVU:** 5.68 **Result:** PE Only

**RUC Recommendation:** Reduce 99238 to 0.5

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**27370** Injection procedure for knee arthrography **Global:** 000 **Issue:** Injection for Knee Arthrography **Screen:** High Volume Growth1 / CMS Fastest Growing / High Volume Growth2 **Complete?** No

**Most Recent RUC Meeting:** October 2009 **Tab** 40 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** February 2008 **2012 Est Medicare Utilization:** 56,742 **2007 Work RVU:** 0.96 **2013 Work RVU:** 0.96 **2007 NF PE RVU:** 3.47 **2013 NF PE RVU:** 3.90 **2007 Fac PE RVU:** 0.32 **2013 Fac PE RVU:** 0.45 **Result:** Maintain

**RUC Recommendation:** Review action plan. CPT Assistant Article published

**CPT Action (if applicable):**

**Referred to CPT Asst** ☒

**Published in CPT Asst:** Clinical Examples

**27446** Arthroplasty, knee, condyle and plateau; medial OR lateral compartment **Global:** 090 **Issue:** Arthroplasty **Screen:** CMS High Expenditure Procedural Codes / Harvard-Valued with Annual Allowed Charges Greater than \$10 million **Complete?** Yes

**Most Recent RUC Meeting:** January 2013 **Tab** 20 **Specialty Developing Recommendation:** AAOS, AAHKS **First Identified:** September 2011 **2012 Est Medicare Utilization:** 12,936 **2007 Work RVU:** 16.26 **2013 Work RVU:** 16.38 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 10.81 **2013 Fac PE RVU:** 13.18 **Result:** Increase

**RUC Recommendation:** 17.48

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**



# Status Report: CMS Requests and Relativity Assessment Issues

**27447** Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty) **Global:** 090 **Issue:** Arthroplasty **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

**Most Recent RUC Meeting:** January 2013

**Tab** 20

**Specialty Developing Recommendation:** AAOS, AAHKS

**First Identified:** September 2011

**2012 Est Medicare Utilization:** 266,177

**2007 Work RVU:** 23.04

**2013 Work RVU:** 23.25

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU:** 14.14

**2013 Fac PE RVU:** 17.82

**Result:** Decrease

**RUC Recommendation:** 19.60

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**27615** Radical resection of tumor (eg, malignant neoplasm), soft tissue of leg or ankle area; less than 5 cm **Global:** 090 **Issue:** Radical Resection of Soft Tissue Tumor Codes **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** February 2009

**Tab** 6

**Specialty Developing Recommendation:** ACS, AAOS

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 575

**2007 Work RVU:** 12.93

**2013 Work RVU:** 15.72

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU:** 9.07

**2013 Fac PE RVU:** 11.55

**Result:** Increase

**RUC Recommendation:** 15.54

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**27619** Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); less than 5 cm **Global:** 090 **Issue:** Excision of Subfascial Soft Tissue Tumor Codes **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** February 2009

**Tab** 5

**Specialty Developing Recommendation:** ACS, AAOS

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 719

**2007 Work RVU:** 8.47

**2013 Work RVU:** 6.91

**2007 NF PE RVU:** 9.65

**2013 NF PE RVU:** NA

**2007 Fac PE RVU:** 5.79

**2013 Fac PE RVU:** 6.11

**Result:** Decrease

**RUC Recommendation:** 6.80

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**27640** Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis); tibia **Global:** 090 **Issue:** Leg Bone Resection Partial **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** February 2008

**Tab** 19

**Specialty Developing Recommendation:** AOFAS, AAOS

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 1,373

**2007 Work RVU:** 12.10

**2013 Work RVU:** 12.24

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU:** 9.79

**2013 Fac PE RVU:** 10.38

**Result:** Maintain

**RUC Recommendation:** 12.10

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

# Status Report: CMS Requests and Relativity Assessment Issues

**27641** Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis); fibula **Global:** 090 **Issue:** Leg Bone Resection Partial **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** February 2008 **Tab** 19 **Specialty Developing Recommendation:** AOFAS, AAOS **First Identified:** February 2008 **2012 Est Medicare Utilization:** 759 **2007 Work RVU:** 9.73 **2013 Work RVU:** 9.84 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 7.96 **2013 Fac PE RVU:** 8.23 **RUC Recommendation:** 9.72 **CPT Action (if applicable):** June 2008 **Published in CPT Asst:** ☐ **Result:** Decrease

**27650** Repair, primary, open or percutaneous, ruptured Achilles tendon; **Global:** 090 **Issue:** Achilles Tendon Repair **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** February 2008 **Tab** 20 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** September 2007 **2012 Est Medicare Utilization:** 2,088 **2007 Work RVU:** 9.94 **2013 Work RVU:** 9.21 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 7.22 **2013 Fac PE RVU:** 9.14 **RUC Recommendation:** 9.00 **CPT Action (if applicable):** **Published in CPT Asst:** ☐ **Result:** Decrease

**27654** Repair, secondary, Achilles tendon, with or without graft **Global:** 090 **Issue:** Achilles Tendon Repair **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** April 2008 **Tab** 33 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2012 Est Medicare Utilization:** 1,946 **2007 Work RVU:** 10.32 **2013 Work RVU:** 10.53 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 6.86 **2013 Fac PE RVU:** 8.96 **RUC Recommendation:** 10.32 **CPT Action (if applicable):** **Published in CPT Asst:** ☐ **Result:** Maintain

**27685** Lengthening or shortening of tendon, leg or ankle; single tendon (separate procedure) **Global:** 090 **Issue:** Tendon Repair **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

**Most Recent RUC Meeting:** September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2012 Est Medicare Utilization:** 3,667 **2007 Work RVU:** 6.57 **2013 Work RVU:** 6.69 **2007 NF PE RVU:** 7.68 **2013 NF PE RVU:** 12.48 **2007 Fac PE RVU:** 5.26 **2013 Fac PE RVU:** 6.23 **RUC Recommendation:** Reduce 99238 to 0.5 **CPT Action (if applicable):** **Published in CPT Asst:** ☐ **Result:** PE Only

## Status Report: CMS Requests and Relativity Assessment Issues

**27687** Gastrocnemius recession (eg, Strayer procedure) **Global:** 090 **Issue:** Tendon Repair **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

**Most Recent RUC Meeting:** September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2012 Est Medicare Utilization:** 4,502 **2007 Work RVU:** 6.30 **2013 Work RVU:** 6.41 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 5.12 **2013 Fac PE RVU:** 6.26 **Result:** PE Only

**RUC Recommendation:** Reduce 99238 to 0.5 **CPT Action (if applicable):** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

**27690** Transfer or transplant of single tendon (with muscle redirection or rerouting); superficial (eg, anterior tibial extensors into midfoot) **Global:** 090 **Issue:** Tendon Transfer **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** April 2008 **Tab** 34 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2012 Est Medicare Utilization:** 1,855 **2007 Work RVU:** 8.96 **2013 Work RVU:** 9.17 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 6.15 **2013 Fac PE RVU:** 8.35 **Result:** Maintain

**RUC Recommendation:** 8.96 **CPT Action (if applicable):** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

**27691** Transfer or transplant of single tendon (with muscle redirection or rerouting); deep (eg, anterior tibial or posterior tibial through interosseous space, flexor digitorum longus, flexor hallucis longus, or peroneal tendon to midfoot or hindfoot) **Global:** 090 **Issue:** Tendon Transfer **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** April 2008 **Tab** 34 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2012 Est Medicare Utilization:** 3,489 **2007 Work RVU:** 10.28 **2013 Work RVU:** 10.49 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 7.51 **2013 Fac PE RVU:** 10.13 **Result:** Maintain

**RUC Recommendation:** 10.28 **CPT Action (if applicable):** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

# Status Report: CMS Requests and Relativity Assessment Issues

**27792** Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed **Global:** 090 **Issue:** Treatment of Ankle Fracture **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** February 2011

**Tab 18** **Specialty Developing Recommendation:** AAOS, AOFAS,

**First Identified:** June 2010

**2012 Est Medicare Utilization:** 6,134

**2007 Work RVU:** 7.91

**2013 Work RVU:** 8.75

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 6.71

**2013 Fac PE RVU:** 9.13

**Result:** Maintain

**RUC Recommendation:** 9.71

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**27818** Closed treatment of trimalleolar ankle fracture; with manipulation

**Global:** 090

**Issue:** Treatment of Fracture

**Screen:** Site of Service Anomaly (99238-Only)

**Complete?** Yes

**Most Recent RUC Meeting:** September 2007

**Tab 16** **Specialty Developing Recommendation:** AAOS

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 2,266

**2007 Work RVU:** 5.57

**2013 Work RVU:** 5.69

**2007 NF PE RVU:** 6.14

**2013 NF PE RVU:** 7.84

**2007 Fac PE RVU** 5

**2013 Fac PE RVU:** 6.30

**Result:** PE Only

**RUC Recommendation:** Reduce 99238 to 0.5

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**28111** Ostectomy, complete excision; first metatarsal head

**Global:** 090

**Issue:** Ostectomy

**Screen:** Site of Service Anomaly (99238-Only)

**Complete?** Yes

**Most Recent RUC Meeting:** September 2007

**Tab 16** **Specialty Developing Recommendation:** APMA, AAOS

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 1,013

**2007 Work RVU:** 5.06

**2013 Work RVU:** 5.15

**2007 NF PE RVU:** 6.55

**2013 NF PE RVU:** 9.63

**2007 Fac PE RVU** 3.58

**2013 Fac PE RVU:** 4.15

**Result:** PE Only

**RUC Recommendation:** Reduce 99238 to 0.5

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**28118** Ostectomy, calcaneus;

**Global:** 090

**Issue:** Ostectomy

**Screen:** Site of Service Anomaly (99238-Only)

**Complete?** Yes

**Most Recent RUC Meeting:** September 2007

**Tab 16** **Specialty Developing Recommendation:** APMA, AAOS

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 2,189

**2007 Work RVU:** 6.02

**2013 Work RVU:** 6.13

**2007 NF PE RVU:** 6.68

**2013 NF PE RVU:** 11.24

**2007 Fac PE RVU** 4.28

**2013 Fac PE RVU:** 5.46

**Result:** PE Only

**RUC Recommendation:** Reduce 99238 to 0.5

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

# Status Report: CMS Requests and Relativity Assessment Issues

**28120** Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus **Global:** 090 **Issue:** Removal of Foot Bone **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** February 2011

**Tab 19 Specialty Developing Recommendation:** AOFAS, APMA, AAOS

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 4,651

**2007 Work RVU:** 5.64

**2013 Work RVU:** 7.31

**2007 NF PE RVU:** 7.5

**2013 NF PE RVU:** 12.34

**2007 Fac PE RVU** 4.31

**2013 Fac PE RVU:** 6.60

**Result:** Increase

**RUC Recommendation:** 8.27

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**28122** Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus **Global:** 090 **Issue:** Removal of Foot Bone **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** February 2011

**Tab 19 Specialty Developing Recommendation:** AOFAS, APMA, AAOS

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 12,415

**2007 Work RVU:** 7.56

**2013 Work RVU:** 6.76

**2007 NF PE RVU:** 7.27

**2013 NF PE RVU:** 10.75

**2007 Fac PE RVU** 5.17

**2013 Fac PE RVU:** 5.67

**Result:** Maintain

**RUC Recommendation:** 7.72

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**28124** Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); phalanx of toe **Global:** 090 **Issue:** Toe Removal **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

**Most Recent RUC Meeting:** September 2007

**Tab 16 Specialty Developing Recommendation:** APMA, AAOS

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 13,674

**2007 Work RVU:** 4.88

**2013 Work RVU:** 5.00

**2007 NF PE RVU:** 5.46

**2013 NF PE RVU:** 9.04

**2007 Fac PE RVU** 3.62

**2013 Fac PE RVU:** 4.40

**Result:** PE Only

**RUC Recommendation:** Remove 99238

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

# Status Report: CMS Requests and Relativity Assessment Issues

<b>28285</b>	<b>Correction, hammertoe (eg, interphalangeal fusion, partial or total phalangectomy)</b>			<b>Global:</b> 090	<b>Issue:</b> Orthopaedic Surgery/Podiatry	<b>Screen:</b> Harvard Valued - Utilization over 30,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2010	<b>Tab</b> 31	<b>Specialty Developing Recommendation:</b> AAOS, AOFAS, APMA	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 87,003	<b>2007 Work RVU:</b> 4.65	<b>2013 Work RVU:</b> 5.62	
<b>RUC Recommendation:</b> 5.62			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2007 NF PE RVU:</b> 5.34	<b>2013 NF PE RVU:</b> 10.04	
					<b>2007 Fac PE RVU</b> 3.42	<b>2013 Fac PE RVU:</b> 5.06	
					<b>Result:</b> Increase		
<hr/>							
<b>28296</b>	<b>Correction, hallux valgus (bunion), with or without sesamoidectomy; with metatarsal osteotomy (eg, Mitchell, Chevron, or concentric type procedures)</b>			<b>Global:</b> 090	<b>Issue:</b> Hallus Valgus Correction	<b>Screen:</b> Site of Service Anomaly	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2008	<b>Tab</b> 23	<b>Specialty Developing Recommendation:</b> AAOS, AOFAS, APMA	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 17,108	<b>2007 Work RVU:</b> 9.31	<b>2013 Work RVU:</b> 8.35	
<b>RUC Recommendation:</b> 8.16			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2007 NF PE RVU:</b> 8.54	<b>2013 NF PE RVU:</b> 12.41	
					<b>2007 Fac PE RVU</b> 5.29	<b>2013 Fac PE RVU:</b> 6.34	
					<b>Result:</b> Decrease		
<hr/>							
<b>28298</b>	<b>Correction, hallux valgus (bunion), with or without sesamoidectomy; by phalanx osteotomy</b>			<b>Global:</b> 090	<b>Issue:</b> Correction of Bunion	<b>Screen:</b> Site of Service Anomaly (99238-Only)	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> September 2007	<b>Tab</b> 16	<b>Specialty Developing Recommendation:</b> APMA, AAOS	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 2,687	<b>2007 Work RVU:</b> 8.01	<b>2013 Work RVU:</b> 8.13	
<b>RUC Recommendation:</b> Reduce 99238 to 0.5			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2007 NF PE RVU:</b> 7.74	<b>2013 NF PE RVU:</b> 12.88	
					<b>2007 Fac PE RVU</b> 4.91	<b>2013 Fac PE RVU:</b> 6.01	
					<b>Result:</b> PE Only		
<hr/>							
<b>28300</b>	<b>Osteotomy; calcaneus (eg, Dwyer or Chambers type procedure), with or without internal fixation</b>			<b>Global:</b> 090	<b>Issue:</b> Osteotomy	<b>Screen:</b> Site of Service Anomaly (99238-Only)	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> September 2007	<b>Tab</b> 16	<b>Specialty Developing Recommendation:</b> AAOS	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 2,298	<b>2007 Work RVU:</b> 9.61	<b>2013 Work RVU:</b> 9.73	
<b>RUC Recommendation:</b> Reduce 99238 to 0.5			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2007 NF PE RVU:</b> NA	<b>2013 NF PE RVU:</b> NA	
					<b>2007 Fac PE RVU</b> 6.81	<b>2013 Fac PE RVU:</b> 8.26	
					<b>Result:</b> PE Only		

# Status Report: CMS Requests and Relativity Assessment Issues

<b>28310</b>	<b>Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)</b>	<b>Global:</b> 090	<b>Issue:</b> Osteotomy	<b>Screen:</b> Site of Service Anomaly (99238-Only)	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> September 2007	<b>Tab</b> 16	<b>Specialty Developing Recommendation:</b> APMA, AAOS	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 2,306	<b>2007 Work RVU:</b> 5.48 <b>2007 NF PE RVU:</b> 6.2 <b>2007 Fac PE RVU:</b> 3.53 <b>Result:</b> PE Only
<b>RUC Recommendation:</b> Reduce 99238 to 0.5			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 5.57 <b>2013 NF PE RVU:</b> 10.44 <b>2013 Fac PE RVU:</b> 4.47

<b>28470</b>	<b>Closed treatment of metatarsal fracture; without manipulation, each</b>	<b>Global:</b> 090	<b>Issue:</b> Treatment of Metatarsal Fracture	<b>Screen:</b> Harvard Valued - Utilization over 30,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> September 2011	<b>Tab</b> 15	<b>Specialty Developing Recommendation:</b> AAOS, APMA, AOFAS	<b>First Identified:</b> April 2011	<b>2012 Est Medicare Utilization:</b> 40,245	<b>2007 Work RVU:</b> 1.99 <b>2007 NF PE RVU:</b> 3.05 <b>2007 Fac PE RVU:</b> 2.43 <b>Result:</b> Maintain
<b>RUC Recommendation:</b> 2.03			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 2.03 <b>2013 NF PE RVU:</b> 4.35 <b>2013 Fac PE RVU:</b> 3.89

<b>28725</b>	<b>Arthrodesis; subtalar</b>	<b>Global:</b> 090	<b>Issue:</b> Foot Arthrodesis	<b>Screen:</b> Site of Service Anomaly	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2011	<b>Tab</b> 20	<b>Specialty Developing Recommendation:</b> AOFAS, APMA, AAOS	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 3,172	<b>2007 Work RVU:</b> 11.97 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 7.93 <b>Result:</b> Maintain
<b>RUC Recommendation:</b> 12.18			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 11.22 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 10.16

<b>28730</b>	<b>Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse;</b>	<b>Global:</b> 090	<b>Issue:</b> Foot Arthrodesis	<b>Screen:</b> Site of Service Anomaly	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2011	<b>Tab</b> 20	<b>Specialty Developing Recommendation:</b> AOFAS, APMA, AAOS	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 2,348	<b>2007 Work RVU:</b> 12.21 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 8.32 <b>Result:</b> Maintain
<b>RUC Recommendation:</b> 12.42			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 10.70 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 9.55



## Status Report: CMS Requests and Relativity Assessment Issues

**28740** Arthrodesis, midtarsal or tarsometatarsal, single joint

**Global:** 090

**Issue:** Arthrodesis

**Screen:** Site of Service Anomaly  
(99238-Only)

**Complete?** Yes

**Most Recent  
RUC Meeting:** September 2007

**Tab** 16

**Specialty Developing  
Recommendation:** AAOS

**First  
Identified:** September 2007

**2012 Est  
Medicare  
Utilization:** 2,767

**2007 Work RVU:** 9.09

**2013 Work RVU:** 9.29

**2007 NF PE RVU:** 10.89

**2013 NF PE RVU:** 15.12

**2007 Fac PE RVU:** 6.37

**2013 Fac PE RVU:** 8.00

**Result:** PE Only

**RUC Recommendation:** Reduce 99238 to 0.5

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**28825** Amputation, toe; interphalangeal joint

**Global:** 090

**Issue:** Partial Amputation of Toe

**Screen:** Site of Service Anomaly

**Complete?** Yes

**Most Recent  
RUC Meeting:** February 2011

**Tab** 21

**Specialty Developing  
Recommendation:** AOFAS,  
ACS, APMA,  
AAOS, SVS

**First  
Identified:** September 2007

**2012 Est  
Medicare  
Utilization:** 11,140

**2007 Work RVU:** 3.71

**2013 Work RVU:** 5.37

**2007 NF PE RVU:** 7.04

**2013 NF PE RVU:** 10.51

**2007 Fac PE RVU:** 3.4

**2013 Fac PE RVU:** 5.11

**Result:** Increase

**RUC Recommendation:** 6.01

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**29075** Application, cast; elbow to finger (short arm)

**Global:** 000

**Issue:** Application of Forearm  
Cast

**Screen:** Harvard Valued -  
Utilization over 30,000

**Complete?** Yes

**Most Recent  
RUC Meeting:** September 2011

**Tab** 16

**Specialty Developing  
Recommendation:** AAOS, ASSH

**First  
Identified:** April 2011

**2012 Est  
Medicare  
Utilization:** 70,955

**2007 Work RVU:** 0.77

**2013 Work RVU:** 0.77

**2007 NF PE RVU:** 1.25

**2013 NF PE RVU:** 1.72

**2007 Fac PE RVU:** 0.68

**2013 Fac PE RVU:** 0.96

**Result:** Maintain

**RUC Recommendation:** 0.77

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**29200** Strapping; thorax

**Global:** 000

**Issue:** RAW

**Screen:** High Volume Growth2

**Complete?** No

**Most Recent  
RUC Meeting:**

**Tab**

**Specialty Developing  
Recommendation:**

**First  
Identified:** April 2013

**2012 Est  
Medicare  
Utilization:** 15,617

**2007 Work RVU:** 0.65

**2013 Work RVU:** 0.65

**2007 NF PE RVU:** 0.69

**2013 NF PE RVU:** 0.89

**2007 Fac PE RVU:** 0.34

**2013 Fac PE RVU:** 0.48

**Result:**

**RUC Recommendation:** Review Action Plan

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**



# Status Report: CMS Requests and Relativity Assessment Issues

**29220 Deleted from CPT**

**Global:** 000

**Issue:** Strapping; low back

**Screen:** High Volume Growth1

**Complete?** Yes

**Most Recent RUC Meeting:** April 2008 **Tab** 57 **Specialty Developing Recommendation:** AAFP

**First Identified:** February 2008

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 0.64

**2013 Work RVU:**

**2007 NF PE RVU:** 0.69

**2013 NF PE RVU:**

**2007 Fac PE RVU** 0.38

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2008

**Referred to CPT Asst** ☒

**Published in CPT Asst:** Deleted from CPT,

**Result:** Deleted from CPT

**29240 Strapping; shoulder (eg, Velpeau)**

**Global:** 000

**Issue:** RAW

**Screen:** High Volume Growth2

**Complete?** No

**Most Recent RUC Meeting:** **Tab** **Specialty Developing Recommendation:**

**First Identified:** April 2013

**2012 Est Medicare Utilization:** 30,531

**2007 Work RVU:** 0.71

**2013 Work RVU:** 0.71

**2007 NF PE RVU:** 0.81

**2013 NF PE RVU:** 0.96

**2007 Fac PE RVU** 0.37

**2013 Fac PE RVU:** 0.54

**RUC Recommendation:** Review Action Plan

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:**

**29520 Strapping; hip**

**Global:** 000

**Issue:** RAW

**Screen:** High Volume Growth2

**Complete?** No

**Most Recent RUC Meeting:** **Tab** **Specialty Developing Recommendation:**

**First Identified:** April 2013

**2012 Est Medicare Utilization:** 15,679

**2007 Work RVU:** 0.54

**2013 Work RVU:** 0.54

**2007 NF PE RVU:** 0.81

**2013 NF PE RVU:** 0.88

**2007 Fac PE RVU** 0.45

**2013 Fac PE RVU:** 0.47

**RUC Recommendation:** Review Action Plan

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:**

**29530 Strapping; knee**

**Global:** 000

**Issue:** RAW

**Screen:** High Volume Growth2

**Complete?** No

**Most Recent RUC Meeting:** **Tab** **Specialty Developing Recommendation:**

**First Identified:** April 2013

**2012 Est Medicare Utilization:** 50,622

**2007 Work RVU:** 0.57

**2013 Work RVU:** 0.57

**2007 NF PE RVU:** 0.75

**2013 NF PE RVU:** 0.96

**2007 Fac PE RVU** 0.34

**2013 Fac PE RVU:** 0.51

**RUC Recommendation:** Review Action Plan

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:**

# Status Report: CMS Requests and Relativity Assessment Issues

<b>29540</b>	<b>Strapping; ankle and/or foot</b>			<b>Global:</b> 000	<b>Issue:</b> Strapping Lower Extremity	<b>Screen:</b> Harvard Valued - Utilization over 100,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab</b> 34	<b>Specialty Developing Recommendation:</b>	APMA	<b>First Identified:</b> October 2009	<b>2012 Est Medicare Utilization:</b> 303,643	<b>2007 Work RVU:</b> 0.51 <b>2007 NF PE RVU:</b> 0.45 <b>2007 Fac PE RVU:</b> 0.31 <b>Result:</b> Decrease	<b>2013 Work RVU:</b> 0.39 <b>2013 NF PE RVU:</b> 0.69 <b>2013 Fac PE RVU:</b> 0.35
<b>RUC Recommendation:</b> 0.39				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

<b>29550</b>	<b>Strapping; toes</b>			<b>Global:</b> 000	<b>Issue:</b> Strapping Lower Extremity	<b>Screen:</b> Harvard Valued - Utilization over 100,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab</b> 34	<b>Specialty Developing Recommendation:</b>	APMA	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 88,043	<b>2007 Work RVU:</b> 0.47 <b>2007 NF PE RVU:</b> 0.46 <b>2007 Fac PE RVU:</b> 0.29 <b>Result:</b> Decrease	<b>2013 Work RVU:</b> 0.25 <b>2013 NF PE RVU:</b> 0.69 <b>2013 Fac PE RVU:</b> 0.32
<b>RUC Recommendation:</b> 0.25				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

<b>29590</b>	<b>Denis-Browne splint strapping</b>			<b>Global:</b> 000	<b>Issue:</b> Dennis-Browne splint revision	<b>Screen:</b> Harvard Valued - Utilization over 100,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2012	<b>Tab</b> 07	<b>Specialty Developing Recommendation:</b>	APMA	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 3,235	<b>2007 Work RVU:</b> 0.76 <b>2007 NF PE RVU:</b> 0.54 <b>2007 Fac PE RVU:</b> 0.29 <b>Result:</b> Deleted from CPT	<b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>
<b>RUC Recommendation:</b> Refer to CPT for deletion				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	February 2012 <b>Published in CPT Asst:</b>		

<b>29805</b>	<b>Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)</b>			<b>Global:</b> 090	<b>Issue:</b> Arthroscopy	<b>Screen:</b> CMS Request - Practice Expense Review	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2008	<b>Tab</b> 51	<b>Specialty Developing Recommendation:</b>	AAOS	<b>First Identified:</b> NA	<b>2012 Est Medicare Utilization:</b> 962	<b>2007 Work RVU:</b> 5.94 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 5.44 <b>Result:</b> PE Only	<b>2013 Work RVU:</b> 6.03 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 6.88
<b>RUC Recommendation:</b> No NF PE inputs				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

## Status Report: CMS Requests and Relativity Assessment Issues

---

<b>29822</b>	<b>Arthroscopy, shoulder, surgical; debridement, limited</b>	<b>Global:</b> 090	<b>Issue:</b> Arthroscopy	<b>Screen:</b> CMS Fastest Growing	<b>Complete?</b> Yes
<b>Most Recent</b>	<b>Tab</b> 26	<b>Specialty Developing</b>	AAOS	<b>First Identified:</b> October 2008	<b>2012 Est Medicare Utilization:</b> 21,113
<b>RUC Meeting:</b> February 2009		<b>Specialty Developing Recommendation:</b>			
<b>RUC Recommendation:</b> Remove from screen			<b>CPT Action (if applicable):</b>		
			<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	
				<b>2007 Work RVU:</b> 7.49	<b>2013 Work RVU:</b> 7.60
				<b>2007 NF PE RVU:</b> NA	<b>2013 NF PE RVU:</b> NA
				<b>2007 Fac PE RVU</b> 6.43	<b>2013 Fac PE RVU:</b> 8.06
				<b>Result:</b> Remove from Screen	

---

<b>29823</b>	<b>Arthroscopy, shoulder, surgical; debridement, extensive</b>	<b>Global:</b> 090	<b>Issue:</b>	<b>Screen:</b> Harvard-Valued Annual Allowed Charges Greater than \$10 million	<b>Complete?</b> Yes
<b>Most Recent</b>	<b>Tab</b> 27	<b>Specialty Developing</b>		<b>First Identified:</b> October 2012	<b>2012 Est Medicare Utilization:</b> 34,086
<b>RUC Meeting:</b> October 2012		<b>Specialty Developing Recommendation:</b>			
<b>RUC Recommendation:</b> Remove from screen			<b>CPT Action (if applicable):</b>		
			<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	
				<b>2007 Work RVU:</b> 8.24	<b>2013 Work RVU:</b> 8.36
				<b>2007 NF PE RVU:</b> NA	<b>2013 NF PE RVU:</b> NA
				<b>2007 Fac PE RVU</b> 6.94	<b>2013 Fac PE RVU:</b> 8.73
				<b>Result:</b> Remove from Screen	

---

<b>29824</b>	<b>Arthroscopy, shoulder, surgical; distal claviclectomy including distal articular surface (Mumford procedure)</b>	<b>Global:</b> 090	<b>Issue:</b> RAW	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent</b>	<b>Tab</b> 34	<b>Specialty Developing</b>	AAOS	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 39,394
<b>RUC Meeting:</b> January 2013		<b>Specialty Developing Recommendation:</b>			
<b>RUC Recommendation:</b> 8.82. Re-review October 2015			<b>CPT Action (if applicable):</b>		
			<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	
				<b>2007 Work RVU:</b> 8.82	<b>2013 Work RVU:</b> 8.98
				<b>2007 NF PE RVU:</b> NA	<b>2013 NF PE RVU:</b> NA
				<b>2007 Fac PE RVU</b> 7.3	<b>2013 Fac PE RVU:</b> 9.47
				<b>Result:</b> Maintain	

---

## Status Report: CMS Requests and Relativity Assessment Issues

<b>29826</b> Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)				<b>Global:</b> ZZZ	<b>Issue:</b> RAW	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2013	<b>Tab</b> 34	<b>Specialty Developing Recommendation:</b>	AAOS	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 74,827	<b>2007 Work RVU:</b> 9.05 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU</b> 7.21 <b>Result:</b> Decrease	<b>2013 Work RVU:</b> 3.00 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 1.60
<b>RUC Recommendation:</b> 3.00. Re-review October 2015				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	
<b>29827</b> Arthroscopy, shoulder, surgical; with rotator cuff repair				<b>Global:</b> 090	<b>Issue:</b> RAW	<b>Screen:</b> CMS Fastest Growing/ Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2013	<b>Tab</b> 34	<b>Specialty Developing Recommendation:</b>	AAOS	<b>First Identified:</b> October 2008	<b>2012 Est Medicare Utilization:</b> 54,194	<b>2007 Work RVU:</b> 15.44 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU</b> 11.01 <b>Result:</b> Maintain	<b>2013 Work RVU:</b> 15.59 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 13.26
<b>RUC Recommendation:</b> 15.59. Re-review October 2015				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	
<b>29828</b> Arthroscopy, shoulder, surgical; biceps tenodesis				<b>Global:</b> 090	<b>Issue:</b> RAW	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2013	<b>Tab</b> 34	<b>Specialty Developing Recommendation:</b>	AAOS	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 9,552	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU</b> <b>Result:</b> Maintain	<b>2013 Work RVU:</b> 13.16 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 11.73
<b>RUC Recommendation:</b> 13.16. Re-review October 2015				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	

# Status Report: CMS Requests and Relativity Assessment Issues

**29830 Arthroscopy, elbow, diagnostic, with or without synovial biopsy (separate procedure)**      **Global:** 090      **Issue:** Arthroscopy      **Screen:** CMS Request - Practice Expense Review      **Complete?** Yes

**Most Recent RUC Meeting:** April 2008      **Tab** 51      **Specialty Developing Recommendation:** AAOS      **First Identified:** NA      **2012 Est Medicare Utilization:** 165      **2007 Work RVU:** 5.80      **2013 Work RVU:** 5.88  
**2007 NF PE RVU:** NA      **2013 NF PE RVU:** NA  
**2007 Fac PE RVU:** 5.14      **2013 Fac PE RVU:** 6.50

**RUC Recommendation:** No NF PE inputs

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** PE Only

**29840 Arthroscopy, wrist, diagnostic, with or without synovial biopsy (separate procedure)**      **Global:** 090      **Issue:** Arthroscopy      **Screen:** CMS Request - Practice Expense Review      **Complete?** Yes

**Most Recent RUC Meeting:** April 2008      **Tab** 51      **Specialty Developing Recommendation:** AAOS      **First Identified:** NA      **2012 Est Medicare Utilization:** 89      **2007 Work RVU:** 5.59      **2013 Work RVU:** 5.68  
**2007 NF PE RVU:** NA      **2013 NF PE RVU:** NA  
**2007 Fac PE RVU:** 5.16      **2013 Fac PE RVU:** 6.69

**RUC Recommendation:** No NF PE inputs

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** PE Only

**29870 Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)**      **Global:** 090      **Issue:** Arthroscopy      **Screen:** CMS Request - Practice Expense Review      **Complete?** Yes

**Most Recent RUC Meeting:** October 2009      **Tab** 13      **Specialty Developing Recommendation:** AAOS      **First Identified:** NA      **2012 Est Medicare Utilization:** 1,739      **2007 Work RVU:** 5.11      **2013 Work RVU:** 5.19  
**2007 NF PE RVU:** NA      **2013 NF PE RVU:** 11.52  
**2007 Fac PE RVU:** 4.72      **2013 Fac PE RVU:** 6.12

**RUC Recommendation:** New PE non-facility inputs

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** PE Only

**29888 Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction**      **Global:** 090      **Issue:** ACL Repair      **Screen:** Site of Service Anomaly      **Complete?** Yes

**Most Recent RUC Meeting:** April 2008      **Tab** 38      **Specialty Developing Recommendation:** AAOS      **First Identified:** September 2007      **2012 Est Medicare Utilization:** 1,607      **2007 Work RVU:** 14.14      **2013 Work RVU:** 14.30  
**2007 NF PE RVU:** NA      **2013 NF PE RVU:** NA  
**2007 Fac PE RVU:** 9.75      **2013 Fac PE RVU:** 12.30

**RUC Recommendation:** 14.14

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Maintain

# Status Report: CMS Requests and Relativity Assessment Issues

**29900** Arthroscopy, metacarpophalangeal joint, diagnostic, includes synovial biopsy      **Global:** 090      **Issue:** Arthroscopy      **Screen:** CMS Request - Practice Expense Review      **Complete?** Yes

**Most Recent RUC Meeting:** April 2008      **Tab** 51      **Specialty Developing Recommendation:** AAOS      **First Identified:** NA      **2012 Est Medicare Utilization:** 3      **2007 Work RVU:** 5.74      **2013 Work RVU:** 5.88  
**2007 NF PE RVU:** NA      **2013 NF PE RVU:** NA  
**2007 Fac PE RVU:** 5.6      **2013 Fac PE RVU:** 7.11

**RUC Recommendation:** No NF PE inputs

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** PE Only

**30465** Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)      **Global:** 090      **Issue:** Repair Nasal Stenosis      **Screen:** Site of Service Anomaly (99238-Only)      **Complete?** Yes

**Most Recent RUC Meeting:** September 2007      **Tab** 16      **Specialty Developing Recommendation:** AAO-HNS      **First Identified:** September 2007      **2012 Est Medicare Utilization:** 1,872      **2007 Work RVU:** 12.20      **2013 Work RVU:** 12.36  
**2007 NF PE RVU:** NA      **2013 NF PE RVU:** NA  
**2007 Fac PE RVU:** 11.58      **2013 Fac PE RVU:** 15.45

**RUC Recommendation:** Reduce 99238 to 0.5

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** PE Only

**30901** Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method      **Global:** 000      **Issue:** Control Nasal Hemorrhage      **Screen:** Harvard Valued - Utilization over 100,000      **Complete?** Yes

**Most Recent RUC Meeting:** April 2010      **Tab** 35      **Specialty Developing Recommendation:** AAO-HNS      **First Identified:** October 2009      **2012 Est Medicare Utilization:** 108,263      **2007 Work RVU:** 1.21      **2013 Work RVU:** 1.10  
**2007 NF PE RVU:** 1.32      **2013 NF PE RVU:** 1.63  
**2007 Fac PE RVU:** 0.31      **2013 Fac PE RVU:** 0.40

**RUC Recommendation:** 1.21

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Maintain

**31231** Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)      **Global:** 000      **Issue:** Diagnostic Nasal Endoscopy      **Screen:** MPC List      **Complete?** Yes

**Most Recent RUC Meeting:** January 2012      **Tab** 19      **Specialty Developing Recommendation:** AAO-HNS      **First Identified:** October 2010      **2012 Est Medicare Utilization:** 457,478      **2007 Work RVU:** 1.10      **2013 Work RVU:** 1.10  
**2007 NF PE RVU:** 3.37      **2013 NF PE RVU:** 5.21  
**2007 Fac PE RVU:** 0.84      **2013 Fac PE RVU:** 0.69

**RUC Recommendation:** 1.10

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Maintain

## Status Report: CMS Requests and Relativity Assessment Issues

<b>31237</b>	Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)	<b>Global:</b> 000	<b>Issue:</b> Nasal/Sinus Endoscopy	<b>Screen:</b> CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 19	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 96,161	<b>2007 Work RVU:</b> 2.98 <b>2007 NF PE RVU:</b> 5.03 <b>2007 Fac PE RVU:</b> 1.72 <b>Result:</b> Decrease
<b>RUC Recommendation:</b> 2.60			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 2.98 <b>2013 NF PE RVU:</b> 6.52 <b>2013 Fac PE RVU:</b> 2.02
<hr/>					
<b>31238</b>	Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage	<b>Global:</b> 000	<b>Issue:</b> Nasal/Sinus Endoscopy	<b>Screen:</b> CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 19	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> January 2012	<b>2012 Est Medicare Utilization:</b> 25,778	<b>2007 Work RVU:</b> 3.26 <b>2007 NF PE RVU:</b> 5.04 <b>2007 Fac PE RVU:</b> 1.90 <b>Result:</b> Decrease
<b>RUC Recommendation:</b> 2.74			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 3.26 <b>2013 NF PE RVU:</b> 6.43 <b>2013 Fac PE RVU:</b> 2.16
<hr/>					
<b>31239</b>	Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy	<b>Global:</b> 010	<b>Issue:</b> Nasal/Sinus Endoscopy	<b>Screen:</b> CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 19	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> January 2012	<b>2012 Est Medicare Utilization:</b> 1,234	<b>2007 Work RVU:</b> 9.23 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 7.59 <b>Result:</b> Decrease
<b>RUC Recommendation:</b> 9.04			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 9.33 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 10.14
<hr/>					
<b>31240</b>	Nasal/sinus endoscopy, surgical; with concha bullosa resection	<b>Global:</b> 000	<b>Issue:</b> Nasal/Sinus Endoscopy	<b>Screen:</b> CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 19	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> January 2012	<b>2012 Est Medicare Utilization:</b> 3,974	<b>2007 Work RVU:</b> 2.61 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 1.59 <b>Result:</b> Maintain
<b>RUC Recommendation:</b> 2.61			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 2.61 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 1.84

# Status Report: CMS Requests and Relativity Assessment Issues

**31571** Laryngoscopy, direct, with injection into vocal cord(s), therapeutic; with operating microscope or telescope **Global:** 000 **Issue:** Laryngoscopy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

**Most Recent** **Tab** 16 **Specialty Developing** AAO-HNS **First** **2012 Est** **2007 Work RVU:** 4.26 **2013 Work RVU:** 4.26  
**RUC Meeting:** September 2007 **Recommendation:** **Identified:** September 2007 **Medicare** **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA  
**Utilization:** 4,305 **2007 Fac PE RVU** 2.36 **2013 Fac PE RVU:** 2.64

**RUC Recommendation:** Reduce 99238 to 0.5

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** PE Only

**31575** Laryngoscopy, flexible fiberoptic; diagnostic

**Global:** 000

**Issue:**

**Screen:** MPC List

**Complete?** Yes

**Most Recent** **Tab** 41 **Specialty Developing** **First** **2012 Est** **2007 Work RVU:** 1.10 **2013 Work RVU:** 1.10  
**RUC Meeting:** February 2011 **Recommendation:** **Identified:** October 2010 **Medicare** **2007 NF PE RVU:** 1.82 **2013 NF PE RVU:** 2.25  
**Utilization:** 617,038 **2007 Fac PE RVU** 0.84 **2013 Fac PE RVU:** 1.06

**RUC Recommendation:** Reaffirmed RUC recommendation

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Maintain

**31579** Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy

**Global:** 000

**Issue:** Laryngoscopy

**Screen:** CMS Fastest Growing

**Complete?** Yes

**Most Recent** **Tab** 26 **Specialty Developing** AAO-HNS **First** **2012 Est** **2007 Work RVU:** 2.26 **2013 Work RVU:** 2.26  
**RUC Meeting:** October 2008 **Recommendation:** **Identified:** October 2008 **Medicare** **2007 NF PE RVU:** 3.5 **2013 NF PE RVU:** 3.85  
**Utilization:** 61,114 **2007 Fac PE RVU** 1.37 **2013 Fac PE RVU:** 1.66

**RUC Recommendation:** Remove from screen

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Remove from Screen

**31611** Construction of tracheoesophageal fistula and subsequent insertion of an alaryngeal speech prosthesis (eg, voice button, Blom-Singer prosthesis)

**Global:** 090

**Issue:** Speech Prosthesis

**Screen:** Site of Service Anomaly

**Complete?** Yes

**Most Recent** **Tab** S **Specialty Developing** AAO-HNS **First** **2012 Est** **2007 Work RVU:** 5.92 **2013 Work RVU:** 6.00  
**RUC Meeting:** February 2008 **Recommendation:** **Identified:** September 2007 **Medicare** **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA  
**Utilization:** 921 **2007 Fac PE RVU** 6.92 **2013 Fac PE RVU:** 9.62

**RUC Recommendation:** Reduce 99238 to 0.5

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** PE Only



## Status Report: CMS Requests and Relativity Assessment Issues

31620	Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) (List separately in addition to code for primary procedure[s])			Global: ZZZ	Issue: RAW	Screen: High Volume Growth2	Complete? No
Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:		First Identified: April 2013	2012 Est Medicare Utilization: 17,956	2007 Work RVU: 1.40 2007 NF PE RVU: 5.73 2007 Fac PE RVU 0.5 Result:	2013 Work RVU: 1.40 2013 NF PE RVU: 7.15 2013 Fac PE RVU: 0.48
RUC Recommendation: Review Action Plan				CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
32201	Pneumonostomy; with percutaneous drainage of abscess or cyst			Global: 000	Issue: Drainage of Abscess	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:		First Identified: January 2012	2012 Est Medicare Utilization: 270	2007 Work RVU: 3.99 2007 NF PE RVU: 20.21 2007 Fac PE RVU 1.26 Result: Deleted from CPT	2013 Work RVU: 3.99 2013 NF PE RVU: 23.15 2013 Fac PE RVU: 1.40
RUC Recommendation: Deleted from CPT				CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>	October 2012 Published in CPT Asst:		
32420	Pneumocentesis, puncture of lung for aspiration			Global: 000	Issue: Thoracentesis with Tube Insertion	Screen: Harvard Valued - Utilization over 30,000	Complete? Yes
Most Recent RUC Meeting:	Tab 17	Specialty Developing Recommendation:	ACCP, ACR, ATS, SIR, SCCM, STS	First Identified: September 2011	2012 Est Medicare Utilization: 312	2007 Work RVU: 2.18 2007 NF PE RVU: NA 2007 Fac PE RVU 0.66 Result: Deleted from CPT	2013 Work RVU: 2013 NF PE RVU: 2013 Fac PE RVU:
RUC Recommendation: Deleted from CPT				CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>	February 2012 Published in CPT Asst:		

## Status Report: CMS Requests and Relativity Assessment Issues

**32421** Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent **Global:** 000 **Issue:** Thoracentesis with Tube Insertion **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

**Most Recent RUC Meeting:** September 2011 **Tab** 17 **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR, SCCM, STS **First Identified:** September 2011 **2012 Est Medicare Utilization:** 82,662 **2007 Work RVU:** **2013 Work RVU:** **2007 NF PE RVU:** **2013 NF PE RVU:** **2007 Fac PE RVU** **2013 Fac PE RVU:** **RUC Recommendation:** Deleted from CPT **CPT Action (if applicable):** February 2012 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Deleted from CPT

**32422** Thoracentesis with insertion of tube, includes water seal (eg, for pneumothorax), when performed (separate procedure) **Global:** 000 **Issue:** Thoracentesis with Tube Insertion **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

**Most Recent RUC Meeting:** September 2011 **Tab** 17 **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR, SCCM, STS **First Identified:** April 2011 **2012 Est Medicare Utilization:** 140,850 **2007 Work RVU:** **2013 Work RVU:** **2007 NF PE RVU:** **2013 NF PE RVU:** **2007 Fac PE RVU** **2013 Fac PE RVU:** **RUC Recommendation:** Deleted from CPT **CPT Action (if applicable):** February 2012 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Deleted from CPT

**32440** Removal of lung, pneumonectomy; **Global:** 090 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request Final Rule for 2013 **Complete?** Yes

**Most Recent RUC Meeting:** January 2013 **Tab** 34 **Specialty Developing Recommendation:** **First Identified:** November 2011 **2012 Est Medicare Utilization:** 656 **2007 Work RVU:** 27.17 **2013 Work RVU:** 27.28 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU** 12.44 **2013 Fac PE RVU:** 13.19 **RUC Recommendation:** No reliable way to determine incremental difference between open thoracotomy to thoroscopic procedures. **CPT Action (if applicable):** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Remove from screen

## Status Report: CMS Requests and Relativity Assessment Issues

<b>32480</b>	<b>Removal of lung, other than pneumonectomy; single lobe (lobectomy)</b>	<b>Global:</b> 090	<b>Issue:</b> RAW Review	<b>Screen:</b> CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request Final Rule for 2013	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2013	<b>Tab</b> 34 <b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> November 2011	<b>2012 Est Medicare Utilization:</b> 9,338	<b>2007 Work RVU:</b> 25.71 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 11.63 <b>Result:</b> Remove from Screen	<b>2013 Work RVU:</b> 25.82 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 12.42
<b>RUC Recommendation:</b> No reliable way to determine incremental difference between open thoracotomy to thoroscopic procedures.		<b>CPT Action (if applicable):</b>			
		<b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	
<b>32482</b>	<b>Removal of lung, other than pneumonectomy; 2 lobes (bilobectomy)</b>	<b>Global:</b> 090	<b>Issue:</b> RAW Review	<b>Screen:</b> CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request Final Rule for 2013	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2013	<b>Tab</b> 34 <b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> November 2011	<b>2012 Est Medicare Utilization:</b> 686	<b>2007 Work RVU:</b> 27.28 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 12.48 <b>Result:</b> Remove from Screen	<b>2013 Work RVU:</b> 27.44 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 13.56
<b>RUC Recommendation:</b> No reliable way to determine incremental difference between open thoracotomy to thoroscopic procedures.		<b>CPT Action (if applicable):</b>			
		<b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	
<b>32491</b>	<b>Removal of lung, other than pneumonectomy; with resection-plication of emphysematous lung(s) (bullous or non-bullous) for lung volume reduction, sternal split or transthoracic approach, includes any pleural procedure, when performed</b>	<b>Global:</b> 090	<b>Issue:</b> RAW Review	<b>Screen:</b> CMS Request to Re-Review Families of Recently Reviewed CPT Codes	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> January 2012	<b>Tab</b> 30 <b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> November 2011	<b>2012 Est Medicare Utilization:</b> 58	<b>2007 Work RVU:</b> 25.09 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 12.13 <b>Result:</b>	<b>2013 Work RVU:</b> 25.24 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 12.89
<b>RUC Recommendation:</b> Request further information from CMS		<b>CPT Action (if applicable):</b>			
		<b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	

## Status Report: CMS Requests and Relativity Assessment Issues

32551	Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open (separate procedure)			Global: 000	Issue: Chest Tube Thoracostomy	Screen: Harvard Valued - Utilization over 30,000	Complete?	Yes			
Most Recent RUC Meeting:	April 2012	Tab 10	Specialty Developing Recommendation:	ACCP, ATS, ACR, ACS, SIR, SCCM, STS	First Identified:	April 2011	2012 Est Medicare Utilization:	61,751	2007 Work RVU:	2013 Work RVU:	3.29
									2007 NF PE RVU:	2013 NF PE RVU:	NA
									2007 Fac PE RVU	2013 Fac PE RVU:	1.21
RUC Recommendation:	3.50				CPT Action (if applicable): Referred to CPT Asst	<input type="checkbox"/>	February 2012	Published in CPT Asst:	Result:	Increase	
32554	Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance			Global: 000	Issue: Chest Tube Interventions	Screen: Harvard Valued - Utilization over 30,000	Complete?	Yes			
Most Recent RUC Meeting:	October 2012	Tab 04	Specialty Developing Recommendation:	ACCP, ACR, ATS, SIR	First Identified:		2012 Est Medicare Utilization:		2007 Work RVU:	2013 Work RVU:	1.82
									2007 NF PE RVU:	2013 NF PE RVU:	14.66
									2007 Fac PE RVU	2013 Fac PE RVU:	0.65
RUC Recommendation:	1.82				CPT Action (if applicable): Referred to CPT Asst	<input type="checkbox"/>	February 2012	Published in CPT Asst:	Result:	Decrease	
32555	Thoracentesis, needle or catheter, aspiration of the pleural space; with imaging guidance			Global: 000	Issue: Chest Tube Interventions	Screen: Harvard Valued - Utilization over 30,000	Complete?	Yes			
Most Recent RUC Meeting:	October 2012	Tab 04	Specialty Developing Recommendation:	ACCP, ACR, ATS, SIR	First Identified:		2012 Est Medicare Utilization:		2007 Work RVU:	2013 Work RVU:	2.27
									2007 NF PE RVU:	2013 NF PE RVU:	16.70
									2007 Fac PE RVU	2013 Fac PE RVU:	0.80
RUC Recommendation:	2.27				CPT Action (if applicable): Referred to CPT Asst	<input type="checkbox"/>	February 2012	Published in CPT Asst:	Result:	Decrease	

## Status Report: CMS Requests and Relativity Assessment Issues

---

**32556** Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance      **Global:** 000      **Issue:** Chest Tube Interventions      **Screen:** Harvard Valued - Utilization over 30,000      **Complete?** Yes

**Most Recent RUC Meeting:** October 2012      **Tab** 04      **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR      **First Identified:**      **2012 Est Medicare Utilization:**      **2007 Work RVU:**      **2013 Work RVU:** 2.50  
**2007 NF PE RVU:**      **2013 NF PE RVU:** 14.80  
**2007 Fac PE RVU**      **2013 Fac PE RVU:** 0.87  
**RUC Recommendation:** 2.50      **CPT Action (if applicable):** February 2012  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

---

**32557** Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance      **Global:** 000      **Issue:** Chest Tube Interventions      **Screen:** Harvard Valued - Utilization over 30,000      **Complete?** Yes

**Most Recent RUC Meeting:** October 2012      **Tab** 04      **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR      **First Identified:**      **2012 Est Medicare Utilization:**      **2007 Work RVU:**      **2013 Work RVU:** 3.12  
**2007 NF PE RVU:**      **2013 NF PE RVU:** 24.68  
**2007 Fac PE RVU**      **2013 Fac PE RVU:** 1.07  
**RUC Recommendation:** 3.62      **CPT Action (if applicable):** February 2012  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

---

**32663** Thoracoscopy, surgical; with lobectomy (single lobe)      **Global:** 090      **Issue:** RAW review      **Screen:** CMS Fastest Growing      **Complete?** Yes

**Most Recent RUC Meeting:** January 2013      **Tab** 34      **Specialty Developing Recommendation:** STS      **First Identified:** October 2008      **2012 Est Medicare Utilization:** 5,612      **2007 Work RVU:** 24.56      **2013 Work RVU:** 24.64  
**2007 NF PE RVU:** NA      **2013 NF PE RVU:** NA  
**2007 Fac PE RVU** 10.44      **2013 Fac PE RVU:** 11.48  
**RUC Recommendation:** No reliable way to determine incremental difference between open thoracotomy to thoracoscopic procedures.      **CPT Action (if applicable):**  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

---

## Status Report: CMS Requests and Relativity Assessment Issues

<b>33207</b>	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular	<b>Global:</b> 090	<b>Issue:</b> Pacemaker or Pacing Carioverter - Defibrillator	<b>Screen:</b> Codes Reported Together 75% or More- Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2011	<b>Tab</b> 10 <b>Specialty Developing Recommendation:</b> ACC	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 23,647	<b>2007 Work RVU:</b> 9.05 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU</b> 4.95 <b>Result:</b> Maintain	<b>2013 Work RVU:</b> 8.05 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 4.48
<b>RUC Recommendation:</b> 8.05		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	February 2011 <b>Published in CPT Asst:</b>		
<hr/>					
<b>33208</b>	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular	<b>Global:</b> 090	<b>Issue:</b> Pacemaker or Pacing Carioverter - Defibrillator	<b>Screen:</b> Codes Reported Together 75% or More- Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2011	<b>Tab</b> 10 <b>Specialty Developing Recommendation:</b> ACC	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 114,189	<b>2007 Work RVU:</b> 8.12 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU</b> 4.95 <b>Result:</b> Maintain	<b>2013 Work RVU:</b> 8.77 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 4.76
<b>RUC Recommendation:</b> 8.77		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	February 2011 <b>Published in CPT Asst:</b>		
<hr/>					
<b>33212</b>	Insertion of pacemaker pulse generator only; with existing single lead	<b>Global:</b> 090	<b>Issue:</b> Pacemaker or Pacing Carioverter - Defibrillator	<b>Screen:</b> Codes Reported Together 75% or More- Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> September 2011	<b>Tab</b> 04 <b>Specialty Developing Recommendation:</b> ACC	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 2,298	<b>2007 Work RVU:</b> 5.51 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU</b> 3.46 <b>Result:</b> Decrease	<b>2013 Work RVU:</b> 5.26 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 3.42
<b>RUC Recommendation:</b> 5.26		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	February 2011 <b>Published in CPT Asst:</b>		

## Status Report: CMS Requests and Relativity Assessment Issues

<b>33213</b>	Insertion of pacemaker pulse generator only; with existing dual leads	<b>Global:</b> 090	<b>Issue:</b> Pacemaker or Pacing Carioverter - Defibrillator	<b>Screen:</b> CMS Fastest Growing / Codes Reported Together 75% or More- Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> September 2011	<b>Tab</b> 04 <b>Specialty Developing Recommendation:</b> ACC	<b>First Identified:</b> October 2008	<b>2012 Est Medicare Utilization:</b> 7,836	<b>2007 Work RVU:</b> 6.36 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU</b> 3.87 <b>Result:</b> Decrease	<b>2013 Work RVU:</b> 5.53 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 3.51
<b>RUC Recommendation:</b> 5.53		<b>CPT Action (if applicable): Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b> February 2011		
<hr/>					
<b>33221</b>	Insertion of pacemaker pulse generator only; with existing multiple leads	<b>Global:</b> 090	<b>Issue:</b> Pacemaker or Pacing Carioverter - Defibrillator	<b>Screen:</b> Codes Reported Together 75% or More- Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> September 2011	<b>Tab</b> 04 <b>Specialty Developing Recommendation:</b> ACC	<b>First Identified:</b> April 2011	<b>2012 Est Medicare Utilization:</b> 295	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU</b> <b>Result:</b> Decrease	<b>2013 Work RVU:</b> 5.80 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 3.61
<b>RUC Recommendation:</b> 5.80		<b>CPT Action (if applicable): Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b> February 2011		
<hr/>					
<b>33227</b>	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system	<b>Global:</b> 090	<b>Issue:</b> Pacemaker or Pacing Carioverter - Defibrillator	<b>Screen:</b> Codes Reported Together 75% or More- Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> September 2011	<b>Tab</b> 04 <b>Specialty Developing Recommendation:</b> ACC	<b>First Identified:</b> April 2011	<b>2012 Est Medicare Utilization:</b> 7,983	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU</b> <b>Result:</b> Decrease	<b>2013 Work RVU:</b> 5.50 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 3.50
<b>RUC Recommendation:</b> 5.50		<b>CPT Action (if applicable): Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b> February 2011		

## Status Report: CMS Requests and Relativity Assessment Issues

**33228** Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system

**Global:** 090

**Issue:** Pacemaker or Pacing  
Carioverter - Defibrillator

**Screen:** Codes Reported  
Together 75% or More-  
Part1

**Complete?** Yes

**Most Recent  
RUC Meeting:** September 2011

**Tab** 04

**Specialty Developing  
Recommendation:** ACC

**First  
Identified:** April 2011

**2012 Est  
Medicare  
Utilization:** 35,677

**2007 Work RVU:**

**2013 Work RVU:** 5.77

**2007 NF PE RVU:**

**2013 NF PE RVU:** NA

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 3.61

**RUC Recommendation:** 5.77

**CPT Action (if applicable):** February 2011

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**33229** Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; multiple lead system

**Global:** 090

**Issue:** Pacemaker or Pacing  
Carioverter - Defibrillator

**Screen:** Codes Reported  
Together 75% or More-  
Part1

**Complete?** Yes

**Most Recent  
RUC Meeting:** September 2011

**Tab** 04

**Specialty Developing  
Recommendation:** ACC

**First  
Identified:** April 2011

**2012 Est  
Medicare  
Utilization:** 1,924

**2007 Work RVU:**

**2013 Work RVU:** 6.04

**2007 NF PE RVU:**

**2013 NF PE RVU:** NA

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 3.71

**RUC Recommendation:** 6.04

**CPT Action (if applicable):** February 2011

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**33230** Insertion of pacing cardioverter-defibrillator pulse generator only; with existing dual leads

**Global:** 090

**Issue:** Pacemaker or Pacing  
Carioverter - Defibrillator

**Screen:** Codes Reported  
Together 75% or More-  
Part1

**Complete?** Yes

**Most Recent  
RUC Meeting:** September 2011

**Tab** 04

**Specialty Developing  
Recommendation:** ACC

**First  
Identified:** April 2011

**2012 Est  
Medicare  
Utilization:** 525

**2007 Work RVU:**

**2013 Work RVU:** 6.32

**2007 NF PE RVU:**

**2013 NF PE RVU:** NA

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 3.85

**RUC Recommendation:** 6.32

**CPT Action (if applicable):** February 2011

**Referred to CPT Asst** ☐

**Published in CPT Asst:**



## Status Report: CMS Requests and Relativity Assessment Issues

**33231** Insertion of pacing cardioverter-defibrillator pulse generator only; with existing multiple leads      **Global:** 090      **Issue:** Pacemaker or Pacing Cardioverter - Defibrillator      **Screen:** Codes Reported Together 75% or More-Part1      **Complete?** Yes

**Most Recent RUC Meeting:** September 2011      **Tab** 04      **Specialty Developing Recommendation:** ACC

**First Identified:** April 2011

**2012 Est Medicare Utilization:** 330

**2007 Work RVU:**

**2013 Work RVU:** 6.59

**2007 NF PE RVU:**

**2013 NF PE RVU:** NA

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 3.95

**RUC Recommendation:** 6.59

**CPT Action (if applicable):** February 2011

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**33233** Removal of permanent pacemaker pulse generator only

**Global:** 090

**Issue:** Pacemaker or Pacing Cardioverter - Defibrillator

**Screen:** Codes Reported Together 75% or More-Part1

**Complete?** Yes

**Most Recent RUC Meeting:** April 2011      **Tab** 10      **Specialty Developing Recommendation:** ACC

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 10,394

**2007 Work RVU:** 3.33

**2013 Work RVU:** 3.39

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 3.29

**2013 Fac PE RVU:** 2.90

**RUC Recommendation:** 3.39

**CPT Action (if applicable):** February 2011

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Maintain

**33240** Insertion of pacing cardioverter-defibrillator pulse generator only; with existing single lead

**Global:** 090

**Issue:** Pacemaker or Pacing Cardioverter - Defibrillator

**Screen:** Codes Reported Together 75% or More-Part1

**Complete?** Yes

**Most Recent RUC Meeting:** September 2011      **Tab** 04      **Specialty Developing Recommendation:** ACC

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 2,950

**2007 Work RVU:** 7.61

**2013 Work RVU:** 6.05

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 4.79

**2013 Fac PE RVU:** 3.74

**RUC Recommendation:** 6.06

**CPT Action (if applicable):** February 2011

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

## Status Report: CMS Requests and Relativity Assessment Issues

### 33241 Removal of pacing cardioverter-defibrillator pulse generator only

Global: 090

Issue: Pacemaker or Pacing  
Carioverter - Defibrillator

Screen: Codes Reported  
Together 75% or More-  
Part1

Complete? Yes

Most Recent  
RUC Meeting: April 2011

Tab 10

Specialty Developing  
Recommendation: ACC

First  
Identified: February 2010

2012 Est  
Medicare  
Utilization: 9,913

2007 Work RVU: 3.26

2013 Work RVU: 3.29

2007 NF PE RVU: NA

2013 NF PE RVU: NA

2007 Fac PE RVU: 2.99

2013 Fac PE RVU: 2.60

RUC Recommendation: 3.29

CPT Action (if applicable): February 2011

Referred to CPT Asst ☐

Published in CPT Asst:

### 33249 Insertion or replacement of permanent pacing cardioverter-defibrillator system with transvenous lead(s), single or dual chamber

Global: 090

Issue: Pacemaker or Pacing  
Carioverter - Defibrillator

Screen: Codes Reported  
Together 75% or More-  
Part1

Complete? Yes

Most Recent  
RUC Meeting: April 2011

Tab 10

Specialty Developing  
Recommendation: ACC

First  
Identified: February 2010

2012 Est  
Medicare  
Utilization: 49,627

2007 Work RVU: 15.02

2013 Work RVU: 15.17

2007 NF PE RVU: NA

2013 NF PE RVU: NA

2007 Fac PE RVU: 8.89

2013 Fac PE RVU: 8.23

RUC Recommendation: 15.17

CPT Action (if applicable): February 2011

Referred to CPT Asst ☐

Published in CPT Asst:

### 33262 Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; single lead system

Global: 090

Issue: Pacemaker or Pacing  
Carioverter - Defibrillator

Screen: Codes Reported  
Together 75% or More-  
Part1

Complete? Yes

Most Recent  
RUC Meeting: September 2011

Tab 04

Specialty Developing  
Recommendation: ACC

First  
Identified: April 2011

2012 Est  
Medicare  
Utilization: 4,064

2007 Work RVU:

2013 Work RVU: 6.06

2007 NF PE RVU:

2013 NF PE RVU: NA

2007 Fac PE RVU

2013 Fac PE RVU: 3.75

RUC Recommendation: 6.06

CPT Action (if applicable): February 2011

Referred to CPT Asst ☐

Published in CPT Asst:

## Status Report: CMS Requests and Relativity Assessment Issues

**33263** Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; dual lead system **Global:** 090 **Issue:** Pacemaker or Pacing Cardioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

**Most Recent RUC Meeting:** September 2011

**Tab** 04

**Specialty Developing Recommendation:** ACC

**First Identified:** April 2011

**2012 Est Medicare Utilization:** 13,080

**2007 Work RVU:**

**2013 Work RVU:** 6.33

**2007 NF PE RVU:**

**2013 NF PE RVU:** NA

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 3.86

**RUC Recommendation:** 6.33

**CPT Action (if applicable):** February 2011  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Decrease

**33264** Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; multiple lead system **Global:** 090 **Issue:** Pacemaker or Pacing Cardioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

**Most Recent RUC Meeting:** September 2011

**Tab** 04

**Specialty Developing Recommendation:** ACC

**First Identified:** April 2011

**2012 Est Medicare Utilization:** 14,379

**2007 Work RVU:**

**2013 Work RVU:** 6.60

**2007 NF PE RVU:**

**2013 NF PE RVU:** NA

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 3.96

**RUC Recommendation:** 6.60

**CPT Action (if applicable):** February 2011  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Decrease

**33282** Implantation of patient-activated cardiac event recorder **Global:** 090 **Issue:** Implantation and Removal of Patient Activated Cardiac Event Recorder **Screen:** CMS Request Final Rule for 2013 **Complete?** Yes

**Most Recent RUC Meeting:** April 2013

**Tab** 20

**Specialty Developing Recommendation:**

**First Identified:** October 2012

**2012 Est Medicare Utilization:** 8,352

**2007 Work RVU:** 4.70

**2013 Work RVU:** 4.80

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 4.1

**2013 Fac PE RVU:** 3.63

**RUC Recommendation:** 3.50

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Decrease

## Status Report: CMS Requests and Relativity Assessment Issues

**33284** Removal of an implantable, patient-activated cardiac event recorder **Global:** 090 **Issue:** Implantation and Removal of Patient Activated Cardiac Event Recorder **Screen:** CMS Request Final Rule for 2013 **Complete?** Yes

**Most Recent RUC Meeting:** April 2013 **Tab** 20 **Specialty Developing Recommendation:** **First Identified:** October 2012 **2012 Est Medicare Utilization:** 3,982 **2007 Work RVU:** 3.04 **2013 Work RVU:** 3.14 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 3.50 **2013 Fac PE RVU:** 3.01 **Result:** Decrease

**RUC Recommendation:** 3.00 **CPT Action (if applicable):** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

**33405** Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve **Global:** 090 **Issue:** Valve Replacement and CABG Procedures **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

**Most Recent RUC Meeting:** April 2012 **Tab** 40 **Specialty Developing Recommendation:** STS **First Identified:** September 2011 **2012 Est Medicare Utilization:** 32,187 **2007 Work RVU:** 41.19 **2013 Work RVU:** 41.32 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 17.58 **2013 Fac PE RVU:** 16.78 **Result:** Maintain

**RUC Recommendation:** 41.32 **CPT Action (if applicable):** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

**33430** Replacement, mitral valve, with cardiopulmonary bypass **Global:** 090 **Issue:** Valve Replacement and CABG Procedures **Screen:** High IWPUT / CMS High Expenditure Procedural Codes **Complete?** Yes

**Most Recent RUC Meeting:** April 2012 **Tab** 40 **Specialty Developing Recommendation:** STS **First Identified:** February 2008 **2012 Est Medicare Utilization:** 8,045 **2007 Work RVU:** 50.75 **2013 Work RVU:** 50.93 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 17.71 **2013 Fac PE RVU:** 20.72 **Result:** Maintain

**RUC Recommendation:** 50.93 **CPT Action (if applicable):** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

# Status Report: CMS Requests and Relativity Assessment Issues

<b>33533</b>	<b>Coronary artery bypass, using arterial graft(s); single arterial graft</b>	<b>Global:</b> 090	<b>Issue:</b> Valve Replacement and CABG Procedures	<b>Screen:</b> CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2012	<b>Tab</b> 40	<b>Specialty Developing Recommendation:</b> STS	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 66,231	<b>2007 Work RVU:</b> 33.64 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 15.55 <b>Result:</b> Increase
<b>RUC Recommendation:</b> 34.98			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 33.75 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 14.15

<b>33863</b>	<b>Ascending aorta graft, with cardiopulmonary bypass, with aortic root replacement using valved conduit and coronary reconstruction (eg, Bentall)</b>	<b>Global:</b> 090	<b>Issue:</b> Aortic Graft	<b>Screen:</b> High IWPUP	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2008	<b>Tab</b> S	<b>Specialty Developing Recommendation:</b> STS, AATS	<b>First Identified:</b> February 2008	<b>2012 Est Medicare Utilization:</b> 1,575	<b>2007 Work RVU:</b> 58.71 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 19.01 <b>Result:</b> Remove from Screen
<b>RUC Recommendation:</b> Remove from screen			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 58.79 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 21.73

<b>35301</b>	<b>Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision</b>	<b>Global:</b> 090	<b>Issue:</b> Thromboendarterectomy	<b>Screen:</b> CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2013	<b>Tab</b> 21	<b>Specialty Developing Recommendation:</b> SVS	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 50,731	<b>2007 Work RVU:</b> 19.53 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 8.04 <b>Result:</b> Increase
<b>RUC Recommendation:</b> 21.16			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 19.61 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 8.05

<b>35454</b>	<b>Deleted from CPT</b>	<b>Global:</b> 000	<b>Issue:</b> Endovascular Revascularization	<b>Screen:</b> CMS Fastest Growing	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab</b> 07	<b>Specialty Developing Recommendation:</b> ACC, ACR, SIR, SVS	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> 6.03 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 2.19 <b>Result:</b> Deleted from CPT
<b>RUC Recommendation:</b> Deleted from CPT			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>

# Status Report: CMS Requests and Relativity Assessment Issues

**35456 Deleted from CPT** **Global:** 000 **Issue:** Endovascular Revascularization **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent RUC Meeting:** April 2010 **Tab** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** **2012 Est Medicare Utilization:** **2007 Work RVU:** 7.34 **2013 Work RVU:** **2007 NF PE RVU:** NA **2013 NF PE RVU:** **2007 Fac PE RVU:** 2.64 **2013 Fac PE RVU:** **RUC Recommendation:** Deleted from CPT **CPT Action (if applicable):** February 2010 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Deleted from CPT

**35459 Deleted from CPT** **Global:** 000 **Issue:** Endovascular Revascularization **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent RUC Meeting:** April 2010 **Tab** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** **2012 Est Medicare Utilization:** **2007 Work RVU:** 8.62 **2013 Work RVU:** **2007 NF PE RVU:** NA **2013 NF PE RVU:** **2007 Fac PE RVU:** 3.01 **2013 Fac PE RVU:** **RUC Recommendation:** Deleted from CPT **CPT Action (if applicable):** February 2010 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Deleted from CPT

**35470 Deleted from CPT** **Global:** 000 **Issue:** Endovascular Revascularization **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent RUC Meeting:** April 2010 **Tab** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** October 2008 **2012 Est Medicare Utilization:** **2007 Work RVU:** 8.62 **2013 Work RVU:** **2007 NF PE RVU:** 81.78 **2013 NF PE RVU:** **2007 Fac PE RVU:** 3.37 **2013 Fac PE RVU:** **RUC Recommendation:** Deleted from CPT **CPT Action (if applicable):** February 2010 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Deleted from CPT

**35471 Transluminal balloon angioplasty, percutaneous; renal or visceral artery** **Global:** 000 **Issue:** Endovascular Revascularization **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent RUC Meeting:** October 2009 **Tab** 40 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** **2012 Est Medicare Utilization:** 7,786 **2007 Work RVU:** 10.05 **2013 Work RVU:** 10.05 **2007 NF PE RVU:** 91.6 **2013 NF PE RVU:** 66.08 **2007 Fac PE RVU:** 4.13 **2013 Fac PE RVU:** 3.63 **RUC Recommendation:** Remove from screen **CPT Action (if applicable):** Removed from CPT referral **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Remove from Screen

# Status Report: CMS Requests and Relativity Assessment Issues

**35472** Transluminal balloon angioplasty, percutaneous; aortic      **Global:** 000      **Issue:** Endovascular Revascularization      **Screen:** CMS Fastest Growing      **Complete?** Yes

**Most Recent RUC Meeting:** October 2009      **Tab** 40      **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS      **First Identified:**      **2012 Est Medicare Utilization:** 647      **2007 Work RVU:** 6.90      **2013 Work RVU:** 6.90  
**2007 NF PE RVU:** 60.05      **2013 NF PE RVU:** 50.69  
**2007 Fac PE RVU:** 2.75      **2013 Fac PE RVU:** 2.46

**RUC Recommendation:** Remove from screen      **CPT Action (if applicable):** Removed from CPT referral  
**Referred to CPT Asst** ☐      **Published in CPT Asst:** **Result:** Remove from Screen

**35473** Deleted from CPT      **Global:** 000      **Issue:** Endovascular Revascularization      **Screen:** CMS Fastest Growing      **Complete?** Yes

**Most Recent RUC Meeting:** April 2010      **Tab** 07      **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS      **First Identified:**      **2012 Est Medicare Utilization:**      **2007 Work RVU:** 6.03      **2013 Work RVU:**      **2007 NF PE RVU:** 56.4      **2013 NF PE RVU:**      **2007 Fac PE RVU:** 2.43      **2013 Fac PE RVU:**      **Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT      **CPT Action (if applicable):** February 2010  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

**35474** Deleted from CPT      **Global:** 000      **Issue:** Endovascular Revascularization      **Screen:** CMS Fastest Growing      **Complete?** Yes

**Most Recent RUC Meeting:** April 2010      **Tab** 07      **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS      **First Identified:** October 2008      **2012 Est Medicare Utilization:**      **2007 Work RVU:** 7.35      **2013 Work RVU:**      **2007 NF PE RVU:** 80.7      **2013 NF PE RVU:**      **2007 Fac PE RVU:** 2.9      **2013 Fac PE RVU:**      **Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT      **CPT Action (if applicable):** February 2010  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

**35475** Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel      **Global:** 000      **Issue:** Repair of Arterial and Venous Blockage      **Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes      **Complete?** Yes

**Most Recent RUC Meeting:** April 2012      **Tab** 41      **Specialty Developing Recommendation:** ACR, RPA, SIR      **First Identified:** September 2011      **2012 Est Medicare Utilization:** 50,078      **2007 Work RVU:** 9.48      **2013 Work RVU:** 5.75  
**2007 NF PE RVU:** 53.95      **2013 NF PE RVU:** 41.47  
**2007 Fac PE RVU:** 3.48      **2013 Fac PE RVU:** 2.22

**RUC Recommendation:** 6.60      **CPT Action (if applicable):** Removed from CPT referral  
**Referred to CPT Asst** ☐      **Published in CPT Asst:** **Result:** Decrease

# Status Report: CMS Requests and Relativity Assessment Issues

**35476** Transluminal balloon angioplasty, percutaneous; venous

**Global:** 000

**Issue:** Repair of Arterial and Venous Blockage

**Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes

**Complete?** Yes

**Most Recent RUC Meeting:** April 2012

**Tab** 41

**Specialty Developing Recommendation:** ACR, RPA, SIR

**First Identified:**

**2012 Est Medicare Utilization:** 288,334

**2007 Work RVU:** 6.03

**2013 Work RVU:** 4.71

**2007 NF PE RVU:** 42.45

**2013 NF PE RVU:** 39.06

**2007 Fac PE RVU:** 2.26

**2013 Fac PE RVU:** 2.18

**RUC Recommendation:** 5.10

**CPT Action (if applicable):** Removed from CPT referral  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**35490** Deleted from CPT

**Global:** 000

**Issue:** Endovascular Revascularization

**Screen:** High Volume Growth1

**Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab** 07

**Specialty Developing Recommendation:** SIR, ACR, SVS

**First Identified:** April 2008

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 11.06

**2013 Work RVU:**

**2007 NF PE RVU:** NA

**2013 NF PE RVU:**

**2007 Fac PE RVU:** 5.11

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** February 2010  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**35491** Deleted from CPT

**Global:** 000

**Issue:** Endovascular Revascularization

**Screen:** High Volume Growth1

**Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab** 07

**Specialty Developing Recommendation:** SIR, ACR, SVS

**First Identified:** April 2008

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 7.60

**2013 Work RVU:**

**2007 NF PE RVU:** NA

**2013 NF PE RVU:**

**2007 Fac PE RVU:** 3.46

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** February 2010  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**35492** Deleted from CPT

**Global:** 000

**Issue:** Endovascular Revascularization

**Screen:** High Volume Growth1

**Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab** 07

**Specialty Developing Recommendation:** SIR, ACR, SVS

**First Identified:** April 2008

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 6.64

**2013 Work RVU:**

**2007 NF PE RVU:** NA

**2013 NF PE RVU:**

**2007 Fac PE RVU:** 3.3

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** February 2010  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**



# Status Report: CMS Requests and Relativity Assessment Issues

**35493 Deleted from CPT** **Global:** 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

**Most Recent RUC Meeting:** April 2010 **Tab** 07 **Specialty Developing Recommendation:** SIR, ACR, SVS

**First Identified:** February 2008

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 8.09

**2013 Work RVU:**

**2007 NF PE RVU:** NA

**2013 NF PE RVU:**

**2007 Fac PE RVU:** 3.89

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** February 2010  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Deleted from CPT

**35494 Deleted from CPT** **Global:** 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

**Most Recent RUC Meeting:** April 2010 **Tab** 07 **Specialty Developing Recommendation:** SIR, ACR, SVS

**First Identified:** April 2008

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 10.42

**2013 Work RVU:**

**2007 NF PE RVU:** NA

**2013 NF PE RVU:**

**2007 Fac PE RVU:** 4.64

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** February 2010  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Deleted from CPT

**35495 Deleted from CPT** **Global:** 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

**Most Recent RUC Meeting:** April 2010 **Tab** 07 **Specialty Developing Recommendation:** SIR, ACR, SVS

**First Identified:** February 2008

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 9.48

**2013 Work RVU:**

**2007 NF PE RVU:** NA

**2013 NF PE RVU:**

**2007 Fac PE RVU:** 4.45

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** February 2010  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Deleted from CPT

**36000 Introduction of needle or intracatheter, vein** **Global:** XXX **Issue:** Introduction of Needle or Intracatheter **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACC, AUR, AAP, AAFP, ACRh

**First Identified:** October 2009

**2012 Est Medicare Utilization:** 1

**2007 Work RVU:** 0.18

**2013 Work RVU:** 0.18

**2007 NF PE RVU:** 0.54

**2013 NF PE RVU:** 0.57

**2007 Fac PE RVU:** 0.05

**2013 Fac PE RVU:** 0.07

**RUC Recommendation:** CMS consider a bundled status for this code

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Maintain

## Status Report: CMS Requests and Relativity Assessment Issues

### 36010 Introduction of catheter, superior or inferior vena cava

Global: XXX

Issue: Introduction of Catheter

Screen: Codes Reported Together 75% or More-Part1

Complete? No

Most Recent  
RUC Meeting: September 2011

Tab 46

Specialty Developing  
Recommendation: ACR, SIR, SVS

First  
Identified: February 2010

2012 Est  
Medicare  
Utilization: 19,422

2007 Work RVU: 2.43

2013 Work RVU: 2.43

2007 NF PE RVU: 17.17

2013 NF PE RVU: 12.62

2007 Fac PE RVU 0.77

2013 Fac PE RVU: 0.81

RUC Recommendation: Review September 2013

CPT Action (if applicable): February 2011

Referred to CPT Asst ☐

Published in CPT Asst:

### 36140 Introduction of needle or intracatheter; extremity artery

Global: XXX

Issue: Introduction of Needle or Intracatheter

Screen: Harvard Valued - Utilization over 30,000

Complete? No

Most Recent  
RUC Meeting: September 2011

Tab 19

Specialty Developing  
Recommendation: SVS, SIR, ACR, ACRO

First  
Identified: April 2011

2012 Est  
Medicare  
Utilization: 21,827

2007 Work RVU: 2.01

2013 Work RVU: 2.01

2007 NF PE RVU: 12.15

2013 NF PE RVU: 11.22

2007 Fac PE RVU 0.65

2013 Fac PE RVU: 0.66

RUC Recommendation: Review September 2013

CPT Action (if applicable):

Referred to CPT Asst ☐

Published in CPT Asst:

### 36145 Deleted from CPT

Global: XXX

Issue: Arteriovenous Shunt Imaging

Screen: Codes Reported Together 95% or More / Harvard Valued - Utilization over 100,000

Complete? Yes

Most Recent  
RUC Meeting: April 2009

Tab 9

Specialty Developing  
Recommendation:

First  
Identified: February 2008

2012 Est  
Medicare  
Utilization:

2007 Work RVU: 2.01

2013 Work RVU:

2007 NF PE RVU: 11.87

2013 NF PE RVU:

2007 Fac PE RVU 0.64

2013 Fac PE RVU:

RUC Recommendation: Deleted from CPT

CPT Action (if applicable): February 2009

Referred to CPT Asst ☐

Published in CPT Asst:

## Status Report: CMS Requests and Relativity Assessment Issues

**36147** Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection[s] of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava) **Global:** XXX **Issue:** Arteriovenous Shunt Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

**Most Recent RUC Meeting:** April 2009

**Tab** 09

**Specialty Developing Recommendation:** SVS, SIR, ACR

**First Identified:** February 2008

**2012 Est Medicare Utilization:** 323,496

**2007 Work RVU:**

**2013 Work RVU:** 3.72

**2007 NF PE RVU:**

**2013 NF PE RVU:** 21.76

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 1.33

**RUC Recommendation:** 3.72

**CPT Action (if applicable):** October 2008

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**36148** Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); additional access for therapeutic intervention (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Arteriovenous Shunt Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

**Most Recent RUC Meeting:** April 2009

**Tab** 09

**Specialty Developing Recommendation:** SVS, SIR, ACR

**First Identified:** February 2008

**2012 Est Medicare Utilization:** 68,998

**2007 Work RVU:**

**2013 Work RVU:** 1.00

**2007 NF PE RVU:**

**2013 NF PE RVU:** 6.98

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 0.34

**RUC Recommendation:** 1.00

**CPT Action (if applicable):** October 2008

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**36215** Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family **Global:** XXX **Issue:** RAW **Screen:** Codes Reported Together 75% or More-Part1 / Harvard-Valued Annual Allowed Charges Greater than \$10 million **Complete?** No

**Most Recent RUC Meeting:** October 2012

**Tab** 27

**Specialty Developing Recommendation:** ACC, ACR, ASNR, AUR, SIR, SVS

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 76,378

**2007 Work RVU:** 4.67

**2013 Work RVU:** 4.67

**2007 NF PE RVU:** 26.59

**2013 NF PE RVU:** 28.47

**2007 Fac PE RVU** 1.65

**2013 Fac PE RVU:** 1.70

**RUC Recommendation:** Review in October 2015

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:**

## Status Report: CMS Requests and Relativity Assessment Issues

36216	Selective catheter placement, arterial system; initial second order thoracic or brachiocephalic branch, within a vascular family	Global: XXX	Issue: RAW	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes
Most Recent RUC Meeting: October 2012	Tab 27	Specialty Developing Recommendation: ACC, ACR, ASNR, AUR, SIR, SVS	First Identified: February 2010	2012 Est Medicare Utilization: 57,336	2007 Work RVU: 5.27 2007 NF PE RVU: 28.57 2007 Fac PE RVU 1.82 2013 Work RVU: 5.27 2013 NF PE RVU: 31.64 2013 Fac PE RVU: 1.98
RUC Recommendation: Remove from screen	CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>			Published in CPT Asst:	Result: Remove from Screen
36217	Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family	Global: XXX	Issue: RAW	Screen: Harvard Valued - Utilization over 30,000	Complete? Yes
Most Recent RUC Meeting: October 2012	Tab 27	Specialty Developing Recommendation: SVS, AUR, ACR, ASNR, SIR	First Identified: April 2011	2012 Est Medicare Utilization: 29,828	2007 Work RVU: 6.29 2007 NF PE RVU: 52.65 2007 Fac PE RVU 2.17 2013 Work RVU: 6.29 2013 NF PE RVU: 57.76 2013 Fac PE RVU: 2.44
RUC Recommendation: Remove from screen	CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>			Published in CPT Asst:	Result: Remove from Screen
36221	Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed	Global: 000	Issue: Cervicocerebral Angiography	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 14	Specialty Developing Recommendation: AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS	First Identified: February 2010	2012 Est Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU 2013 Work RVU: 4.17 2013 NF PE RVU: 29.27 2013 Fac PE RVU: 1.39
RUC Recommendation: 4.51	CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>			February 2012 Published in CPT Asst:	Result: Decrease

## Status Report: CMS Requests and Relativity Assessment Issues

<b>36222</b>	Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral extracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed	<b>Global:</b> 000	<b>Issue:</b> Cervicocerebral Angiography	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2012	<b>Tab 14</b>	<b>Specialty Developing Recommendation:</b> AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU:</b> <b>2013 Work RVU:</b> 5.53 <b>2013 NF PE RVU:</b> 35.93 <b>2013 Fac PE RVU:</b> 2.13
<b>RUC Recommendation:</b> 6.00			<b>CPT Action (if applicable):</b> February 2012 <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b> Decrease
<b>36223</b>	Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed	<b>Global:</b> 000	<b>Issue:</b> Cervicocerebral Angiography	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2012	<b>Tab 14</b>	<b>Specialty Developing Recommendation:</b> AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU:</b> <b>2013 Work RVU:</b> 6.00 <b>2013 NF PE RVU:</b> 39.37 <b>2013 Fac PE RVU:</b> 2.28
<b>RUC Recommendation:</b> 6.50			<b>CPT Action (if applicable):</b> February 2012 <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b> Decrease
<b>36224</b>	Selective catheter placement, internal carotid artery, unilateral, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed	<b>Global:</b> 000	<b>Issue:</b> Cervicocerebral Angiography	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2012	<b>Tab 14</b>	<b>Specialty Developing Recommendation:</b> AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU:</b> <b>2013 Work RVU:</b> 6.50 <b>2013 NF PE RVU:</b> 42.83 <b>2013 Fac PE RVU:</b> 2.57
<b>RUC Recommendation:</b> 7.55			<b>CPT Action (if applicable):</b> February 2012 <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b> Decrease

## Status Report: CMS Requests and Relativity Assessment Issues

36225	Selective catheter placement, subclavian or innominate artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed	Global: 000	Issue: Cervicocerebral Angiography	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 14 Specialty Developing Recommendation: AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS	First Identified: February 2010	2012 Est Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU	2013 Work RVU: 6.00 2013 NF PE RVU: 39.04 2013 Fac PE RVU: 2.25
RUC Recommendation: 6.50		CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>	February 2012 Published in CPT Asst:	Result: Decrease	
36226	Selective catheter placement, vertebral artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed	Global: 000	Issue: Cervicocerebral Angiography	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 14 Specialty Developing Recommendation: AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS	First Identified: February 2010	2012 Est Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU	2013 Work RVU: 6.50 2013 NF PE RVU: 43.81 2013 Fac PE RVU: 2.59
RUC Recommendation: 7.55		CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>	February 2012 Published in CPT Asst:	Result: Decrease	
36227	Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Cervicocerebral Angiography	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 14 Specialty Developing Recommendation: AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS	First Identified: February 2010	2012 Est Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU	2013 Work RVU: 2.09 2013 NF PE RVU: 4.98 2013 Fac PE RVU: 0.80
RUC Recommendation: 2.32		CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>	February 2012 Published in CPT Asst:	Result: Decrease	

## Status Report: CMS Requests and Relativity Assessment Issues

36228	Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all associated radiological supervision and interpretation (eg, middle cerebral artery, posterior inferior cerebellar artery) (List separately in addition to code for primary procedure)			Global: ZZZ	Issue: Cervicocerebral Angiography	Screen: Codes Reported Together 75% or More-Part1	Complete?	Yes				
Most Recent RUC Meeting:	April 2012	Tab 14	Specialty Developing Recommendation:	AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS	First Identified:	February 2010	2012 Est Medicare Utilization:		2007 Work RVU:		2013 Work RVU:	4.25
									2007 NF PE RVU:		2013 NF PE RVU:	30.37
									2007 Fac PE RVU		2013 Fac PE RVU:	1.64
RUC Recommendation:	4.25				CPT Action (if applicable): Referred to CPT Asst	<input type="checkbox"/>	February 2012	Published in CPT Asst:	Result:	Decrease		
36245	Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family			Global: XXX	Issue: Selective Catheter Placement		Screen: Harvard Valued - Utilization over 100,000 / Codes Reported Together 75% or More-Part1 / Harvard-Valued Annual Allowed Charges Greater than \$10 million	Complete?	Yes			
Most Recent RUC Meeting:	January 2013	Tab 22	Specialty Developing Recommendation:	ACC, ACR, SIR, SCAI, SVS	First Identified:	October 2009	2012 Est Medicare Utilization:	57,153	2007 Work RVU:	4.67	2013 Work RVU:	4.67
									2007 NF PE RVU:	31.17	2013 NF PE RVU:	25.06
									2007 Fac PE RVU	1.78	2013 Fac PE RVU:	1.65
RUC Recommendation:	4.90				CPT Action (if applicable): Referred to CPT Asst	<input type="checkbox"/>	February 2010 and February 2011	Published in CPT Asst:	Result:	Decrease		
36246	Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family			Global: 000	Issue: Vascular Injection Procedures		Screen: Harvard Valued - Utilization over 100,000	Complete?	Yes			
Most Recent RUC Meeting:	October 2012	Tab 27	Specialty Developing Recommendation:	SVS, SIR, ACR, ACC	First Identified:	February 2010	2012 Est Medicare Utilization:	41,009	2007 Work RVU:	5.27	2013 Work RVU:	5.27
									2007 NF PE RVU:	29.18	2013 NF PE RVU:	21.22
									2007 Fac PE RVU	1.84	2013 Fac PE RVU:	1.73
RUC Recommendation:	5.27				CPT Action (if applicable): Referred to CPT Asst	<input type="checkbox"/>		Published in CPT Asst:	Result:	Maintain		

## Status Report: CMS Requests and Relativity Assessment Issues

36247	Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family	Global: 000	Issue: Vascular Injection Procedures	Screen: Harvard Valued - Utilization over 100,000	Complete?	Yes	
Most Recent RUC Meeting:	October 2012	Tab 27	Specialty Developing Recommendation: SVS, SIR, ACR, ACC	First Identified: February 2010	2012 Est Medicare Utilization: 54,878	2007 Work RVU: 6.29 2007 NF PE RVU: 48.22 2007 Fac PE RVU 2.17 Result: Increase	2013 Work RVU: 6.29 2013 NF PE RVU: 41.58 2013 Fac PE RVU: 2.07
RUC Recommendation:	7.00	CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:			
36248	Selective catheter placement, arterial system; additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)	Global: ZZZ	Issue: Catheter Placement	Screen: CMS Fastest Growing	Complete?	Yes	
Most Recent RUC Meeting:	October 2009	Tab 40	Specialty Developing Recommendation: ACR, SIR	First Identified: October 2008	2012 Est Medicare Utilization: 19,849	2007 Work RVU: 1.01 2007 NF PE RVU: 3.81 2007 Fac PE RVU 0.35 Result: Remove from Screen	2013 Work RVU: 1.01 2013 NF PE RVU: 3.52 2013 Fac PE RVU: 0.34
RUC Recommendation:	Remove from screen	CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:			
36251	Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral	Global: 000	Issue: Renal Angiography	Screen: Codes Reported Together 75% or More-Part1	Complete?	Yes	
Most Recent RUC Meeting:	April 2011	Tab 11	Specialty Developing Recommendation:	First Identified:	2012 Est Medicare Utilization: 7,250	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2013 Work RVU: 5.35 2013 NF PE RVU: 38.35 2013 Fac PE RVU: 1.95
RUC Recommendation:	5.45	CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:			



## Status Report: CMS Requests and Relativity Assessment Issues

**36252** Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral

**Global:** 000 **Issue:** Renal Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

**Most Recent RUC Meeting:** April 2011

**Tab** 11

**Specialty Developing Recommendation:**

**First Identified:**

**2012 Est Medicare Utilization:** 23,035

**2007 Work RVU:**

**2013 Work RVU:** 6.99

**2007 NF PE RVU:**

**2013 NF PE RVU:** 40.59

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 2.51

**RUC Recommendation:** 7.38

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**36253** Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral

**Global:** 000

**Issue:** Renal Angiography

**Screen:** Codes Reported Together 75% or More-Part1

**Complete?** Yes

**Most Recent RUC Meeting:** April 2011

**Tab** 11

**Specialty Developing Recommendation:**

**First Identified:**

**2012 Est Medicare Utilization:** 1,325

**2007 Work RVU:**

**2013 Work RVU:** 7.55

**2007 NF PE RVU:**

**2013 NF PE RVU:** 59.20

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 2.55

**RUC Recommendation:** 7.55

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**36254** Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral

**Global:** 000

**Issue:** Renal Angiography

**Screen:** Codes Reported Together 75% or More-Part1

**Complete?** Yes

**Most Recent RUC Meeting:** April 2011

**Tab** 11

**Specialty Developing Recommendation:**

**First Identified:**

**2012 Est Medicare Utilization:** 636

**2007 Work RVU:**

**2013 Work RVU:** 8.15

**2007 NF PE RVU:**

**2013 NF PE RVU:** 61.11

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 2.75

**RUC Recommendation:** 8.15

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

## Status Report: CMS Requests and Relativity Assessment Issues

**36410** Venipuncture, age 3 years or older, necessitating the skill of a physician or other qualified health care professional (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture) **Global:** XXX **Issue:** Venipuncture **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab** 36 **Specialty Developing Recommendation:** ACP

**First Identified:** October 2009

**2012 Est Medicare Utilization:** 222,095

**2007 Work RVU:** 0.18

**2013 Work RVU:** 0.18

**2007 NF PE RVU:** 0.3

**2013 NF PE RVU:** 0.30

**2007 Fac PE RVU** 0.05

**2013 Fac PE RVU:** 0.07

**Result:** Maintain

**RUC Recommendation:** 0.18

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**36475** Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated

**Global:** 000

**Issue:** RAW

**Screen:** High Volume Growth2

**Complete?** No

**Most Recent RUC Meeting:**

**Tab** **Specialty Developing Recommendation:**

**First Identified:** April 2013

**2012 Est Medicare Utilization:** 70,082

**2007 Work RVU:** 6.72

**2013 Work RVU:** 6.72

**2007 NF PE RVU:** 47.57

**2013 NF PE RVU:** 45.13

**2007 Fac PE RVU** 2.39

**2013 Fac PE RVU:** 2.47

**Result:**

**RUC Recommendation:** Review Action Plan

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**36478** Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated

**Global:** 000

**Issue:** RAW

**Screen:** High Volume Growth2

**Complete?** No

**Most Recent RUC Meeting:**

**Tab** **Specialty Developing Recommendation:**

**First Identified:** April 2013

**2012 Est Medicare Utilization:** 72,394

**2007 Work RVU:** 6.72

**2013 Work RVU:** 6.72

**2007 NF PE RVU:** 42.85

**2013 NF PE RVU:** 33.68

**2007 Fac PE RVU** 2.41

**2013 Fac PE RVU:** 2.47

**Result:**

**RUC Recommendation:** Review Action Plan

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

36479	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; second and subsequent veins treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)			Global: ZZZ	Issue: RAW	Screen: High Volume Growth2	Complete?	No
Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:		First Identified: April 2013	2012 Est Medicare Utilization: 11,911	2007 Work RVU: 3.38 2007 NF PE RVU: 7.59 2007 Fac PE RVU 1.1	2013 Work RVU: 3.38 2013 NF PE RVU: 7.99 2013 Fac PE RVU: 1.15	
RUC Recommendation: Review Action Plan				CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:		
36481	Percutaneous portal vein catheterization by any method			Global: 000	Issue: Interventional Radiology Procedures	Screen: CMS Request - Practice Expense Review	Complete?	Yes
Most Recent RUC Meeting:	February 2009	Tab 21	Specialty Developing Recommendation: ACR, SIR	First Identified: NA	2012 Est Medicare Utilization: 656	2007 Work RVU: 6.98 2007 NF PE RVU: NA 2007 Fac PE RVU 2.46	2013 Work RVU: 6.98 2013 NF PE RVU: 56.55 2013 Fac PE RVU: 2.73	
RUC Recommendation: New PE Inputs				CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:		
36516	Therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion			Global: 000	Issue: Therapeutic Apheresis	Screen: CMS Fastest Growing	Complete?	Yes
Most Recent RUC Meeting:	September 2011	Tab 51	Specialty Developing Recommendation: CAP	First Identified: October 2008	2012 Est Medicare Utilization: 1,829	2007 Work RVU: 1.22 2007 NF PE RVU: 75.37 2007 Fac PE RVU 0.46	2013 Work RVU: 1.22 2013 NF PE RVU: 62.41 2013 Fac PE RVU: 0.53	
RUC Recommendation: Remove from screen				CPT Action (if applicable): Referred to CPT Asst <input checked="" type="checkbox"/>		Published in CPT Asst: Sep 2009		

## Status Report: CMS Requests and Relativity Assessment Issues

---

**36818** Arteriovenous anastomosis, open; by upper arm cephalic vein transposition      **Global:** 090      **Issue:** RAW      **Screen:** CMS Request Final Rule for 2013      **Complete?** No

**Most Recent RUC Meeting:** January 2013      **Tab** 34      **Specialty Developing Recommendation:**      **First Identified:** November 2012      **2012 Est Medicare Utilization:** 7,399      **2007 Work RVU:** 11.81      **2013 Work RVU:** 11.89  
**2007 NF PE RVU:** NA      **2013 NF PE RVU:** NA  
**2007 Fac PE RVU:** 5.73      **2013 Fac PE RVU:** 5.91

**RUC Recommendation:** Survey for work and PE October 2013      **CPT Action (if applicable):**  
**Referred to CPT Asst** ☐      **Published in CPT Asst:** **Result:**

---

**36819** Arteriovenous anastomosis, open; by upper arm basilic vein transposition      **Global:** 090      **Issue:** RAW      **Screen:** CMS Request Final Rule for 2013      **Complete?** No

**Most Recent RUC Meeting:** January 2013      **Tab** 34      **Specialty Developing Recommendation:**      **First Identified:** November 2012      **2012 Est Medicare Utilization:** 12,604      **2007 Work RVU:** 14.39      **2013 Work RVU:** 13.29  
**2007 NF PE RVU:** NA      **2013 NF PE RVU:** NA  
**2007 Fac PE RVU:** 6.08      **2013 Fac PE RVU:** 6.19

**RUC Recommendation:** Survey for work and PE October 2013      **CPT Action (if applicable):**  
**Referred to CPT Asst** ☐      **Published in CPT Asst:** **Result:**

---

**36820** Arteriovenous anastomosis, open; by forearm vein transposition      **Global:** 090      **Issue:** RAW      **Screen:** Site of Service Anomaly / CMS Request Final Rule for 2013      **Complete?** No

**Most Recent RUC Meeting:** January 2013      **Tab** 34      **Specialty Developing Recommendation:** SVS, ACS      **First Identified:** September 2007      **2012 Est Medicare Utilization:** 2,516      **2007 Work RVU:** 14.39      **2013 Work RVU:** 14.47  
**2007 NF PE RVU:** NA      **2013 NF PE RVU:** NA  
**2007 Fac PE RVU:** 6.11      **2013 Fac PE RVU:** 6.87

**RUC Recommendation:** Survey for work and PE October 2013      **CPT Action (if applicable):**  
**Referred to CPT Asst** ☐      **Published in CPT Asst:** **Result:**

---

## Status Report: CMS Requests and Relativity Assessment Issues

36821	Arteriovenous anastomosis, open; direct, any site (eg, Cimino type) (separate procedure)		Global: 090	Issue: RAW		Screen: Site of Service Anomaly / CMS Request Final Rule for 2013	Complete?	No				
Most Recent RUC Meeting:	January 2013	Tab 34	Specialty Developing Recommendation:	ACS, SVS	First Identified:	September 2007	2012 Est Medicare Utilization:	36,851	2007 Work RVU:	9.15	2013 Work RVU:	12.11
									2007 NF PE RVU:	NA	2013 NF PE RVU:	NA
									2007 Fac PE RVU	4.49	2013 Fac PE RVU:	6.33
RUC Recommendation:	Survey for work and PE October 2013				CPT Action (if applicable):				Result:			
					Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:					
36825	Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft		Global: 090	Issue: RAW			Screen: Site of Service Anomaly / CMS Request Final Rule for 2013	Complete?	No			
Most Recent RUC Meeting:	January 2013	Tab 34	Specialty Developing Recommendation:	ACS, SVS	First Identified:	September 2007	2012 Est Medicare Utilization:	3,410	2007 Work RVU:	10.00	2013 Work RVU:	14.17
									2007 NF PE RVU:	NA	2013 NF PE RVU:	NA
									2007 Fac PE RVU	4.87	2013 Fac PE RVU:	6.91
RUC Recommendation:	Survey for work and PE October 2013				CPT Action (if applicable):				Result:			
					Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:					
36830	Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft (eg, biological collagen, thermoplastic graft)		Global: 090	Issue: RAW			Screen: CMS Request Final Rule for 2013	Complete?	No			
Most Recent RUC Meeting:	January 2013	Tab 34	Specialty Developing Recommendation:		First Identified:	November 2012	2012 Est Medicare Utilization:	23,413	2007 Work RVU:	12.00	2013 Work RVU:	12.03
									2007 NF PE RVU:	NA	2013 NF PE RVU:	NA
									2007 Fac PE RVU	4.98	2013 Fac PE RVU:	5.24
RUC Recommendation:	Survey for work and PE October 2013				CPT Action (if applicable):				Result:			
					Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:					

# Status Report: CMS Requests and Relativity Assessment Issues

---

<b>36834</b>	<b>Deleted from CPT</b>		<b>Global:</b> 090	<b>Issue:</b> Aneurysm Repair	<b>Screen:</b> Site of Service Anomaly	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> September 2007	<b>Tab</b> 16	<b>Specialty Developing Recommendation:</b> AVA, ACS	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> 11.11 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 4.68	<b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>
<b>RUC Recommendation:</b> Deleted from CPT			<b>CPT Action (if applicable):</b> February 2009	<b>Published in CPT Asst:</b>	<b>Result:</b> Deleted from CPT	
			<b>Referred to CPT Asst</b> <input type="checkbox"/>			

---

<b>36870</b>	<b>Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)</b>		<b>Global:</b> 090	<b>Issue:</b> Percutaneous Thrombectomy	<b>Screen:</b> Site of Service Anomaly (99238-Only) / CMS High Expenditure Procedural Codes	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> January 2013	<b>Tab</b> 23	<b>Specialty Developing Recommendation:</b> ACR, SIR, SVS	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 59,615	<b>2007 Work RVU:</b> 5.17 <b>2007 NF PE RVU:</b> 49.54 <b>2007 Fac PE RVU:</b> 2.99	<b>2013 Work RVU:</b> 5.20 <b>2013 NF PE RVU:</b> 51.38 <b>2013 Fac PE RVU:</b> 3.16
<b>RUC Recommendation:</b> Refer to CPT. Reduced 99238 to 0.5			<b>CPT Action (if applicable):</b>	<b>Published in CPT Asst:</b>	<b>Result:</b> PE Only	
			<b>Referred to CPT Asst</b> <input type="checkbox"/>			

---

<b>37183</b>	<b>Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanalization/dilatation, stent placement and all associated imaging guidance and documentation)</b>		<b>Global:</b> 000	<b>Issue:</b> Interventional Radiology Procedures	<b>Screen:</b> CMS Request - Practice Expense Review	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2009	<b>Tab</b> 21	<b>Specialty Developing Recommendation:</b> ACR, SIR	<b>First Identified:</b> NA	<b>2012 Est Medicare Utilization:</b> 701	<b>2007 Work RVU:</b> 7.99 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 2.89	<b>2013 Work RVU:</b> 7.99 <b>2013 NF PE RVU:</b> 172.52 <b>2013 Fac PE RVU:</b> 2.89
<b>RUC Recommendation:</b> New PE inputs			<b>CPT Action (if applicable):</b>	<b>Published in CPT Asst:</b>	<b>Result:</b> PE Only	
			<b>Referred to CPT Asst</b> <input type="checkbox"/>			

---

## Status Report: CMS Requests and Relativity Assessment Issues

37191	Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed	Global: 000	Issue: IVC Transcatheter Procedure	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes		
Most Recent RUC Meeting:	April 2011	Tab 12	Specialty Developing Recommendation: ACR, SIR, SVS	First Identified:	2012 Est Medicare Utilization: 58,010	2007 Work RVU:	2013 Work RVU: 4.71
						2007 NF PE RVU:	2013 NF PE RVU: 76.78
						2007 Fac PE RVU Result: Decrease	2013 Fac PE RVU: 1.68
RUC Recommendation:	4.71			CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>	February 2011	Published in CPT Asst:	
37192	Repositioning of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed	Global: 000	Issue: IVC Transcatheter Procedure	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes		
Most Recent RUC Meeting:	April 2011	Tab 12	Specialty Developing Recommendation: ACR, SIR, SVS	First Identified:	2012 Est Medicare Utilization: 114	2007 Work RVU:	2013 Work RVU: 7.35
						2007 NF PE RVU:	2013 NF PE RVU: 45.16
						2007 Fac PE RVU Result: Decrease	2013 Fac PE RVU: 2.46
RUC Recommendation:	8.00			CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>	February 2011	Published in CPT Asst:	
37193	Retrieval (removal) of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed	Global: 000	Issue: IVC Transcatheter Procedure	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes		
Most Recent RUC Meeting:	April 2011	Tab 12	Specialty Developing Recommendation: ACR, SIR, SVS	First Identified:	2012 Est Medicare Utilization: 3,971	2007 Work RVU:	2013 Work RVU: 7.35
						2007 NF PE RVU:	2013 NF PE RVU: 42.74
						2007 Fac PE RVU Result: Decrease	2013 Fac PE RVU: 2.48
RUC Recommendation:	8.00			CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>	February 2011	Published in CPT Asst:	

## Status Report: CMS Requests and Relativity Assessment Issues

<b>37201</b>	Transcatheter therapy, infusion for thrombolysis other than coronary	<b>Global:</b> 000	<b>Issue:</b> Bundle Thrombolysis	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2012	<b>Tab</b> 15	<b>Specialty Developing Recommendation:</b> ACR, SIR, SVS	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 14,333	<b>2007 Work RVU:</b> 4.99 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 2.43 <b>Result:</b> Deleted from CPT
<b>RUC Recommendation:</b> Deleted from CPT			<b>CPT Action (if applicable):</b> Referred to CPT Asst <input type="checkbox"/>	October 2011 <b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>
<b>37203</b>	Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter)	<b>Global:</b> 000	<b>Issue:</b> Transcatheter Procedures	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab</b> 45	<b>Specialty Developing Recommendation:</b> ACC, ACR, SIR, SVS	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 1,739	<b>2007 Work RVU:</b> 5.02 <b>2007 NF PE RVU:</b> 31.87 <b>2007 Fac PE RVU:</b> 1.98 <b>Result:</b> Maintain
<b>RUC Recommendation:</b> Maintain. Editorially revised.			<b>CPT Action (if applicable):</b> Referred to CPT Asst <input type="checkbox"/>	June 2011 <b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>
<b>37204</b>	Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck	<b>Global:</b> 000	<b>Issue:</b> Embolization and Occlusion Procedures	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 08	<b>Specialty Developing Recommendation:</b> ACC, ACR, SIR, SVS	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 33,386	<b>2007 Work RVU:</b> 18.11 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 5.75 <b>Result:</b> Deleted from CPT
<b>RUC Recommendation:</b> Deleted from CPT			<b>CPT Action (if applicable):</b> Referred to CPT Asst <input type="checkbox"/>	February 2013 <b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 18.11 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 6.05



# Status Report: CMS Requests and Relativity Assessment Issues

<b>37205</b>	Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; initial vessel	<b>Global:</b> 000	<b>Issue:</b> Endovascular Revascularization	<b>Screen:</b> High Volume Growth1 / Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab</b> 07 <b>Specialty Developing Recommendation:</b> SVS, ACS, SIR, ACR, ACC	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 51,167	<b>2007 Work RVU:</b> 8.27 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 3.77 <b>Result:</b> Deleted from CPT	<b>2013 Work RVU:</b> 8.27 <b>2013 NF PE RVU:</b> 124.29 <b>2013 Fac PE RVU:</b> 2.80
<b>RUC Recommendation:</b> Deleted from CPT		<b>CPT Action (if applicable):</b> February 2013 <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		
<b>37206</b>	Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; each additional vessel (List separately in addition to code for primary procedure)	<b>Global:</b> ZZZ	<b>Issue:</b> Endovascular Revascularization	<b>Screen:</b> High Volume Growth1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab</b> 07 <b>Specialty Developing Recommendation:</b> SVS, ACS, SIR, ACR, ACC	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 4,447	<b>2007 Work RVU:</b> 4.12 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 1.46 <b>Result:</b> Deleted from CPT	<b>2013 Work RVU:</b> 4.12 <b>2013 NF PE RVU:</b> 74.38 <b>2013 Fac PE RVU:</b> 1.35
<b>RUC Recommendation:</b> Deleted from CPT		<b>CPT Action (if applicable):</b> February 2013 <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		
<b>37207</b>	Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; initial vessel	<b>Global:</b> 000	<b>Issue:</b> Endovascular Revascularization	<b>Screen:</b> High Volume Growth1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab</b> 07 <b>Specialty Developing Recommendation:</b> SVS, ACS, SIR, ACR, ACC	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 1,482	<b>2007 Work RVU:</b> 8.27 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 2.98 <b>Result:</b> Deleted from CPT	<b>2013 Work RVU:</b> 8.27 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 2.81
<b>RUC Recommendation:</b> Deleted from CPT		<b>CPT Action (if applicable):</b> February 2013 <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

## Status Report: CMS Requests and Relativity Assessment Issues

**37208** Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; each additional vessel (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab** 07

**Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 254

**2007 Work RVU:** 4.12

**2013 Work RVU:** 4.12

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU:** 1.30

**2013 Fac PE RVU:** 1.15

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** February 2013

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**37209** Exchange of a previously placed intravascular catheter during thrombolytic therapy

**Global:** 000

**Issue:** Bundle Thrombolysis

**Screen:** Codes Reported Together 75% or More-Part1

**Complete?** Yes

**Most Recent RUC Meeting:** April 2012

**Tab** 15

**Specialty Developing Recommendation:** ACR, SIR, SVS

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 3,273

**2007 Work RVU:** 2.27

**2013 Work RVU:**

**2007 NF PE RVU:** NA

**2013 NF PE RVU:**

**2007 Fac PE RVU:** 0.72

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2011

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**37210** Uterine fibroid embolization (UFE, embolization of the uterine arteries to treat uterine fibroids, leiomyomata), percutaneous approach inclusive of vascular access, vessel selection, embolization, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the procedure

**Global:** 000

**Issue:** Embolization and Occlusion Procedures

**Screen:** Codes Reported Together 75% or More-Part1

**Complete?** Yes

**Most Recent RUC Meeting:** April 2013

**Tab** 08

**Specialty Developing Recommendation:**

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 320

**2007 Work RVU:** 10.60

**2013 Work RVU:** 10.60

**2007 NF PE RVU:** 46.03

**2013 NF PE RVU:** 99.69

**2007 Fac PE RVU:** 3.13

**2013 Fac PE RVU:** 3.85

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** February 2013

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**37211** Transcatheter therapy, arterial infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, initial treatment day **Global:** 000 **Issue:** Bundle Thrombolysis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

**Most Recent RUC Meeting:** April 2012

**Tab** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS

**First Identified:** February 2010

**2012 Est Medicare Utilization:**

**2007 Work RVU:**

**2013 Work RVU:** 8.00

**2007 NF PE RVU:**

**2013 NF PE RVU:** NA

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 2.56

**RUC Recommendation:** 8.00

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**37212** Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day **Global:** 000 **Issue:** Bundle Thrombolysis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

**Most Recent RUC Meeting:** April 2012

**Tab** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS

**First Identified:** February 2010

**2012 Est Medicare Utilization:**

**2007 Work RVU:**

**2013 Work RVU:** 7.06

**2007 NF PE RVU:**

**2013 NF PE RVU:** NA

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 2.26

**RUC Recommendation:** 7.06

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**37213** Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed; **Global:** 000 **Issue:** Bundle Thrombolysis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

**Most Recent RUC Meeting:** April 2012

**Tab** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS

**First Identified:** February 2010

**2012 Est Medicare Utilization:**

**2007 Work RVU:**

**2013 Work RVU:** 5.00

**2007 NF PE RVU:**

**2013 NF PE RVU:** NA

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 1.50

**RUC Recommendation:** 5.00

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

## Status Report: CMS Requests and Relativity Assessment Issues

<b>37214</b>	Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed; cessation of thrombolysis including removal of catheter and vessel closure by any method	<b>Global:</b> 000	<b>Issue:</b> Bundle Thrombolysis	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2012	<b>Tab</b> 15	<b>Specialty Developing Recommendation:</b> ACR, SIR, SVS	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease <b>2013 Work RVU:</b> 2.74 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 1.11
<b>RUC Recommendation:</b> 3.04			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	
<hr/>					
<b>37220</b>	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	<b>Global:</b> 000	<b>Issue:</b> Endovascular Revascularization	<b>Screen:</b> High Volume Growth1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab</b> 07	<b>Specialty Developing Recommendation:</b> SVS, ACS, SIR, ACR, ACC	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 11,102	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease <b>2013 Work RVU:</b> 8.15 <b>2013 NF PE RVU:</b> 90.85 <b>2013 Fac PE RVU:</b> 2.65
<b>RUC Recommendation:</b> 8.15			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	
<hr/>					
<b>37221</b>	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	<b>Global:</b> 000	<b>Issue:</b> Endovascular Revascularization	<b>Screen:</b> High Volume Growth1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab</b> 07	<b>Specialty Developing Recommendation:</b> SVS, ACS, SIR, ACR, ACC	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 38,236	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease <b>2013 Work RVU:</b> 10.00 <b>2013 NF PE RVU:</b> 135.36 <b>2013 Fac PE RVU:</b> 3.29
<b>RUC Recommendation:</b> 10.00			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	

## Status Report: CMS Requests and Relativity Assessment Issues

**37222** Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)

**Global:** ZZZ

**Issue:** Endovascular  
Revascularization

**Screen:** High Volume Growth1

**Complete?** Yes

**Most Recent  
RUC Meeting:** April 2010

**Tab** 07

**Specialty Developing  
Recommendation:** SVS, ACS,  
SIR, ACR,  
ACC

**First  
Identified:** February 2010

**2012 Est  
Medicare  
Utilization:** 3,061

**2007 Work RVU:**

**2013 Work RVU:** 3.73

**2007 NF PE RVU:**

**2013 NF PE RVU:** 23.83

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 1.13

**RUC Recommendation:** 3.73

**CPT Action (if applicable):** February 2010

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**37223** Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)

**Global:** ZZZ

**Issue:** Endovascular  
Revascularization

**Screen:** High Volume Growth1

**Complete?** Yes

**Most Recent  
RUC Meeting:** April 2010

**Tab** 07

**Specialty Developing  
Recommendation:** SVS, ACS,  
SIR, ACR,  
ACC

**First  
Identified:** February 2010

**2012 Est  
Medicare  
Utilization:** 5,688

**2007 Work RVU:**

**2013 Work RVU:** 4.25

**2007 NF PE RVU:**

**2013 NF PE RVU:** 77.08

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 1.34

**RUC Recommendation:** 4.25

**CPT Action (if applicable):** February 2010

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**37224** Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty

**Global:** 000

**Issue:** Endovascular  
Revascularization

**Screen:** High Volume Growth1

**Complete?** Yes

**Most Recent  
RUC Meeting:** April 2010

**Tab** 07

**Specialty Developing  
Recommendation:** SVS, ACS,  
SIR, ACR,  
ACC

**First  
Identified:** February 2010

**2012 Est  
Medicare  
Utilization:** 31,139

**2007 Work RVU:**

**2013 Work RVU:** 9.00

**2007 NF PE RVU:**

**2013 NF PE RVU:** 110.44

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 2.95

**RUC Recommendation:** 9.00

**CPT Action (if applicable):** February 2010

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

## Status Report: CMS Requests and Relativity Assessment Issues

<b>37225</b>	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	<b>Global:</b> 000	<b>Issue:</b> Endovascular Revascularization	<b>Screen:</b> High Volume Growth1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab</b> 07 <b>Specialty Developing Recommendation:</b> SVS, ACS, SIR, ACR, ACC	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 25,123	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease	<b>2013 Work RVU:</b> 12.00 <b>2013 NF PE RVU:</b> 333.59 <b>2013 Fac PE RVU:</b> 4.07
<b>RUC Recommendation:</b> 12.00	<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>			
<b>37226</b>	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	<b>Global:</b> 000	<b>Issue:</b> Endovascular Revascularization	<b>Screen:</b> High Volume Growth1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab</b> 07 <b>Specialty Developing Recommendation:</b> SVS, ACS, SIR, ACR, ACC	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 32,827	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease	<b>2013 Work RVU:</b> 10.49 <b>2013 NF PE RVU:</b> 274.30 <b>2013 Fac PE RVU:</b> 3.45
<b>RUC Recommendation:</b> 10.49	<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>			
<b>37227</b>	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	<b>Global:</b> 000	<b>Issue:</b> Endovascular Revascularization	<b>Screen:</b> High Volume Growth1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab</b> 07 <b>Specialty Developing Recommendation:</b> SVS, ACS, SIR, ACR, ACC	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 12,144	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease	<b>2013 Work RVU:</b> 14.50 <b>2013 NF PE RVU:</b> 452.78 <b>2013 Fac PE RVU:</b> 4.87
<b>RUC Recommendation:</b> 14.50	<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>			

## Status Report: CMS Requests and Relativity Assessment Issues

<b>37228</b>	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty	<b>Global:</b> 000	<b>Issue:</b> Endovascular Revascularization	<b>Screen:</b> High Volume Growth1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab 07</b>	<b>Specialty Developing Recommendation:</b> SVS, ACS, SIR, ACR, ACC	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 23,975	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease <b>2013 Work RVU:</b> 11.00 <b>2013 NF PE RVU:</b> 159.64 <b>2013 Fac PE RVU:</b> 3.54
<b>RUC Recommendation:</b> 11.00			<b>CPT Action (if applicable):</b> February 2010 <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	
<hr/>					
<b>37229</b>	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed	<b>Global:</b> 000	<b>Issue:</b> Endovascular Revascularization	<b>Screen:</b> High Volume Growth1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab 07</b>	<b>Specialty Developing Recommendation:</b> SVS, ACS, SIR, ACR, ACC	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 15,135	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease <b>2013 Work RVU:</b> 14.05 <b>2013 NF PE RVU:</b> 325.83 <b>2013 Fac PE RVU:</b> 4.67
<b>RUC Recommendation:</b> 14.05			<b>CPT Action (if applicable):</b> February 2010 <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	
<hr/>					
<b>37230</b>	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	<b>Global:</b> 000	<b>Issue:</b> Endovascular Revascularization	<b>Screen:</b> High Volume Growth1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab 07</b>	<b>Specialty Developing Recommendation:</b> SVS, ACS, SIR, ACR, ACC	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 3,306	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease <b>2013 Work RVU:</b> 13.80 <b>2013 NF PE RVU:</b> 244.93 <b>2013 Fac PE RVU:</b> 4.61
<b>RUC Recommendation:</b> 13.80			<b>CPT Action (if applicable):</b> February 2010 <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	

## Status Report: CMS Requests and Relativity Assessment Issues

<b>37231</b>	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	<b>Global:</b> 000	<b>Issue:</b> Endovascular Revascularization	<b>Screen:</b> High Volume Growth1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab 07</b>	<b>Specialty Developing Recommendation:</b> SVS, ACS, SIR, ACR, ACC	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 1,444	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease
<b>RUC Recommendation:</b> 15.00			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>February 2010</b> <b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 15.00 <b>2013 NF PE RVU:</b> 399.37 <b>2013 Fac PE RVU:</b> 5.02
<b>37232</b>	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)	<b>Global:</b> ZZZ	<b>Issue:</b> Endovascular Revascularization	<b>Screen:</b> High Volume Growth1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab 07</b>	<b>Specialty Developing Recommendation:</b> SVS, ACS, SIR, ACR, ACC	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 7,858	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease
<b>RUC Recommendation:</b> 4.00			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>February 2010</b> <b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 4.00 <b>2013 NF PE RVU:</b> 33.54 <b>2013 Fac PE RVU:</b> 1.27
<b>37233</b>	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	<b>Global:</b> ZZZ	<b>Issue:</b> Endovascular Revascularization	<b>Screen:</b> High Volume Growth1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab 07</b>	<b>Specialty Developing Recommendation:</b> SVS, ACS, SIR, ACR, ACC	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 3,616	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease
<b>RUC Recommendation:</b> 6.50			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>February 2010</b> <b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 6.50 <b>2013 NF PE RVU:</b> 38.01 <b>2013 Fac PE RVU:</b> 2.07



## Status Report: CMS Requests and Relativity Assessment Issues

<b>37234</b>	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	<b>Global:</b> ZZZ	<b>Issue:</b> Endovascular Revascularization	<b>Screen:</b> High Volume Growth1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab 07</b>	<b>Specialty Developing Recommendation:</b> SVS, ACS, SIR, ACR, ACC	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 321	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease
<b>RUC Recommendation:</b> 5.50			<b>CPT Action (if applicable):</b> February 2010 <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 5.50 <b>2013 NF PE RVU:</b> 117.54 <b>2013 Fac PE RVU:</b> 1.81
<b>37235</b>	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	<b>Global:</b> ZZZ	<b>Issue:</b> Endovascular Revascularization	<b>Screen:</b> High Volume Growth1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab 07</b>	<b>Specialty Developing Recommendation:</b> SVS, ACS, SIR, ACR, ACC	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 80	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease
<b>RUC Recommendation:</b> 7.80			<b>CPT Action (if applicable):</b> February 2010 <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 7.80 <b>2013 NF PE RVU:</b> 117.25 <b>2013 Fac PE RVU:</b> 2.26
<b>372XX1</b>		<b>Global:</b> 000	<b>Issue:</b> Embolization and Occlusion Procedures	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab 08</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease
<b>RUC Recommendation:</b> 9.00			<b>CPT Action (if applicable):</b> February 2013 <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>

## Status Report: CMS Requests and Relativity Assessment Issues

372XX2

Global: 000

Issue: Embolization and Occlusion Procedures

Screen: Codes Reported Together 75% or More-Part1

Complete? Yes

Most Recent  
RUC Meeting: April 2013

Tab 08

Specialty Developing  
Recommendation:

First  
Identified: February 2010

2012 Est  
Medicare  
Utilization:

2007 Work RVU:

2013 Work RVU:

2007 NF PE RVU:

2013 NF PE RVU:

2007 Fac PE RVU

2013 Fac PE RVU:

RUC Recommendation: 11.98

CPT Action (if applicable): February 2013

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Decrease

372XX3

Global: 000

Issue: Embolization and Occlusion Procedures

Screen: Codes Reported Together 75% or More-Part1

Complete? Yes

Most Recent  
RUC Meeting: April 2013

Tab 08

Specialty Developing  
Recommendation:

First  
Identified: February 2010

2012 Est  
Medicare  
Utilization:

2007 Work RVU:

2013 Work RVU:

2007 NF PE RVU:

2013 NF PE RVU:

2007 Fac PE RVU

2013 Fac PE RVU:

RUC Recommendation: 14.00

CPT Action (if applicable): February 2013

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Decrease

372XX4

Global: 000

Issue: Embolization and Occlusion Procedures

Screen: Codes Reported Together 75% or More-Part1

Complete? Yes

Most Recent  
RUC Meeting: April 2013

Tab 08

Specialty Developing  
Recommendation:

First  
Identified: February 2010

2012 Est  
Medicare  
Utilization:

2007 Work RVU:

2013 Work RVU:

2007 NF PE RVU:

2013 NF PE RVU:

2007 Fac PE RVU

2013 Fac PE RVU:

RUC Recommendation: 14.00

CPT Action (if applicable): February 2013

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Decrease

## Status Report: CMS Requests and Relativity Assessment Issues

372XX5

Global: 000

Issue: Transcatheter Placement  
of Intravascular Stent

Screen: Codes Reported  
Together 75% or More-  
Part1

Complete? Yes

Most Recent  
RUC Meeting: April 2013

Tab 09

Specialty Developing  
Recommendation:

First  
Identified:

2012 Est  
Medicare  
Utilization:

2007 Work RVU:

2013 Work RVU:

2007 NF PE RVU:

2013 NF PE RVU:

2007 Fac PE RVU

2013 Fac PE RVU:

RUC Recommendation: 9.00

CPT Action (if applicable): February 2013

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Decrease

372XX6

Global: ZZZ

Issue: Transcatheter Placement  
of Intravascular Stent

Screen: Codes Reported  
Together 75% or More-  
Part1

Complete? Yes

Most Recent  
RUC Meeting: April 2013

Tab 09

Specialty Developing  
Recommendation:

First  
Identified:

2012 Est  
Medicare  
Utilization:

2007 Work RVU:

2013 Work RVU:

2007 NF PE RVU:

2013 NF PE RVU:

2007 Fac PE RVU

2013 Fac PE RVU:

RUC Recommendation: 4.25

CPT Action (if applicable): February 2013

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Decrease

372XX7

Global: 000

Issue: Transcatheter Placement  
of Intravascular Stent

Screen: Codes Reported  
Together 75% or More-  
Part1

Complete? Yes

Most Recent  
RUC Meeting: April 2013

Tab 09

Specialty Developing  
Recommendation:

First  
Identified:

2012 Est  
Medicare  
Utilization:

2007 Work RVU:

2013 Work RVU:

2007 NF PE RVU:

2013 NF PE RVU:

2007 Fac PE RVU

2013 Fac PE RVU:

RUC Recommendation: 6.29

CPT Action (if applicable): February 2013

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Decrease

# Status Report: CMS Requests and Relativity Assessment Issues

**372XX8**

**Global:** ZZZ

**Issue:** Transcatheter Placement of Intravascular Stent

**Screen:** Codes Reported Together 75% or More-Part1

**Complete?** Yes

**Most Recent RUC Meeting:** April 2013

**Tab** 09

**Specialty Developing Recommendation:**

**First Identified:**

**2012 Est Medicare Utilization:**

**2007 Work RVU:**

**2013 Work RVU:**

**2007 NF PE RVU:**

**2013 NF PE RVU:**

**2007 Fac PE RVU**

**2013 Fac PE RVU:**

**RUC Recommendation:** 3.34

**CPT Action (if applicable):** February 2013

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**37609** Ligation or biopsy, temporal artery

**Global:** 010

**Issue:** Ligation

**Screen:** Site of Service Anomaly (99238-Only)

**Complete?** Yes

**Most Recent RUC Meeting:** September 2007

**Tab** 16

**Specialty Developing Recommendation:** SVS, ACS

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 18,529

**2007 Work RVU:** 3.02

**2013 Work RVU:** 3.05

**2007 NF PE RVU:** 4.43

**2013 NF PE RVU:** 5.94

**2007 Fac PE RVU** 1.93

**2013 Fac PE RVU:** 2.65

**RUC Recommendation:** Reduce 99238 to 0.5

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** PE Only

**37619** Ligation of inferior vena cava

**Global:** 090

**Issue:** Ligation of Inferior Vena Cava

**Screen:** Codes Reported Together 75% or More-Part1

**Complete?** Yes

**Most Recent RUC Meeting:** April 2011

**Tab** 13

**Specialty Developing Recommendation:** ACS, SVS

**First Identified:**

**2012 Est Medicare Utilization:** 543

**2007 Work RVU:**

**2013 Work RVU:** 30.00

**2007 NF PE RVU:**

**2013 NF PE RVU:** NA

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 13.95

**RUC Recommendation:** 37.60

**CPT Action (if applicable):** February 2011

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Increase

## Status Report: CMS Requests and Relativity Assessment Issues

**37620** Interruption, partial or complete, of inferior vena cava by suture, ligation, plication, clip, extravascular, intravascular (umbrella device) **Global:** 090 **Issue:** Major Vein Revision **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab** 45

**Specialty Developing Recommendation:** ACR, SIR, SVS

**First Identified:** February 2010

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 11.49

**2013 Work RVU:**

**2007 NF PE RVU:** NA

**2013 NF PE RVU:**

**2007 Fac PE RVU** 5.52

**2013 Fac PE RVU:**

**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** February 2011  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**37760** Ligation of perforator veins, subfascial, radical (Linton type), including skin graft, when performed, open,1 leg **Global:** 090 **Issue:** Perorator Vein Ligation **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** April 2009

**Tab** 10

**Specialty Developing Recommendation:** SVS, ACS

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 434

**2007 Work RVU:** 10.69

**2013 Work RVU:** 10.78

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 5.14

**2013 Fac PE RVU:** 5.40

**Result:** Maintain

**RUC Recommendation:** 10.69

**CPT Action (if applicable):** February 2009  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**37761** Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg **Global:** 090 **Issue:** Perforator Vein Ligation **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** April 2009

**Tab** 10

**Specialty Developing Recommendation:** SVS, ACS

**First Identified:**

**2012 Est Medicare Utilization:** 667

**2007 Work RVU:**

**2013 Work RVU:** 9.13

**2007 NF PE RVU:**

**2013 NF PE RVU:** NA

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 5.63

**Result:** Increase

**RUC Recommendation:** 9.00

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

# Status Report: CMS Requests and Relativity Assessment Issues

<b>37765</b>	<b>Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions</b>			<b>Global:</b> 090	<b>Issue:</b> Stab Phlebectomy of Varicose Veins	<b>Screen:</b> High Volume Growth1 / CMS Fastest Growing	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> February 2010	<b>Tab</b> 21	<b>Specialty Developing Recommendation:</b>	ACS	<b>First Identified:</b> February 2008	<b>2012 Est Medicare Utilization:</b> 14,691	<b>2007 Work RVU:</b> 7.63 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 4.36 <b>Result:</b> PE Only	<b>2013 Work RVU:</b> 7.71 <b>2013 NF PE RVU:</b> 10.94 <b>2013 Fac PE RVU:</b> 4.41
<b>RUC Recommendation:</b> Review September 2013. Non-Facility PE Inputs.				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	

<b>37766</b>	<b>Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions</b>			<b>Global:</b> 090	<b>Issue:</b> Stab Phlebectomy of Varicose Veins	<b>Screen:</b> High Volume Growth1 / CMS Fastest Growing	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> February 2010	<b>Tab</b> 21	<b>Specialty Developing Recommendation:</b>	ACS	<b>First Identified:</b> February 2008	<b>2012 Est Medicare Utilization:</b> 10,342	<b>2007 Work RVU:</b> 9.58 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 5.01 <b>Result:</b> PE Only	<b>2013 Work RVU:</b> 9.66 <b>2013 NF PE RVU:</b> 12.37 <b>2013 Fac PE RVU:</b> 5.17
<b>RUC Recommendation:</b> Review September 2013. Non-Facility PE Inputs.				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	

<b>37785</b>	<b>Ligation, division, and/or excision of varicose vein cluster(s), 1 leg</b>			<b>Global:</b> 090	<b>Issue:</b> Ligation	<b>Screen:</b> Site of Service Anomaly (99238-Only)	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> September 2007	<b>Tab</b> 16	<b>Specialty Developing Recommendation:</b>	APMA, SVS, ACS	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 2,324	<b>2007 Work RVU:</b> 3.87 <b>2007 NF PE RVU:</b> 5.12 <b>2007 Fac PE RVU:</b> 2.69 <b>Result:</b> PE Only	<b>2013 Work RVU:</b> 3.93 <b>2013 NF PE RVU:</b> 6.23 <b>2013 Fac PE RVU:</b> 3.26
<b>RUC Recommendation:</b> Reduce 99238 to 0.5				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	

<b>38542</b>	<b>Dissection, deep jugular node(s)</b>			<b>Global:</b> 090	<b>Issue:</b> Jugular Node Dissection	<b>Screen:</b> Site of Service Anomaly	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2008	<b>Tab</b> 40	<b>Specialty Developing Recommendation:</b>	ACS, AAO-HNS	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 956	<b>2007 Work RVU:</b> 6.08 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 4.3 <b>Result:</b> Increase	<b>2013 Work RVU:</b> 7.95 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 6.21
<b>RUC Recommendation:</b> 7.85				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	

# Status Report: CMS Requests and Relativity Assessment Issues

<b>38571</b>	<b>Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy</b>	<b>Global:</b> 010	<b>Issue:</b> Laparoscopic Pelvic Lymphadenectomy	<b>Screen:</b> CMS Fastest Growing	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2009	<b>Tab</b> 40 <b>Specialty Developing Recommendation:</b> AUA	<b>First Identified:</b> October 2008	<b>2012 Est Medicare Utilization:</b> 9,045	<b>2007 Work RVU:</b> 14.70 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 5.97 <b>Result:</b> Remove from Screen	<b>2013 Work RVU:</b> 14.76 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 6.57
<b>RUC Recommendation:</b> Remove from screen	<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>		

<b>40490</b>	<b>Biopsy of lip</b>	<b>Global:</b> 000	<b>Issue:</b> Biopsy of Lip	<b>Screen:</b> Harvard Valued - Utilization over 30,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> September 2011	<b>Tab</b> 21 <b>Specialty Developing Recommendation:</b> AAO-HNS, AAD	<b>First Identified:</b> April 2011	<b>2012 Est Medicare Utilization:</b> 42,367	<b>2007 Work RVU:</b> 1.22 <b>2007 NF PE RVU:</b> 1.75 <b>2007 Fac PE RVU:</b> 0.61 <b>Result:</b> Maintain	<b>2013 Work RVU:</b> 1.22 <b>2013 NF PE RVU:</b> 2.52 <b>2013 Fac PE RVU:</b> 0.79
<b>RUC Recommendation:</b> 1.22	<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>		

<b>42145</b>	<b>Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)</b>	<b>Global:</b> 090	<b>Issue:</b> Palatopharyngoplasty	<b>Screen:</b> Site of Service Anomaly	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2008	<b>Tab</b> 41 <b>Specialty Developing Recommendation:</b> AAO-HNS	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 1,421	<b>2007 Work RVU:</b> 9.63 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 7.33 <b>Result:</b> Maintain	<b>2013 Work RVU:</b> 9.78 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 10.40
<b>RUC Recommendation:</b> 9.63	<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>		

<b>42415</b>	<b>Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve</b>	<b>Global:</b> 090	<b>Issue:</b> Excise Parotid Gland/Lesion	<b>Screen:</b> Site of Service Anomaly	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2011	<b>Tab</b> 27 <b>Specialty Developing Recommendation:</b> ACS, AAO-HNS	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 5,059	<b>2007 Work RVU:</b> 17.99 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 10.11 <b>Result:</b> Maintain	<b>2013 Work RVU:</b> 17.16 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 12.22
<b>RUC Recommendation:</b> 18.12	<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>		

# Status Report: CMS Requests and Relativity Assessment Issues

**42420**    **Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve**    **Global:** 090    **Issue:** Excise Parotid Gland/Lesion    **Screen:** Site of Service Anomaly    **Complete?** Yes

**Most Recent RUC Meeting:** February 2011    **Tab** 27    **Specialty Developing Recommendation:** ACS, AAO-HNS    **First Identified:** September 2007    **2012 Est Medicare Utilization:** 1,642    **2007 Work RVU:** 20.87    **2013 Work RVU:** 19.53  
**2007 NF PE RVU:** NA    **2013 NF PE RVU:** NA  
**2007 Fac PE RVU:** 11.46    **2013 Fac PE RVU:** 13.37  
**Result:** Maintain

**RUC Recommendation:** 21.00    **CPT Action (if applicable):**  
**Referred to CPT Asst** ☐    **Published in CPT Asst:**

**42440**    **Excision of submandibular (submaxillary) gland**    **Global:** 090    **Issue:** Submandibular Gland Excision    **Screen:** Site of Service Anomaly    **Complete?** Yes

**Most Recent RUC Meeting:** October 2010    **Tab** 64    **Specialty Developing Recommendation:** AAO-HNS, ACS    **First Identified:** September 2007    **2012 Est Medicare Utilization:** 2,064    **2007 Work RVU:** 7.05    **2013 Work RVU:** 6.14  
**2007 NF PE RVU:** NA    **2013 NF PE RVU:** NA  
**2007 Fac PE RVU:** 4.48    **2013 Fac PE RVU:** 5.49  
**Result:** Maintain

**RUC Recommendation:** 7.13    **CPT Action (if applicable):**  
**Referred to CPT Asst** ☐    **Published in CPT Asst:**

**4319X1**    **Global:**    **Issue:** Esophagoscopy    **Screen:** MPC List    **Complete?** Yes

**Most Recent RUC Meeting:** October 2012    **Tab** 10    **Specialty Developing Recommendation:** AAO-HNS, ASGE, SAGES    **First Identified:** September 2011    **2012 Est Medicare Utilization:**    **2007 Work RVU:**    **2013 Work RVU:**  
**2007 NF PE RVU:**    **2013 NF PE RVU:**  
**2007 Fac PE RVU:**    **2013 Fac PE RVU:**  
**Result:** Increase

**RUC Recommendation:** 2.78    **CPT Action (if applicable):**  
**Referred to CPT Asst** ☐    **Published in CPT Asst:**

**4319X2**    **Global:**    **Issue:** Esophagoscopy    **Screen:** MPC List    **Complete?** Yes

**Most Recent RUC Meeting:** October 2012    **Tab** 10    **Specialty Developing Recommendation:** AAO-HNS, ASGE, SAGES    **First Identified:** September 2011    **2012 Est Medicare Utilization:**    **2007 Work RVU:**    **2013 Work RVU:**  
**2007 NF PE RVU:**    **2013 NF PE RVU:**  
**2007 Fac PE RVU:**    **2013 Fac PE RVU:**  
**Result:** Increase

**RUC Recommendation:** 3.21    **CPT Action (if applicable):**  
**Referred to CPT Asst** ☐    **Published in CPT Asst:**



## Status Report: CMS Requests and Relativity Assessment Issues

4319X3

<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b> 10	<b>Specialty Developing Recommendation:</b> AAO-HNS, ASGE, SAGES	<b>Global:</b>	<b>Issue:</b> Esophagoscopy	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>RUC Recommendation:</b> 3.36			<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Increase	<b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>
			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

4319X4

<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b> 10	<b>Specialty Developing Recommendation:</b> AAO-HNS, ASGE, SAGES	<b>Global:</b>	<b>Issue:</b> Esophagoscopy	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>RUC Recommendation:</b> 3.99			<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Increase	<b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>
			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

4319X5

<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b> 10	<b>Specialty Developing Recommendation:</b> AAO-HNS, ASGE, SAGES	<b>Global:</b>	<b>Issue:</b> Esophagoscopy	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>RUC Recommendation:</b> 3.21			<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Increase	<b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>
			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

4319X6

<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b> 10	<b>Specialty Developing Recommendation:</b> AAO-HNS, ASGE, SAGES	<b>Global:</b>	<b>Issue:</b> Esophagoscopy	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>RUC Recommendation:</b> 3.36			<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Increase	<b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>
			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

## Status Report: CMS Requests and Relativity Assessment Issues

<b>4319X7</b>				<b>Global:</b>	<b>Issue:</b> Esophagoscopy	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b> 10	<b>Specialty Developing Recommendation:</b>	AAO-HNS, ASGE, SAGES, AGA	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Maintain	<b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>
<b>RUC Recommendation:</b> 1.59				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		
<hr/>							
<b>4319X8</b>				<b>Global:</b>	<b>Issue:</b> Esophagoscopy	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b> 10	<b>Specialty Developing Recommendation:</b>	AAO-HNS, ASGE, SAGES, AGA	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Maintain	<b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>
<b>RUC Recommendation:</b> 1.89				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		
<hr/>							
<b>43200</b>	<b>Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)</b>			<b>Global:</b> 000	<b>Issue:</b> Esophagoscopy	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b> 10	<b>Specialty Developing Recommendation:</b>	AAO-HNS, AGA, ASGE, SAGES	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 14,871	<b>2007 Work RVU:</b> 1.59 <b>2007 NF PE RVU:</b> 3.98 <b>2007 Fac PE RVU Result:</b> Maintain	<b>2013 Work RVU:</b> 1.59 <b>2013 NF PE RVU:</b> 4.77 <b>2013 Fac PE RVU:</b> 1.32
<b>RUC Recommendation:</b> 1.59				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	May 2012 <b>Published in CPT Asst:</b>		
<hr/>							
<b>43201</b>	<b>Esophagoscopy, rigid or flexible; with directed submucosal injection(s), any substance</b>			<b>Global:</b> 000	<b>Issue:</b> Esophagoscopy	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b> 10	<b>Specialty Developing Recommendation:</b>	AGA, ASGE, SAGES	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 512	<b>2007 Work RVU:</b> 2.09 <b>2007 NF PE RVU:</b> 4.86 <b>2007 Fac PE RVU Result:</b> Decrease	<b>2013 Work RVU:</b> 2.09 <b>2013 NF PE RVU:</b> 7.22 <b>2013 Fac PE RVU:</b> 1.43
<b>RUC Recommendation:</b> 1.90				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	May 2012 <b>Published in CPT Asst:</b>		
<hr/>							

## *Status Report: CMS Requests and Relativity Assessment Issues*

<b>43202</b>	<b>Esophagoscopy, rigid or flexible; with biopsy, single or multiple</b>	<b>Global:</b> 000	<b>Issue:</b> Esophagoscopy	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b> 10	<b>Specialty Developing Recommendation:</b> AAO-HNS, AGA, ASGE, SAGES	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 3,678	<b>2007 Work RVU:</b> 1.89 <b>2013 Work RVU:</b> 1.89 <b>2007 NF PE RVU:</b> 5.44 <b>2013 NF PE RVU:</b> 6.68 <b>2007 Fac PE RVU:</b> 0.95 <b>2013 Fac PE RVU:</b> 1.29
<b>RUC Recommendation:</b> 1.89			<b>CPT Action (if applicable):</b> Referred to CPT Asst <input type="checkbox"/>	May 2012 <b>Published in CPT Asst:</b>	<b>Result:</b> Maintain

<b>43204</b>	Esophagoscopy, rigid or flexible; with injection sclerosis of esophageal varices	<b>Global:</b> 000	<b>Issue:</b> Esophagoscopy	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b> 10	<b>Specialty Developing Recommendation:</b> AGA, ASGE, SAGES	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 55	<b>2007 Work RVU:</b> 3.76 <b>2013 Work RVU:</b> 3.76 <b>2007 NF PE RVU:</b> NA <b>2013 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 1.63 <b>2013 Fac PE RVU:</b> 2.37
<b>RUC Recommendation:</b> 2.89			<b>CPT Action (if applicable):</b> Referred to CPT Asst <input type="checkbox"/>	May 2012 <b>Published in CPT Asst:</b>	<b>Result:</b> Decrease

43205 Esophagoscopy, rigid or flexible; with band ligation of esophageal varices				Global: 000	Issue: Esophagoscopy	Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: October 2012	Tab 10	Specialty Developing Recommendation:	AGA, ASGE, SAGES	First Identified: September 2011	2012 Est Medicare Utilization: 212	2007 Work RVU: 3.78 2007 NF PE RVU: NA 2007 Fac PE RVU 1.66	2013 Work RVU: 3.78 2013 NF PE RVU: NA 2013 Fac PE RVU: 2.34
RUC Recommendation: 3.00				CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>	May 2012 Published in CPT Asst:	Result: Decrease	

<b>43206</b>	Esophagoscopy, rigid or flexible; with optical endomicroscopy	<b>Global:</b> YYY	<b>Issue:</b> Esophagoscopy	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b> 10	<b>Specialty Developing Recommendation:</b> AGA, ASGE, SAGES	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> 0.00 <b>2007 NF PE RVU:</b> 0.00 <b>2007 Fac PE RVU Result:</b> 0.00
<b>RUC Recommendation:</b> 2.39			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	

# Status Report: CMS Requests and Relativity Assessment Issues

**43215 Esophagoscopy, rigid or flexible; with removal of foreign body** Global: 000 Issue: Esophagoscopy Screen: MPC List Complete? Yes

Most Recent Tab 10 Specialty Developing AAO-HNS, First 2012 Est 2007 Work RVU: 2.60 2013 Work RVU: 2.60  
RUC Meeting: October 2012 Recommendation: AGA, ASGE, Identified: September 2011 Medicare Utilization: 1,467 2007 NF PE RVU: NA 2013 NF PE RVU: NA  
2007 Fac PE RVU 1.22 2013 Fac PE RVU: 1.60  
RUC Recommendation: 2.60 CPT Action (if applicable): May 2012 Result: Maintain  
Referred to CPT Asst ☐ Published in CPT Asst:

**43216 Esophagoscopy, rigid or flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery** Global: 000 Issue: Esophagoscopy Screen: MPC List Complete? Yes

Most Recent Tab 10 Specialty Developing AGA, ASGE, First 2012 Est 2007 Work RVU: 2.40 2013 Work RVU: 2.40  
RUC Meeting: October 2012 Recommendation: SAGES Identified: September 2011 Medicare Utilization: 82 2007 NF PE RVU: 1.55 2013 NF PE RVU: 4.06  
2007 Fac PE RVU 1.10 2013 Fac PE RVU: 1.70  
RUC Recommendation: 2.40 CPT Action (if applicable): May 2012 Result: Maintain  
Referred to CPT Asst ☐ Published in CPT Asst:

**43217 Esophagoscopy, rigid or flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique** Global: 000 Issue: Esophagoscopy Screen: MPC List Complete? Yes

Most Recent Tab 10 Specialty Developing AGA, ASGE, First 2012 Est 2007 Work RVU: 2.90 2013 Work RVU: 2.90  
RUC Meeting: October 2012 Recommendation: SAGES Identified: September 2011 Medicare Utilization: 174 2007 NF PE RVU: 6.85 2013 NF PE RVU: 8.42  
2007 Fac PE RVU 1.25 2013 Fac PE RVU: 1.77  
RUC Recommendation: 2.90 CPT Action (if applicable): May 2012 Result: Maintain  
Referred to CPT Asst ☐ Published in CPT Asst:

**43219 Esophagoscopy, rigid or flexible; with insertion of plastic tube or stent** Global: 000 Issue: Esophagoscopy Screen: MPC List Complete? Yes

Most Recent Tab 10 Specialty Developing AGA, ASGE, First 2012 Est 2007 Work RVU: 2.80 2013 Work RVU: 2.80  
RUC Meeting: October 2012 Recommendation: SAGES Identified: September 2011 Medicare Utilization: 708 2007 NF PE RVU: NA 2013 NF PE RVU: NA  
2007 Fac PE RVU 1.40 2013 Fac PE RVU: 1.82  
RUC Recommendation: 2.80 CPT Action (if applicable): May 2012 Result: Maintain  
Referred to CPT Asst ☐ Published in CPT Asst:

# Status Report: CMS Requests and Relativity Assessment Issues

<b>4321X1</b>				<b>Global:</b>	<b>Issue:</b> Esophagoscopy	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b> 10	<b>Specialty Developing Recommendation:</b>		<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease	<b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>
<b>RUC Recommendation:</b> 2.39				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		
<hr/>							
<b>43220</b> Esophagoscopy, rigid or flexible; with balloon dilation (less than 30 mm diameter)				<b>Global:</b> 000	<b>Issue:</b> Esophagoscopy	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b> 10	<b>Specialty Developing Recommendation:</b>	AGA, ASGE, SAGES	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 2,893	<b>2007 Work RVU:</b> 2.10 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU Result:</b> Maintain	<b>2013 Work RVU:</b> 2.10 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 1.39
<b>RUC Recommendation:</b> 2.10				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	May 2012 <b>Published in CPT Asst:</b>		
<hr/>							
<b>43226</b> Esophagoscopy, rigid or flexible; with insertion of guide wire followed by dilation over guide wire				<b>Global:</b> 000	<b>Issue:</b> Esophagoscopy	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b> 10	<b>Specialty Developing Recommendation:</b>	AAO-HNS, AGA, ASGE, SAGES	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 2,689	<b>2007 Work RVU:</b> 2.34 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU Result:</b> Maintain	<b>2013 Work RVU:</b> 2.34 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 1.50
<b>RUC Recommendation:</b> 2.34				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	May 2012 <b>Published in CPT Asst:</b>		
<hr/>							
<b>43227</b> Esophagoscopy, rigid or flexible; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)				<b>Global:</b> 000	<b>Issue:</b> Esophagoscopy	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b> 10	<b>Specialty Developing Recommendation:</b>	AGA, ASGE, SAGES	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 531	<b>2007 Work RVU:</b> 3.59 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU Result:</b> Decrease	<b>2013 Work RVU:</b> 3.59 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 2.21
<b>RUC Recommendation:</b> 3.26				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	May 2012 <b>Published in CPT Asst:</b>		

# Status Report: CMS Requests and Relativity Assessment Issues

**43228** Esophagoscopy, rigid or flexible; with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

**Most Recent RUC Meeting:** October 2012

**Tab** 10

**Specialty Developing Recommendation:**

AGA, ASGE, SAGES

**First Identified:** September 2011

**2012 Est Medicare Utilization:** 4,856

**2007 Work RVU:** 3.76

**2013 Work RVU:** 3.76

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 1.63

**2013 Fac PE RVU:** 2.30

**RUC Recommendation:** 3.25

**CPT Action (if applicable):** May 2012

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**43231** Esophagoscopy, rigid or flexible; with endoscopic ultrasound examination **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

**Most Recent RUC Meeting:** April 2013

**Tab** 10

**Specialty Developing Recommendation:**

AGA, ASGE, SAGES

**First Identified:** September 2011

**2012 Est Medicare Utilization:** 476

**2007 Work RVU:** 3.19

**2013 Work RVU:** 3.19

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 1.42

**2013 Fac PE RVU:** 2.00

**RUC Recommendation:** 3.19

**CPT Action (if applicable):** May 2012

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Maintain

**43232** Esophagoscopy, rigid or flexible; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

**Most Recent RUC Meeting:** April 2013

**Tab** 10

**Specialty Developing Recommendation:**

AGA, ASGE, SAGES

**First Identified:** September 2011

**2012 Est Medicare Utilization:** 404

**2007 Work RVU:** 4.47

**2013 Work RVU:** 4.47

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 1.96

**2013 Fac PE RVU:** 2.60

**RUC Recommendation:** 3.83

**CPT Action (if applicable):** May 2012

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**43234** Upper gastrointestinal endoscopy, simple primary examination (eg, with small diameter flexible endoscope) (separate procedure) **Global:** 000 **Issue:** **Screen:** MPC List **Complete?** Yes

**Most Recent RUC Meeting:**

**Tab**

**Specialty Developing Recommendation:**

**First Identified:** September 2011

**2012 Est Medicare Utilization:** 2,174

**2007 Work RVU:** 2.01

**2013 Work RVU:**

**2007 NF PE RVU:** 5.23

**2013 NF PE RVU:**

**2007 Fac PE RVU** 0.91

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** February 2012

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Deleted from CPT

## Status Report: CMS Requests and Relativity Assessment Issues

<b>43235</b>	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	<b>Global:</b> 000	<b>Issue:</b> EGD	<b>Screen:</b> MPC List / CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2013	<b>Tab</b> 08	<b>Specialty Developing Recommendation:</b> AGA, ASGE, SAGES	<b>First Identified:</b> October 2010	<b>2012 Est Medicare Utilization:</b> 387,560	<b>2007 Work RVU:</b> 2.39 <b>2007 NF PE RVU:</b> 5.19 <b>2007 Fac PE RVU:</b> 1.11 <b>2013 Work RVU:</b> 2.39 <b>2013 NF PE RVU:</b> 6.40 <b>2013 Fac PE RVU:</b> 1.59
<b>RUC Recommendation:</b> 2.26			<b>CPT Action (if applicable):</b> October 2012 <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b> Decrease
<hr/>					
<b>43236</b>	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any substance	<b>Global:</b> 000	<b>Issue:</b> EGD	<b>Screen:</b> CMS Fastest Growing / MPC List	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2013	<b>Tab</b> 08	<b>Specialty Developing Recommendation:</b> AGA, ASGE, SAGES	<b>First Identified:</b> October 2008	<b>2012 Est Medicare Utilization:</b> 15,389	<b>2007 Work RVU:</b> 2.92 <b>2007 NF PE RVU:</b> 6.47 <b>2007 Fac PE RVU:</b> 1.33 <b>2013 Work RVU:</b> 2.92 <b>2013 NF PE RVU:</b> 8.40 <b>2013 Fac PE RVU:</b> 1.89
<b>RUC Recommendation:</b> 2.57			<b>CPT Action (if applicable):</b> October 2012 <b>Referred to CPT Asst</b> <input checked="" type="checkbox"/>	<b>Published in CPT Asst:</b> Apr 2009 and Jun	<b>Result:</b> Decrease
<hr/>					
<b>43237</b>	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with endoscopic ultrasound examination limited to the esophagus	<b>Global:</b> 000	<b>Issue:</b> EGD	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 11	<b>Specialty Developing Recommendation:</b> AGA, ASGE, SAGES	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 863	<b>2007 Work RVU:</b> 3.98 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 1.74 <b>2013 Work RVU:</b> 3.98 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 2.39
<b>RUC Recommendation:</b> 3.85			<b>CPT Action (if applicable):</b> February 2013 <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b> Decrease

## Status Report: CMS Requests and Relativity Assessment Issues

<b>43238</b>	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), esophagus (includes endoscopic ultrasound examination limited to the esophagus)	<b>Global:</b> 000	<b>Issue:</b> EGD	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 11	<b>Specialty Developing Recommendation:</b> AGA, ASGE, SAGES	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 644	<b>2007 Work RVU:</b> 5.02 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 2.11 <b>2013 Work RVU:</b> 5.02 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 2.89
<b>RUC Recommendation:</b> 4.50			<b>CPT Action (if applicable):</b> February 2013 <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	
<b>43239</b>	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple	<b>Global:</b> 000	<b>Issue:</b> EGD	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2013	<b>Tab</b> 08	<b>Specialty Developing Recommendation:</b> AGA, ASGE, SAGES	<b>First Identified:</b> October 2010	<b>2012 Est Medicare Utilization:</b> 1,488,443	<b>2007 Work RVU:</b> 2.87 <b>2007 NF PE RVU:</b> 5.79 <b>2007 Fac PE RVU:</b> 1.29 <b>2013 Work RVU:</b> 2.87 <b>2013 NF PE RVU:</b> 7.27 <b>2013 Fac PE RVU:</b> 1.84
<b>RUC Recommendation:</b> 2.56			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	
<b>43240</b>	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transmural drainage of pseudocyst	<b>Global:</b> 000	<b>Issue:</b> EGD	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 11	<b>Specialty Developing Recommendation:</b> AGA, ASGE, SAGES	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 352	<b>2007 Work RVU:</b> 6.85 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 2.82 <b>2013 Work RVU:</b> 6.85 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 3.91
<b>RUC Recommendation:</b> 7.25			<b>CPT Action (if applicable):</b> February 2013 <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	



# Status Report: CMS Requests and Relativity Assessment Issues

**43241** Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic intraluminal tube or catheter placement **Global:** 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

**Most Recent RUC Meeting:** January 2013 **Tab** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2012 Est Medicare Utilization:** 3,672 **2007 Work RVU:** 2.59 **2013 Work RVU:** 2.59 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 1.18 **2013 Fac PE RVU:** 1.68 **RUC Recommendation:** 2.59 **CPT Action (if applicable):** October 2012 **Published in CPT Asst:** ☐ **Referred to CPT Asst**

**43242** Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum and/or jejunum as appropriate) **Global:** 000 **Issue:** EGD **Screen:** CMS Fastest Growing / MPC List **Complete?** Yes

**Most Recent RUC Meeting:** April 2013 **Tab** 11 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** October 2008 **2012 Est Medicare Utilization:** 28,840 **2007 Work RVU:** 7.30 **2013 Work RVU:** 7.30 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 2.98 **2013 Fac PE RVU:** 4.20 **RUC Recommendation:** 5.39 **CPT Action (if applicable):** February 2013 **Published in CPT Asst:** Mar 2009 **Referred to CPT Asst** ☒

**43243** Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with injection sclerosis of esophageal and/or gastric varices **Global:** 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

**Most Recent RUC Meeting:** January 2013 **Tab** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2012 Est Medicare Utilization:** 1,919 **2007 Work RVU:** 4.56 **2013 Work RVU:** 4.56 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 1.94 **2013 Fac PE RVU:** 2.72 **RUC Recommendation:** 4.37 **CPT Action (if applicable):** October 2012 **Published in CPT Asst:** ☐ **Referred to CPT Asst**

## Status Report: CMS Requests and Relativity Assessment Issues

**43244** Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with band ligation of esophageal and/or gastric varices **Global:** 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

**Most Recent RUC Meeting:** January 2013

**Tab** 08

**Specialty Developing Recommendation:**

AGA, ASGE, SAGES

**First Identified:** September 2011

**2012 Est Medicare Utilization:** 16,558

**2007 Work RVU:** 5.04

**2013 Work RVU:** 5.04

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU:** 2.14

**2013 Fac PE RVU:** 3.00

**RUC Recommendation:** 4.50

**CPT Action (if applicable):** October 2012  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Decrease

**43245** Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with dilation of gastric outlet for obstruction (eg, balloon, guide wire, bougie) **Global:** 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

**Most Recent RUC Meeting:** January 2013

**Tab** 08

**Specialty Developing Recommendation:**

AGA, ASGE, SAGES

**First Identified:** September 2011

**2012 Est Medicare Utilization:** 12,724

**2007 Work RVU:** 3.18

**2013 Work RVU:** 3.18

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU:** 1.39

**2013 Fac PE RVU:** 1.93

**RUC Recommendation:** 3.18

**CPT Action (if applicable):** October 2012  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Maintain

**43246** Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube **Global:** 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

**Most Recent RUC Meeting:** April 2013

**Tab** 11

**Specialty Developing Recommendation:**

AGA, ASGE, SAGES

**First Identified:** September 2011

**2012 Est Medicare Utilization:** 111,931

**2007 Work RVU:** 4.32

**2013 Work RVU:** 4.32

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU:** 1.80

**2013 Fac PE RVU:** 2.49

**RUC Recommendation:** 4.32

**CPT Action (if applicable):** October 2012  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Maintain

## Status Report: CMS Requests and Relativity Assessment Issues

**43247** Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of foreign body      **Global:** 000      **Issue:** EGD      **Screen:** MPC List      **Complete?** Yes

**Most Recent RUC Meeting:** January 2013      **Tab** 08      **Specialty Developing Recommendation:** AGA, ASGE, SAGES      **First Identified:** September 2011      **2012 Est Medicare Utilization:** 28,328      **2007 Work RVU:** 3.38      **2013 Work RVU:** 3.38  
**2007 NF PE RVU:** NA      **2013 NF PE RVU:** NA  
**2007 Fac PE RVU:** 1.48      **2013 Fac PE RVU:** 2.08  
**RUC Recommendation:** 3.27      **CPT Action (if applicable):** October 2012      **Result:** Decrease  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

**43248** Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with insertion of guide wire followed by dilation of esophagus over guide wire      **Global:** 000      **Issue:** EGD      **Screen:** MPC List      **Complete?** Yes

**Most Recent RUC Meeting:** January 2013      **Tab** 08      **Specialty Developing Recommendation:** AGA, ASGE, SAGES      **First Identified:** September 2011      **2012 Est Medicare Utilization:** 106,510      **2007 Work RVU:** 3.15      **2013 Work RVU:** 3.15  
**2007 NF PE RVU:** NA      **2013 NF PE RVU:** NA  
**2007 Fac PE RVU:** 1.43      **2013 Fac PE RVU:** 2.01  
**RUC Recommendation:** 3.01      **CPT Action (if applicable):** October 2012      **Result:** Decrease  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

**43249** Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with balloon dilation of esophagus (less than 30 mm diameter)      **Global:** 000      **Issue:** EGD      **Screen:** MPC List      **Complete?** Yes

**Most Recent RUC Meeting:** January 2013      **Tab** 08      **Specialty Developing Recommendation:** AGA, ASGE, SAGES      **First Identified:** September 2011      **2012 Est Medicare Utilization:** 96,783      **2007 Work RVU:** 2.90      **2013 Work RVU:** 2.90  
**2007 NF PE RVU:** NA      **2013 NF PE RVU:** NA  
**2007 Fac PE RVU:** 1.32      **2013 Fac PE RVU:** 1.86  
**RUC Recommendation:** 2.77      **CPT Action (if applicable):** October 2012      **Result:** Decrease  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

---

<b>43250</b> Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	<b>Global:</b> 000	<b>Issue:</b> EGD	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
--	--------------------	-------------------	-------------------------	----------------------

**Most Recent RUC Meeting:** January 2013

**Tab** 08

**Specialty Developing Recommendation:** AGA, ASGE, SAGES

**First Identified:** September 2011

**2012 Est Medicare Utilization:** 6,105

**2007 Work RVU:** 3.20

**2013 Work RVU:** 3.20

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 1.40

**2013 Fac PE RVU:** 1.93

**RUC Recommendation:** 3.07

**CPT Action (if applicable):** October 2012

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

---

<b>43251</b> Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	<b>Global:</b> 000	<b>Issue:</b> EGD	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
--	--------------------	-------------------	-------------------------	----------------------

**Most Recent RUC Meeting:** April 2013

**Tab** 11

**Specialty Developing Recommendation:** AGA, ASGE, SAGES

**First Identified:** September 2011

**2012 Est Medicare Utilization:** 27,535

**2007 Work RVU:** 3.69

**2013 Work RVU:** 3.69

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 1.60

**2013 Fac PE RVU:** 2.26

**RUC Recommendation:** 3.57

**CPT Action (if applicable):** October 2012

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

---

<b>43255</b> Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with control of bleeding, any method	<b>Global:</b> 000	<b>Issue:</b> EGD	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
---	--------------------	-------------------	-------------------------	----------------------

**Most Recent RUC Meeting:** January 2013

**Tab** 08

**Specialty Developing Recommendation:** AGA, ASGE, SAGES

**First Identified:** September 2011

**2012 Est Medicare Utilization:** 52,486

**2007 Work RVU:** 4.81

**2013 Work RVU:** 4.81

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 2.05

**2013 Fac PE RVU:** 2.88

**RUC Recommendation:** 4.20

**CPT Action (if applicable):** October 2012

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

# Status Report: CMS Requests and Relativity Assessment Issues

**43256** Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic stent placement (includes predilation) **Global:** 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

**Most Recent RUC Meeting:** January 2013 **Tab** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2012 Est Medicare Utilization:** 4,306 **2007 Work RVU:** 4.34 **2013 Work RVU:** 4.34 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 1.85 **2013 Fac PE RVU:** 2.55 **RUC Recommendation:** Deleted from CPT **CPT Action (if applicable):** October 2012 **Published in CPT Asst:** ☐

**43257** Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease **Global:** 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

**Most Recent RUC Meeting:** January 2013 **Tab** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2012 Est Medicare Utilization:** 54 **2007 Work RVU:** 5.50 **2013 Work RVU:** 5.50 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 2.16 **2013 Fac PE RVU:** 3.34 **RUC Recommendation:** 4.25 **CPT Action (if applicable):** October 2012 **Published in CPT Asst:** ☐

**43258** Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique **Global:** 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

**Most Recent RUC Meeting:** January 2013 **Tab** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2012 Est Medicare Utilization:** 16,927 **2007 Work RVU:** 4.54 **2013 Work RVU:** 4.54 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 1.94 **2013 Fac PE RVU:** 2.73 **RUC Recommendation:** Deleted from CPT **CPT Action (if applicable):** October 2012 **Published in CPT Asst:** ☐

## Status Report: CMS Requests and Relativity Assessment Issues

43259	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum and/or jejunum as appropriate			Global: 000	Issue: EGD		Screen: CMS Fastest Growing	Complete? Yes
Most Recent RUC Meeting: April 2013	Tab 11	Specialty Developing Recommendation: AGA, ASGE, SAGES	First Identified: October 2008		2012 Est Medicare Utilization: 38,325		2007 Work RVU: 5.19 2007 NF PE RVU: NA 2007 Fac PE RVU 2.17 Result: Decrease	2013 Work RVU: 5.19 2013 NF PE RVU: NA 2013 Fac PE RVU: 3.09
RUC Recommendation: 4.74			CPT Action (if applicable): Referred to CPT Asst <input checked="" type="checkbox"/>		February 2013 Published in CPT Asst:		Mar 2009	
4325X3				Global: 000	Issue: EGD		Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: April 2013	Tab 11	Specialty Developing Recommendation: AGA, ASGE, SAGES	First Identified:		2012 Est Medicare Utilization:		2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2013 Work RVU: 2013 NF PE RVU: 2013 Fac PE RVU:
RUC Recommendation: 5.39			CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>		February 2013 Published in CPT Asst:			
4325X4				Global:	Issue: EGD		Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: January 2013	Tab 08	Specialty Developing Recommendation: AGA, ASGE, SAGES	First Identified:		2012 Est Medicare Utilization:		2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2013 Work RVU: 2013 NF PE RVU: 2013 Fac PE RVU:
RUC Recommendation: 5.25			CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>		October 2012 Published in CPT Asst:			
43260	Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)			Global: 000	Issue: ERCP		Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: April 2013	Tab 12	Specialty Developing Recommendation:	First Identified: September 2011		2012 Est Medicare Utilization: 9,696		2007 Work RVU: 5.95 2007 NF PE RVU: NA 2007 Fac PE RVU 2.49 Result: Maintain	2013 Work RVU: 5.95 2013 NF PE RVU: NA 2013 Fac PE RVU: 3.47
RUC Recommendation: 5.95			CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>		February 2013 Published in CPT Asst:			

## Status Report: CMS Requests and Relativity Assessment Issues

---

<b>43261</b>	Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple	<b>Global:</b> 000	<b>Issue:</b> ERCP	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
--------------	--	--------------------	--------------------	-------------------------	----------------------

<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 12	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 8,214	<b>2007 Work RVU:</b> 6.26	<b>2013 Work RVU:</b> 6.26
					<b>2007 NF PE RVU:</b> NA	<b>2013 NF PE RVU:</b> NA
					<b>2007 Fac PE RVU</b> 2.61	<b>2013 Fac PE RVU:</b> 3.64
<b>RUC Recommendation:</b> 6.25			<b>CPT Action (if applicable):</b>	January 2013	<b>Result:</b> Decrease	
			<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

---

<b>43262</b>	Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy	<b>Global:</b> 000	<b>Issue:</b> ERCP	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
--------------	--	--------------------	--------------------	-------------------------	----------------------

<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 12	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 58,844	<b>2007 Work RVU:</b> 7.38	<b>2013 Work RVU:</b> 7.38
					<b>2007 NF PE RVU:</b> NA	<b>2013 NF PE RVU:</b> NA
					<b>2007 Fac PE RVU</b> 3.03	<b>2013 Fac PE RVU:</b> 4.23
<b>RUC Recommendation:</b> 6.60			<b>CPT Action (if applicable):</b>	January 2013	<b>Result:</b> Decrease	
			<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

---

<b>43263</b>	Endoscopic retrograde cholangiopancreatography (ERCP); with pressure measurement of sphincter of Oddi (pancreatic duct or common bile duct)	<b>Global:</b> 000	<b>Issue:</b> ERCP	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
--------------	---	--------------------	--------------------	-------------------------	----------------------

<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 12	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 743	<b>2007 Work RVU:</b> 7.28	<b>2013 Work RVU:</b> 7.28
					<b>2007 NF PE RVU:</b> NA	<b>2013 NF PE RVU:</b> NA
					<b>2007 Fac PE RVU</b> 3.02	<b>2013 Fac PE RVU:</b> 4.20
<b>RUC Recommendation:</b> 7.28			<b>CPT Action (if applicable):</b>	February 2013	<b>Result:</b> Maintain	
			<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

---

## Status Report: CMS Requests and Relativity Assessment Issues

<b>43264</b>	Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of calculus/calculi from biliary and/or pancreatic ducts	<b>Global:</b> 000	<b>Issue:</b> ERCP	<b>Screen:</b> Harvard Valued - Utilization over 30,000 / MPC List / Harvard-Valued Annual Allowed Charges Greater than \$10 million	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 12 <b>Specialty Developing Recommendation:</b> AGA, ASGE, SAGES	<b>First Identified:</b> April 2011	<b>2012 Est Medicare Utilization:</b> 47,705	<b>2007 Work RVU:</b> 8.89 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 3.61 <b>Result:</b> Decrease	<b>2013 Work RVU:</b> 8.89 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 5.02
<b>RUC Recommendation:</b> 6.73		<b>CPT Action (if applicable):</b> February 2013 <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		
<b>43265</b>	Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde destruction, lithotripsy of calculus/calculi, any method	<b>Global:</b> 000	<b>Issue:</b> ERCP	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 12 <b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 2,743	<b>2007 Work RVU:</b> 10.00 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 4.03 <b>Result:</b> Decrease	<b>2013 Work RVU:</b> 10.00 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 5.60
<b>RUC Recommendation:</b> 8.03		<b>CPT Action (if applicable):</b> February 2013 <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		
<b>43267</b>	Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde insertion of nasobiliary or nasopancreatic drainage tube	<b>Global:</b> 000	<b>Issue:</b> ERCP	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 12 <b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 193	<b>2007 Work RVU:</b> 7.38 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 3.01 <b>Result:</b> Deleted from CPT	<b>2013 Work RVU:</b> 7.38 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 4.13
<b>RUC Recommendation:</b> Deleted from CPT		<b>CPT Action (if applicable):</b> February 2013 <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		



## Status Report: CMS Requests and Relativity Assessment Issues

**43268** Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde insertion of tube or stent into bile or pancreatic duct **Global:** 000 **Issue:** ERCP **Screen:** Harvard Valued - Utilization over 30,000 / MPC List **Complete?** Yes

**Most Recent RUC Meeting:** April 2013

**Tab** 12

**Specialty Developing Recommendation:**

AGA, ASGE, SAGES

**First Identified:** April 2011

**2012 Est Medicare Utilization:** 36,820

**2007 Work RVU:** 7.38

**2013 Work RVU:** 7.38

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 3.15

**2013 Fac PE RVU:** 4.42

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** February 2013  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Deleted from CPT

**43269** Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of foreign body and/or change of tube or stent

**Global:** 000

**Issue:** ERCP

**Screen:** MPC List

**Complete?** Yes

**Most Recent RUC Meeting:** April 2013

**Tab** 12

**Specialty Developing Recommendation:**

**First Identified:** September 2011

**2012 Est Medicare Utilization:** 21,964

**2007 Work RVU:** 8.20

**2013 Work RVU:** 8.20

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 3.35

**2013 Fac PE RVU:** 4.65

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** February 2013  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Deleted from CPT

**4326X7**

**Global:**

**Issue:** EGD

**Screen:** MPC List

**Complete?** Yes

**Most Recent RUC Meeting:** January 2013

**Tab** 08

**Specialty Developing Recommendation:**

AGA, ASGE, SAGES

**First Identified:**

**2012 Est Medicare Utilization:**

**2007 Work RVU:**

**2013 Work RVU:**

**2007 NF PE RVU:**

**2013 NF PE RVU:**

**2007 Fac PE RVU**

**2013 Fac PE RVU:**

**RUC Recommendation:** 4.45

**CPT Action (if applicable):** October 2012  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Decrease

**4326X8**

**Global:**

**Issue:** EGD

**Screen:** MPC List

**Complete?** Yes

**Most Recent RUC Meeting:** January 2013

**Tab** 08

**Specialty Developing Recommendation:**

AGA, ASGE, SAGES

**First Identified:**

**2012 Est Medicare Utilization:**

**2007 Work RVU:**

**2013 Work RVU:**

**2007 NF PE RVU:**

**2013 NF PE RVU:**

**2007 Fac PE RVU**

**2013 Fac PE RVU:**

**RUC Recommendation:** 4.40

**CPT Action (if applicable):** October 2012  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Decrease

# Status Report: CMS Requests and Relativity Assessment Issues

<b>4326X9</b>				<b>Global:</b>	<b>Issue:</b> EGD	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2013	<b>Tab</b> 08	<b>Specialty Developing Recommendation:</b> AGA, ASGE, SAGES	<b>First Identified:</b>		<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU</b> <b>Result:</b> Decrease	<b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>
<b>RUC Recommendation:</b> 4.39			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	October 2012	<b>Published in CPT Asst:</b>		
<hr/>							
<b>43271</b>	<b>Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde balloon dilation of ampulla, biliary and/or pancreatic duct(s)</b>			<b>Global:</b> 000	<b>Issue:</b> ERCP	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 12	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> September 2011		<b>2012 Est Medicare Utilization:</b> 13,570	<b>2007 Work RVU:</b> 7.38 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU</b> 3.03 <b>Result:</b> Deleted from CPT	<b>2013 Work RVU:</b> 7.38 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 4.22
<b>RUC Recommendation:</b> Deleted from CPT			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	February 2013	<b>Published in CPT Asst:</b>		
<hr/>							
<b>43272</b>	<b>Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique</b>			<b>Global:</b> 000	<b>Issue:</b> ERCP	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 12	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> September 2011		<b>2012 Est Medicare Utilization:</b> 415	<b>2007 Work RVU:</b> 7.38 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU</b> 3.05 <b>Result:</b> Deleted from CPT	<b>2013 Work RVU:</b> 7.38 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 4.25
<b>RUC Recommendation:</b> Deleted from CPT			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	February 2013	<b>Published in CPT Asst:</b>		
<hr/>							
<b>43273</b>	<b>Endoscopic cannulation of papilla with direct visualization of common bile duct(s) and/or pancreatic duct(s) (List separately in addition to code(s) for primary procedure)</b>			<b>Global:</b> ZZZ	<b>Issue:</b> ERCP	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 12	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> September 2011		<b>2012 Est Medicare Utilization:</b> 3,980	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU</b> <b>Result:</b> Maintain	<b>2013 Work RVU:</b> 2.24 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 1.17
<b>RUC Recommendation:</b> 2.24			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	February 2013	<b>Published in CPT Asst:</b>		

## Status Report: CMS Requests and Relativity Assessment Issues

4327X4

Global: 000

Issue: ERCP

Screen: MPC List

Complete? Yes

Most Recent  
RUC Meeting: April 2013

Tab 12

Specialty Developing  
Recommendation:

First  
Identified: September 2011

2012 Est  
Medicare  
Utilization:

2007 Work RVU:

2013 Work RVU:

2007 NF PE RVU:

2013 NF PE RVU:

2007 Fac PE RVU

2013 Fac PE RVU:

Result: Decrease

RUC Recommendation: 8.74

CPT Action (if applicable): February 2013

Referred to CPT Asst ☐

Published in CPT Asst:

4327X5

Global: 000

Issue: ERCP

Screen: MPC List

Complete? Yes

Most Recent  
RUC Meeting: April 2013

Tab 12

Specialty Developing  
Recommendation:

First  
Identified: September 2011

2012 Est  
Medicare  
Utilization:

2007 Work RVU:

2013 Work RVU:

2007 NF PE RVU:

2013 NF PE RVU:

2007 Fac PE RVU

2013 Fac PE RVU:

Result: Decrease

RUC Recommendation: 6.96

CPT Action (if applicable): February 2013

Referred to CPT Asst ☐

Published in CPT Asst:

4327X6

Global: 000

Issue: ERCP

Screen: MPC List

Complete? Yes

Most Recent  
RUC Meeting: April 2013

Tab 12

Specialty Developing  
Recommendation:

First  
Identified: September 2011

2012 Est  
Medicare  
Utilization:

2007 Work RVU:

2013 Work RVU:

2007 NF PE RVU:

2013 NF PE RVU:

2007 Fac PE RVU

2013 Fac PE RVU:

Result: Decrease

RUC Recommendation: 9.10

CPT Action (if applicable): February 2013

Referred to CPT Asst ☐

Published in CPT Asst:

4327X7

Global: 000

Issue: ERCP

Screen: MPC List

Complete? Yes

Most Recent  
RUC Meeting: April 2013

Tab 12

Specialty Developing  
Recommendation:

First  
Identified: September 2011

2012 Est  
Medicare  
Utilization:

2007 Work RVU:

2013 Work RVU:

2007 NF PE RVU:

2013 NF PE RVU:

2007 Fac PE RVU

2013 Fac PE RVU:

Result: Decrease

RUC Recommendation: 7.11

CPT Action (if applicable): February 2013

Referred to CPT Asst ☐

Published in CPT Asst:

## *Status Report: CMS Requests and Relativity Assessment Issues*

<b>43450</b>	Dilation of esophagus, by unguided sound or bougie, single or multiple passes	<b>Global:</b> 000	<b>Issue:</b> Dilation of Esophagus	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b> 17	<b>Specialty Developing Recommendation:</b> AGA, ASGE, SAGES, AAO-HNS	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 79,684	<b>2007 Work RVU:</b> 1.38 <b>2013 Work RVU:</b> 1.38 <b>2007 NF PE RVU:</b> 2.64 <b>2013 NF PE RVU:</b> 3.14 <b>2007 Fac PE RVU:</b> 0.75 <b>2013 Fac PE RVU:</b> 1.08
<b>RUC Recommendation:</b> 1.30			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b> Decrease

<b>43453</b>	<b>Dilation of esophagus, over guide wire</b>			<b>Global:</b> 000	<b>Issue:</b> Dilation of Esophagus	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b> 17	<b>Specialty Developing Recommendation:</b>	AGA, ASGE, SAGES, AAO-HNS	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 2,869	<b>2007 Work RVU:</b> 1.51 <b>2007 NF PE RVU:</b> 6.12 <b>2007 Fac PE RVU:</b> 0.8	<b>2013 Work RVU:</b> 1.51 <b>2013 NF PE RVU:</b> 7.41 <b>2013 Fac PE RVU:</b> 1.14
<b>RUC Recommendation:</b> 1.51				<b>CPT Action (if applicable):</b> Referred to CPT Asst <input type="checkbox"/>	May 2012	<b>Result:</b> Maintain	
					<b>Published in CPT Asst:</b>		

<b>43456</b>	Dilation of esophagus, by balloon or dilator, retrograde			<b>Global:</b> 000	<b>Issue:</b> Dilation of Esophagus	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b> 17	<b>Specialty Developing Recommendation:</b>	AGA, ASGE, SAGES, AAO-HNS	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 1,818	<b>2007 Work RVU:</b> 2.57 <b>2007 NF PE RVU:</b> 13.55 <b>2007 Fac PE RVU:</b> 1.20	<b>2013 Work RVU:</b> 2.57 <b>2013 NF PE RVU:</b> 15.65 <b>2013 Fac PE RVU:</b> 1.68
<b>RUC Recommendation:</b> Deleted from CPT				<b>CPT Action (if applicable):</b> October 2012		<b>Result:</b> Deleted from CPT	
				<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

<b>43458</b>	Dilation of esophagus with balloon (30 mm diameter or larger) for achalasia			<b>Global:</b> 000	<b>Issue:</b> Dilation of Esophagus	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b> 17	<b>Specialty Developing Recommendation:</b>	AGA, ASGE, SAGES, AAO-HNS	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 1,419	<b>2007 Work RVU:</b> 3.06 <b>2007 NF PE RVU:</b> 6.72 <b>2007 Fac PE RVU:</b> 1.37	<b>2013 Work RVU:</b> 3.06 <b>2013 NF PE RVU:</b> 8.37 <b>2013 Fac PE RVU:</b> 1.89
<b>RUC Recommendation:</b> Deleted from CPT				<b>CPT Action (if applicable):</b> October 2012	<b>Result:</b> Deleted from CPT		
				<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

## Status Report: CMS Requests and Relativity Assessment Issues

**44205** Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocolostomy **Global:** 090 **Issue:** Laproscopic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent RUC Meeting:** October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACS, ASCRS **First Identified:** October 2008 **2012 Est Medicare Utilization:** 10,542 **2007 Work RVU:** 22.86 **2013 Work RVU:** 22.95 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 8.6 **2013 Fac PE RVU:** 12.24

**RUC Recommendation:** Remove from screen

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Remove from Screen

**44207** Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis) **Global:** 090 **Issue:** Laproscopic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent RUC Meeting:** October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACS, ASCRS **First Identified:** February 2008 **2012 Est Medicare Utilization:** 7,235 **2007 Work RVU:** 31.79 **2013 Work RVU:** 31.92 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 11.17 **2013 Fac PE RVU:** 16.02

**RUC Recommendation:** Remove from screen

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Remove from Screen

**44360** Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure) **Global:** 000 **Issue:** Antegrade Enteroscopy **Screen:** MPC List **Complete?** No

**Most Recent RUC Meeting:** **Tab** **Specialty Developing Recommendation:** **First Identified:** September 2011 **2012 Est Medicare Utilization:** 5,879 **2007 Work RVU:** 2.59 **2013 Work RVU:** 2.59 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 1.21 **2013 Fac PE RVU:** 1.72

**RUC Recommendation:** Specialty intends on resurveying entire GI endoscopy family.

**CPT Action (if applicable):** January 2013

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:**

## Status Report: CMS Requests and Relativity Assessment Issues

**44361** Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with biopsy, single or multiple      **Global:** 000      **Issue:** Antegrade Enteroscopy      **Screen:** MPC List      **Complete?** No

<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 15,232	<b>2007 Work RVU:</b> 2.87 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU Result:</b> 1.32	<b>2013 Work RVU:</b> 2.87 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 1.87
<b>RUC Recommendation:</b> Specialty intends on resurveying entire GI endoscopy family.			<b>CPT Action (if applicable):</b> January 2013			
			<b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	

**44363** Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of foreign body      **Global:** 000      **Issue:** Antegrade Enteroscopy      **Screen:** MPC List      **Complete?** No

<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 149	<b>2007 Work RVU:</b> 3.49 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU Result:</b> 1.53	<b>2013 Work RVU:</b> 3.49 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 2.14
<b>RUC Recommendation:</b> Specialty intends on resurveying entire GI endoscopy family.			<b>CPT Action (if applicable):</b> January 2013			
			<b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	

**44364** Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique      **Global:** 000      **Issue:** Antegrade Enteroscopy      **Screen:** MPC List      **Complete?** No

<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 320	<b>2007 Work RVU:</b> 3.73 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU Result:</b> 1.63	<b>2013 Work RVU:</b> 3.73 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 2.29
<b>RUC Recommendation:</b> Specialty intends on resurveying entire GI endoscopy family.			<b>CPT Action (if applicable):</b> January 2013			
			<b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	

## Status Report: CMS Requests and Relativity Assessment Issues

<b>44365</b>	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	<b>Global:</b> 000	<b>Issue:</b> Antegrade Enteroscopy	<b>Screen:</b> MPC List	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 181	<b>2007 Work RVU:</b> 3.31 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 1.47 <b>2013 Work RVU:</b> 3.31 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 2.05
<b>RUC Recommendation:</b>	Specialty intends on resurveying entire GI endoscopy family.		<b>CPT Action (if applicable):</b>	January 2013	<b>Result:</b>
			<b>Referred to CPT Asst</b>	<input type="checkbox"/>	<b>Published in CPT Asst:</b>
<b>44366</b>	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)	<b>Global:</b> 000	<b>Issue:</b> Antegrade Enteroscopy	<b>Screen:</b> MPC List	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 2,997	<b>2007 Work RVU:</b> 4.40 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 1.90 <b>2013 Work RVU:</b> 4.40 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 2.69
<b>RUC Recommendation:</b>	Specialty intends on resurveying entire GI endoscopy family.		<b>CPT Action (if applicable):</b>	January 2013	<b>Result:</b>
			<b>Referred to CPT Asst</b>	<input type="checkbox"/>	<b>Published in CPT Asst:</b>
<b>44369</b>	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	<b>Global:</b> 000	<b>Issue:</b> Antegrade Enteroscopy	<b>Screen:</b> MPC List	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 1,391	<b>2007 Work RVU:</b> 4.51 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 1.91 <b>2013 Work RVU:</b> 4.51 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 2.74
<b>RUC Recommendation:</b>	Specialty intends on resurveying entire GI endoscopy family.		<b>CPT Action (if applicable):</b>	January 2013	<b>Result:</b>
			<b>Referred to CPT Asst</b>	<input type="checkbox"/>	<b>Published in CPT Asst:</b>

## Status Report: CMS Requests and Relativity Assessment Issues

44370	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with transendoscopic stent placement (includes predilation)	Global: 000	Issue: Antegrade Enteroscopy	Screen: MPC List	Complete? No
Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:	First Identified: September 2011	2012 Est Medicare Utilization: 113	2007 Work RVU: 4.79 2007 NF PE RVU: NA 2007 Fac PE RVU 2.12 2013 Work RVU: 4.79 2013 NF PE RVU: NA 2013 Fac PE RVU: 3.07
RUC Recommendation:	Specialty intends on resurveying entire GI endoscopy family.		CPT Action (if applicable):	January 2013	Result:
			Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	
44372	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with placement of percutaneous jejunostomy tube	Global: 000	Issue: Antegrade Enteroscopy	Screen: MPC List	Complete? No
Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:	First Identified: September 2011	2012 Est Medicare Utilization: 1,243	2007 Work RVU: 4.40 2007 NF PE RVU: NA 2007 Fac PE RVU 1.84 2013 Work RVU: 4.40 2013 NF PE RVU: NA 2013 Fac PE RVU: 2.58
RUC Recommendation:	Specialty intends on resurveying entire GI endoscopy family.		CPT Action (if applicable):	January 2013	Result:
			Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	
44373	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with conversion of percutaneous gastrostomy tube to percutaneous jejunostomy tube	Global: 000	Issue: Antegrade Enteroscopy	Screen: MPC List	Complete? No
Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:	First Identified: September 2011	2012 Est Medicare Utilization: 1,269	2007 Work RVU: 3.49 2007 NF PE RVU: NA 2007 Fac PE RVU 1.5 2013 Work RVU: 3.49 2013 NF PE RVU: NA 2013 Fac PE RVU: 2.12
RUC Recommendation:	Specialty intends on resurveying entire GI endoscopy family.		CPT Action (if applicable):	January 2013	Result:
			Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	



## Status Report: CMS Requests and Relativity Assessment Issues

**44376** Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure) **Global:** 000 **Issue:** Antegrade Enteroscopy **Screen:** MPC List **Complete?** No

<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 1,765	<b>2007 Work RVU:</b> 5.25 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 2.14 <b>Result:</b>	<b>2013 Work RVU:</b> 5.25 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 2.95
<b>RUC Recommendation:</b> Specialty intends on resurveying entire GI endoscopy family.			<b>CPT Action (if applicable):</b> January 2013			
			<b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	

**44377** Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with biopsy, single or multiple **Global:** 000 **Issue:** Antegrade Enteroscopy **Screen:** MPC List **Complete?** No

<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 1,380	<b>2007 Work RVU:</b> 5.52 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 2.31 <b>Result:</b>	<b>2013 Work RVU:</b> 5.52 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 3.21
<b>RUC Recommendation:</b> Specialty intends on resurveying entire GI endoscopy family.			<b>CPT Action (if applicable):</b> January 2013			
			<b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	

**44378** Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator) **Global:** 000 **Issue:** Antegrade Enteroscopy **Screen:** MPC List **Complete?** No

<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 924	<b>2007 Work RVU:</b> 7.12 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 2.92 <b>Result:</b>	<b>2013 Work RVU:</b> 7.12 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 4.08
<b>RUC Recommendation:</b> Specialty intends on resurveying entire GI endoscopy family.			<b>CPT Action (if applicable):</b> January 2013			
			<b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	

## Status Report: CMS Requests and Relativity Assessment Issues

**44379** Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with transendoscopic stent placement (includes predilation) **Global:** 000 **Issue:** Antegrade Enteroscopy **Screen:** MPC List **Complete?** No

**Most Recent RUC Meeting:** **Tab** **Specialty Developing Recommendation:**

**First Identified:** September 2011

**2012 Est Medicare Utilization:** 13

**2007 Work RVU:** 7.46

**2013 Work RVU:** 7.46

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 3.02

**2013 Fac PE RVU:** 4.51

**RUC Recommendation:** Specialty intends on resurveying entire GI endoscopy family.

**CPT Action (if applicable):** January 2013

**Result:**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**44380** Ileoscopy, through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)

**Global:** 000

**Issue:** Ileoscopy  
Ileoscopy

**Screen:** MPC List

**Complete?** No

**Most Recent RUC Meeting:** **Tab** **Specialty Developing Recommendation:**

**First Identified:** September 2011

**2012 Est Medicare Utilization:** 2,166

**2007 Work RVU:** 1.05

**2013 Work RVU:** 1.05

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 0.60

**2013 Fac PE RVU:** 0.84

**RUC Recommendation:** Specialty intends on resurveying entire GI endoscopy family.

**CPT Action (if applicable):** May 2013

**Result:**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**44382** Ileoscopy, through stoma; with biopsy, single or multiple

**Global:** 000

**Issue:** Ileoscopy  
Ileoscopy  
Ileoscopy  
Ileoscopy

**Screen:** MPC List

**Complete?** No

**Most Recent RUC Meeting:** **Tab** **Specialty Developing Recommendation:**

**First Identified:** September 2011

**2012 Est Medicare Utilization:** 1,333

**2007 Work RVU:** 1.27

**2013 Work RVU:** 1.27

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 0.67

**2013 Fac PE RVU:** 0.97

**RUC Recommendation:** Specialty intends on resurveying entire GI endoscopy family.

**CPT Action (if applicable):** May 2013

**Result:**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

44383	Ileoscopy, through stoma; with transendoscopic stent placement (includes predilation)			Global: 000	Issue: Ileoscopy	Screen: MPC List	Complete?	No
Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:	First Identified: September 2011	2012 Est Medicare Utilization: 252	2007 Work RVU: 2.94 2007 NF PE RVU: NA 2007 Fac PE RVU Result: 1.36	2013 Work RVU: 2.94 2013 NF PE RVU: NA 2013 Fac PE RVU: 1.51		
RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.			CPT Action (if applicable): May 2013					
			Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:				
44385	Endoscopic evaluation of small intestinal (abdominal or pelvic) pouch; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)			Global: 000	Issue: Ileoscopy	Screen: MPC List	Complete?	No
Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:	First Identified: September 2011	2012 Est Medicare Utilization: 1,140	2007 Work RVU: 1.82 2007 NF PE RVU: 3.73 2007 Fac PE RVU 0.79	2013 Work RVU: 1.82 2013 NF PE RVU: 6.06 2013 Fac PE RVU: 1.11		
RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.			CPT Action (if applicable): May 2013					
			Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:				
44386	Endoscopic evaluation of small intestinal (abdominal or pelvic) pouch; with biopsy, single or multiple			Global: 000	Issue: Ileoscopy	Screen: MPC List	Complete?	No
Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:	First Identified: September 2011	2012 Est Medicare Utilization: 947	2007 Work RVU: 2.12 2007 NF PE RVU: 6.66 2007 Fac PE RVU 0.93	2013 Work RVU: 2.12 2013 NF PE RVU: 8.66 2013 Fac PE RVU: 1.38		
RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.			CPT Action (if applicable): May 2013					
			Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:				

## Status Report: CMS Requests and Relativity Assessment Issues

44388	Colonoscopy through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)			Global: 000	Issue: Colonoscopy via stoma	Screen: MPC List	Complete? No
Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:	First Identified: September 2011	2012 Est Medicare Utilization: 4,679	2007 Work RVU: 2.82 2007 NF PE RVU: 5.34 2007 Fac PE RVU 1.21	2013 Work RVU: 2.82 2013 NF PE RVU: 7.69 2013 Fac PE RVU: 1.71	
RUC Recommendation:	Specialty intends on resurveying entire GI endoscopy family.			CPT Action (if applicable): October 2013	Result:		
			Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:			

44389 Colonoscopy through stoma; with biopsy, single or multiple			Global: 000	Issue: Colonoscopy via stoma	Screen: MPC List	Complete? No
Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:	First Identified: September 2011	2012 Est Medicare Utilization: 2,068	2007 Work RVU: 3.13 2007 NF PE RVU: 6.73 2007 Fac PE RVU 1.35	2013 Work RVU: 3.13 2013 NF PE RVU: 8.76 2013 Fac PE RVU: 1.92
RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.			CPT Action (if applicable): October 2013		Result:	
			Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

44390	Colonoscopy through stoma; with removal of foreign body			Global: 000	Issue: Colonoscopy via stoma	Screen: MPC List	Complete? No
Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:	First Identified: September 2011	2012 Est Medicare Utilization: 22	2007 Work RVU: 3.82 2007 NF PE RVU: 7.32 2007 Fac PE RVU 1.57	2013 Work RVU: 3.82 2013 NF PE RVU: 10.21 2013 Fac PE RVU: 2.40	
RUC Recommendation:	Specialty intends on resurveying entire GI endoscopy family.			CPT Action (if applicable): October 2013	Result:		
				Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

## Status Report: CMS Requests and Relativity Assessment Issues

44391	Colonoscopy through stoma; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)	Global: 000	Issue: Colonoscopy via stoma	Screen: MPC List	Complete? No
Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:	First Identified: September 2011	2012 Est Medicare Utilization: 209	2007 Work RVU: 4.31 2007 NF PE RVU: 8.78 2007 Fac PE RVU 1.83 2013 Work RVU: 4.31 2013 NF PE RVU: 10.59 2013 Fac PE RVU: 2.56
RUC Recommendation:	Specialty intends on resurveying entire GI endoscopy family.		CPT Action (if applicable):	October 2013	Result:
			Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	
44392	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	Global: 000	Issue: Colonoscopy via stoma	Screen: MPC List	Complete? No
Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:	First Identified: September 2011	2012 Est Medicare Utilization: 635	2007 Work RVU: 3.81 2007 NF PE RVU: 6.78 2007 Fac PE RVU 1.55 2013 Work RVU: 3.81 2013 NF PE RVU: 9.26 2013 Fac PE RVU: 2.16
RUC Recommendation:	Specialty intends on resurveying entire GI endoscopy family.		CPT Action (if applicable):	October 2013	Result:
			Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	
44393	Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	Global: 000	Issue: Colonoscopy via stoma	Screen: MPC List	Complete? No
Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:	First Identified: September 2011	2012 Est Medicare Utilization: 180	2007 Work RVU: 4.83 2007 NF PE RVU: 7.14 2007 Fac PE RVU 1.91 2013 Work RVU: 4.83 2013 NF PE RVU: 10.09 2013 Fac PE RVU: 2.70
RUC Recommendation:	Specialty intends on resurveying entire GI endoscopy family.		CPT Action (if applicable):	October 2013	Result:
			Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	

## Status Report: CMS Requests and Relativity Assessment Issues

<b>44394</b>	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique		<b>Global:</b> 000	<b>Issue:</b> Colonoscopy via stoma	<b>Screen:</b> MPC List	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 1,409	<b>2007 Work RVU:</b> 4.42 <b>2007 NF PE RVU:</b> 7.97 <b>2007 Fac PE RVU:</b> 1.81 <b>Result:</b>	<b>2013 Work RVU:</b> 4.42 <b>2013 NF PE RVU:</b> 10.33 <b>2013 Fac PE RVU:</b> 2.54
<b>RUC Recommendation:</b>	Specialty intends on resurveying entire GI endoscopy family.		<b>CPT Action (if applicable):</b>	October 2013		
			<b>Referred to CPT Asst</b>	<input type="checkbox"/>	<b>Published in CPT Asst:</b>	
<b>44397</b>	Colonoscopy through stoma; with transendoscopic stent placement (includes predilation)		<b>Global:</b> 000	<b>Issue:</b> Colonoscopy via stoma	<b>Screen:</b> MPC List	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 15	<b>2007 Work RVU:</b> 4.70 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 1.93 <b>Result:</b>	<b>2013 Work RVU:</b> 4.70 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 2.83
<b>RUC Recommendation:</b>	Specialty intends on resurveying entire GI endoscopy family.		<b>CPT Action (if applicable):</b>	October 2013		
			<b>Referred to CPT Asst</b>	<input type="checkbox"/>	<b>Published in CPT Asst:</b>	
<b>44901</b>	Incision and drainage of appendiceal abscess; percutaneous		<b>Global:</b> 000	<b>Issue:</b> Drainage of Abscess	<b>Screen:</b> Codes Reported Together 75% or More-Part2	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> January 2012	<b>2012 Est Medicare Utilization:</b> 217	<b>2007 Work RVU:</b> 3.37 <b>2007 NF PE RVU:</b> 25.61 <b>2007 Fac PE RVU:</b> 1.07 <b>Result:</b> Deleted from CPT	<b>2013 Work RVU:</b> 3.37 <b>2013 NF PE RVU:</b> 23.25 <b>2013 Fac PE RVU:</b> 1.19
<b>RUC Recommendation:</b>	Deleted from CPT		<b>CPT Action (if applicable):</b>	October 2012		
			<b>Referred to CPT Asst</b>	<input type="checkbox"/>	<b>Published in CPT Asst:</b>	

## Status Report: CMS Requests and Relativity Assessment Issues

---

**44970** Laparoscopy, surgical, appendectomy **Global:** 090 **Issue:** Laproscopic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

<b>Most Recent RUC Meeting:</b> October 2008	<b>Tab</b> 26	<b>Specialty Developing Recommendation:</b>	ACS	<b>First Identified:</b> October 2008	<b>2012 Est Medicare Utilization:</b> 18,104	<b>2007 Work RVU:</b> 9.35	<b>2013 Work RVU:</b> 9.45
						<b>2007 NF PE RVU:</b> NA	<b>2013 NF PE RVU:</b> NA
						<b>2007 Fac PE RVU:</b> 4.11	<b>2013 Fac PE RVU:</b> 6.40

**RUC Recommendation:** Remove from screen **CPT Action (if applicable):**  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

---

**45170** Deleted from CPT **Global:** 090 **Issue:** Rectal Tumor Excision **Screen:** Site of Service Anomaly **Complete?** Yes

<b>Most Recent RUC Meeting:</b> February 2009	<b>Tab</b> 11	<b>Specialty Developing Recommendation:</b>	ACS, ASCRS, ASGS	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> 12.48	<b>2013 Work RVU:</b>
						<b>2007 NF PE RVU:</b> NA	<b>2013 NF PE RVU:</b>
						<b>2007 Fac PE RVU:</b> 5.28	<b>2013 Fac PE RVU:</b>

**RUC Recommendation:** Deleted from CPT **CPT Action (if applicable):** October 2008  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

---

**45171** Excision of rectal tumor, transanal approach; not including muscularis propria (ie, partial thickness) **Global:** 090 **Issue:** Rectal Tumor Excision **Screen:** Site of Service Anomaly **Complete?** Yes

<b>Most Recent RUC Meeting:</b> February 2009	<b>Tab</b> 11	<b>Specialty Developing Recommendation:</b>	ACS, ASCRS, ASGS	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 3,189	<b>2007 Work RVU:</b>	<b>2013 Work RVU:</b> 8.13
						<b>2007 NF PE RVU:</b>	<b>2013 NF PE RVU:</b> NA
						<b>2007 Fac PE RVU:</b>	<b>2013 Fac PE RVU:</b> 8.45

**RUC Recommendation:** 8.00 **CPT Action (if applicable):**  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

---

**45172** Excision of rectal tumor, transanal approach; including muscularis propria (ie, full thickness) **Global:** 090 **Issue:** Rectal Tumor Excision **Screen:** Site of Service Anomaly **Complete?** Yes

<b>Most Recent RUC Meeting:</b> February 2009	<b>Tab</b> 11	<b>Specialty Developing Recommendation:</b>	ACS, ASCRS, ASGS	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 2,105	<b>2007 Work RVU:</b>	<b>2013 Work RVU:</b> 12.13
						<b>2007 NF PE RVU:</b>	<b>2013 NF PE RVU:</b> NA
						<b>2007 Fac PE RVU:</b>	<b>2013 Fac PE RVU:</b> 10.00

**RUC Recommendation:** 12.00 **CPT Action (if applicable):**  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

---

## Status Report: CMS Requests and Relativity Assessment Issues

**45330** Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure) **Global:** 000 **Issue:** Diagnostic Sigmoidoscopy **Screen:** Harvard Valued - Utilization over 30,000 / MPC List **Complete?** Yes

**Most Recent RUC Meeting:** September 2011

**Tab** 22

**Specialty Developing Recommendation:** AGA, ASGE, SAGES

**First Identified:** April 2011

**2012 Est Medicare Utilization:** 63,047

**2007 Work RVU:** 0.96

**2013 Work RVU:** 0.96

**2007 NF PE RVU:** 2.33

**2013 NF PE RVU:** 3.17

**2007 Fac PE RVU** 0.53

**2013 Fac PE RVU:** 0.82

**RUC Recommendation:** Specialty intends on revising entire GI endoscopy family. 0.96

**CPT Action (if applicable):** May 2013

**Result:** Maintain

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**45331** Sigmoidoscopy, flexible; with biopsy, single or multiple

**Global:** 000

**Issue:** Flexible Sigmoidoscopy

**Screen:** MPC List

**Complete?** No

**Most Recent RUC Meeting:**

**Tab**

**Specialty Developing Recommendation:**

**First Identified:** September 2011

**2012 Est Medicare Utilization:** 37,231

**2007 Work RVU:** 1.15

**2013 Work RVU:** 1.15

**2007 NF PE RVU:** 3.11

**2013 NF PE RVU:** 3.81

**2007 Fac PE RVU** 0.64

**2013 Fac PE RVU:** 0.96

**RUC Recommendation:** Specialty intends on resurveying entire GI endoscopy family.

**CPT Action (if applicable):** May 2013

**Result:**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**45332** Sigmoidoscopy, flexible; with removal of foreign body

**Global:** 000

**Issue:** Flexible Sigmoidoscopy

**Screen:** MPC List

**Complete?** No

**Most Recent RUC Meeting:**

**Tab**

**Specialty Developing Recommendation:**

**First Identified:** September 2011

**2012 Est Medicare Utilization:** 275

**2007 Work RVU:** 1.79

**2013 Work RVU:** 1.79

**2007 NF PE RVU:** 5.15

**2013 NF PE RVU:** 7.13

**2007 Fac PE RVU** 0.86

**2013 Fac PE RVU:** 1.26

**RUC Recommendation:** Specialty intends on resurveying entire GI endoscopy family.

**CPT Action (if applicable):** May 2013

**Result:**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**



## Status Report: CMS Requests and Relativity Assessment Issues

**45333** Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery      **Global:** 000      **Issue:** Flexible Sigmoidoscopy      **Screen:** MPC List      **Complete?** No

<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 1,730	<b>2007 Work RVU:</b> 1.79 <b>2007 NF PE RVU:</b> 5.06 <b>2007 Fac PE RVU:</b> 0.85 <b>Result:</b>	<b>2013 Work RVU:</b> 1.79 <b>2013 NF PE RVU:</b> 7.26 <b>2013 Fac PE RVU:</b> 1.23
<b>RUC Recommendation:</b> Specialty intends on resurveying entire GI endoscopy family.			<b>CPT Action (if applicable):</b> May 2013			
			<b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	

**45334** Sigmoidoscopy, flexible; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)      **Global:** 000      **Issue:** Flexible Sigmoidoscopy      **Screen:** MPC List      **Complete?** No

<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 3,205	<b>2007 Work RVU:</b> 2.73 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 1.24 <b>Result:</b>	<b>2013 Work RVU:</b> 2.73 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 1.77
<b>RUC Recommendation:</b> Specialty intends on resurveying entire GI endoscopy family.			<b>CPT Action (if applicable):</b> May 2013			
			<b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	

**45335** Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance      **Global:** 000      **Issue:** Flexible Sigmoidoscopy      **Screen:** MPC List      **Complete?** No

<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 2,614	<b>2007 Work RVU:</b> 1.46 <b>2007 NF PE RVU:</b> 3.74 <b>2007 Fac PE RVU:</b> 0.75 <b>Result:</b>	<b>2013 Work RVU:</b> 1.46 <b>2013 NF PE RVU:</b> 7.02 <b>2013 Fac PE RVU:</b> 1.09
<b>RUC Recommendation:</b> Specialty intends on resurveying entire GI endoscopy family.			<b>CPT Action (if applicable):</b> May 2013			
			<b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	

## Status Report: CMS Requests and Relativity Assessment Issues

<b>45337</b>	<b>Sigmoidoscopy, flexible; with decompression of volvulus, any method</b>	<b>Global:</b> 000	<b>Issue:</b> Flexible Sigmoidoscopy	<b>Screen:</b> MPC List	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 1,050	<b>2007 Work RVU:</b> 2.36 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU Result:</b> 1.06 <b>2013 Work RVU:</b> 2.36 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 1.54
<b>RUC Recommendation:</b> Specialty intends on resurveying entire GI endoscopy family.			<b>CPT Action (if applicable):</b> May 2013		
			<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	
<b>45338</b>	<b>Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique</b>	<b>Global:</b> 000	<b>Issue:</b> Flexible Sigmoidoscopy	<b>Screen:</b> MPC List	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 4,497	<b>2007 Work RVU:</b> 2.34 <b>2007 NF PE RVU:</b> 5.37 <b>2007 Fac PE RVU Result:</b> 1.07 <b>2013 Work RVU:</b> 2.34 <b>2013 NF PE RVU:</b> 7.31 <b>2013 Fac PE RVU:</b> 1.53
<b>RUC Recommendation:</b> Specialty intends on resurveying entire GI endoscopy family.			<b>CPT Action (if applicable):</b> May 2013		
			<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	
<b>45339</b>	<b>Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique</b>	<b>Global:</b> 000	<b>Issue:</b> Flexible Sigmoidoscopy	<b>Screen:</b> MPC List	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 1,680	<b>2007 Work RVU:</b> 3.14 <b>2007 NF PE RVU:</b> 4.03 <b>2007 Fac PE RVU Result:</b> 1.38 <b>2013 Work RVU:</b> 3.14 <b>2013 NF PE RVU:</b> 7.01 <b>2013 Fac PE RVU:</b> 1.95
<b>RUC Recommendation:</b> Specialty intends on resurveying entire GI endoscopy family.			<b>CPT Action (if applicable):</b> May 2013		
			<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	

## Status Report: CMS Requests and Relativity Assessment Issues

<b>45340</b>	<b>Sigmoidoscopy, flexible; with dilation by balloon, 1 or more strictures</b>	<b>Global:</b> 000	<b>Issue:</b> Flexible Sigmoidoscopy	<b>Screen:</b> MPC List	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 1,155	<b>2007 Work RVU:</b> 1.89 <b>2007 NF PE RVU:</b> 7.18 <b>2007 Fac PE RVU Result:</b> 0.89 <b>2013 Work RVU:</b> 1.89 <b>2013 NF PE RVU:</b> 13.39 <b>2013 Fac PE RVU:</b> 1.30
<b>RUC Recommendation:</b> Specialty intends on resurveying entire GI endoscopy family.			<b>CPT Action (if applicable):</b> May 2013		
			<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	

<b>45341</b>	<b>Sigmoidoscopy, flexible; with endoscopic ultrasound examination</b>	<b>Global:</b> 000	<b>Issue:</b> Flexible Sigmoidoscopy	<b>Screen:</b> MPC List	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 3,461	<b>2007 Work RVU:</b> 2.60 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU Result:</b> 1.17 <b>2013 Work RVU:</b> 2.60 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 1.71
<b>RUC Recommendation:</b> Specialty intends on resurveying entire GI endoscopy family.			<b>CPT Action (if applicable):</b> May 2013		
			<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	

<b>45342</b>	<b>Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)</b>	<b>Global:</b> 000	<b>Issue:</b> Flexible Sigmoidoscopy	<b>Screen:</b> MPC List	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 335	<b>2007 Work RVU:</b> 4.05 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU Result:</b> 1.71 <b>2013 Work RVU:</b> 4.05 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 2.48
<b>RUC Recommendation:</b> Specialty intends on resurveying entire GI endoscopy family.			<b>CPT Action (if applicable):</b> May 2013		
			<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	

## Status Report: CMS Requests and Relativity Assessment Issues

**45345** Sigmoidoscopy, flexible; with transendoscopic stent placement (includes predilation) **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** No

<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 463	<b>2007 Work RVU:</b> 2.92 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 1.26 <b>Result:</b>	<b>2013 Work RVU:</b> 2.92 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 1.86
<b>RUC Recommendation:</b> Specialty intends on resurveying entire GI endoscopy family.			<b>CPT Action (if applicable):</b> May 2013			
			<b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	

**45355** Colonoscopy, rigid or flexible, transabdominal via colotomy, single or multiple **Global:** 000 **Issue:** Colonoscopy via stoma **Screen:** MPC List **Complete?** No

<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 548	<b>2007 Work RVU:</b> 3.51 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 1.43 <b>Result:</b>	<b>2013 Work RVU:</b> 3.51 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 2.03
<b>RUC Recommendation:</b> Specialty intends on resurveying entire GI endoscopy family.			<b>CPT Action (if applicable):</b> October 2013			
			<b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	

**45378** Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure) **Global:** 000 **Issue:** Flexible Colonoscopy **Screen:** CMS High Expenditure Procedural Codes / MPC List **Complete?** No

<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 612,801	<b>2007 Work RVU:</b> 3.69 <b>2007 NF PE RVU:</b> 6.2 <b>2007 Fac PE RVU:</b> 1.57 <b>Result:</b>	<b>2013 Work RVU:</b> 3.69 <b>2013 NF PE RVU:</b> 7.79 <b>2013 Fac PE RVU:</b> 2.20
<b>RUC Recommendation:</b> Specialty intends on resurveying entire GI endoscopy family.			<b>CPT Action (if applicable):</b> October 2013			
			<b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	

## Status Report: CMS Requests and Relativity Assessment Issues

45379	Colonoscopy, flexible, proximal to splenic flexure; with removal of foreign body			Global: 000	Issue:	Screen: MPC List	Complete?	No
Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:		First Identified: September 2011	2012 Est Medicare Utilization: 819	2007 Work RVU: 4.68 2007 NF PE RVU: 7.78 2007 Fac PE RVU 1.92 Result:	2013 Work RVU: 4.68 2013 NF PE RVU: 10.12 2013 Fac PE RVU: 2.71	
RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family.			CPT Action (if applicable):		October 2013			
			Referred to CPT Asst		<input type="checkbox"/>	Published in CPT Asst:		
45380	Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple			Global: 000	Issue: Colonoscopy	Screen: MPC List	Complete?	No
Most Recent RUC Meeting:	Tab 34	Specialty Developing Recommendation:	AGA, ASGE, SAGES	First Identified: October 2010	2012 Est Medicare Utilization: 902,752	2007 Work RVU: 4.43 2007 NF PE RVU: 7.33 2007 Fac PE RVU 1.87 Result:	2013 Work RVU: 4.43 2013 NF PE RVU: 9.28 2013 Fac PE RVU: 2.63	
RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family. Remove from MPC List.			CPT Action (if applicable):		October 2013			
			Referred to CPT Asst		<input type="checkbox"/>	Published in CPT Asst:		
45381	Colonoscopy, flexible, proximal to splenic flexure; with directed submucosal injection(s), any substance			Global: 000	Issue: Colonoscopy	Screen: CMS Fastest Growing / MPC List	Complete?	No
Most Recent RUC Meeting:	Tab 51	Specialty Developing Recommendation:	AGA, ASGE, SAGES	First Identified: October 2008	2012 Est Medicare Utilization: 66,419	2007 Work RVU: 4.19 2007 NF PE RVU: 7.26 2007 Fac PE RVU 1.79 Result:	2013 Work RVU: 4.19 2013 NF PE RVU: 9.67 2013 Fac PE RVU: 2.52	
RUC Recommendation: Specialty intends on resurveying entire GI endoscopy family. Review September 2013 if not addressed in entire review. CPT Assistant article published.			CPT Action (if applicable):		October 2013			
			Referred to CPT Asst		<input checked="" type="checkbox"/>	Published in CPT Asst: Mar 2009		

## Status Report: CMS Requests and Relativity Assessment Issues

45382	Colonoscopy, flexible, proximal to splenic flexure; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)	Global: 000	Issue:	Screen: MPC List	Complete?	No
Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:	First Identified: September 2011	2012 Est Medicare Utilization: 21,357	2007 Work RVU: 5.68 2007 NF PE RVU: 10.04 2007 Fac PE RVU 2.37 Result:	2013 Work RVU: 5.68 2013 NF PE RVU: 12.21 2013 Fac PE RVU: 3.31
RUC Recommendation:	Specialty intends on resurveying entire GI endoscopy family.		CPT Action (if applicable):	October 2013		
			Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:	
45383	Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	Global: 000	Issue:	Screen: MPC List	Complete?	No
Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:	First Identified: September 2011	2012 Est Medicare Utilization: 54,097	2007 Work RVU: 5.86 2007 NF PE RVU: 8.08 2007 Fac PE RVU 2.34 Result:	2013 Work RVU: 5.86 2013 NF PE RVU: 10.59 2013 Fac PE RVU: 3.26
RUC Recommendation:	Specialty intends on resurveying entire GI endoscopy family.		CPT Action (if applicable):	October 2013		
			Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:	
45384	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	Global: 000	Issue:	Screen: MPC List	Complete?	No
Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:	First Identified: September 2011	2012 Est Medicare Utilization: 156,758	2007 Work RVU: 4.69 2007 NF PE RVU: 6.9 2007 Fac PE RVU 1.93 Result:	2013 Work RVU: 4.69 2013 NF PE RVU: 8.88 2013 Fac PE RVU: 2.65
RUC Recommendation:	Specialty intends on resurveying entire GI endoscopy family.		CPT Action (if applicable):	October 2013		
			Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:	

## Status Report: CMS Requests and Relativity Assessment Issues

---

**45385** Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique      **Global:** 000      **Issue:** Colonoscopy      **Screen:** MPC List      **Complete?** No

**Most Recent RUC Meeting:** September 2011      **Tab** 34      **Specialty Developing Recommendation:** AGA, ASGE, SAGES      **First Identified:** October 2010      **2012 Est Medicare Utilization:** 688,850      **2007 Work RVU:** 5.30      **2013 Work RVU:** 5.30  
**2007 NF PE RVU:** 7.94      **2013 NF PE RVU:** 10.08  
**2007 Fac PE RVU:** 2.18      **2013 Fac PE RVU:** 3.07

**RUC Recommendation:** Specialty intends on resurveying entire GI endoscopy family. Remove from MPC List.      **CPT Action (if applicable):** October 2013      **Result:**

**Referred to CPT Asst** ☐      **Published in CPT Asst:**

---

**45386** Colonoscopy, flexible, proximal to splenic flexure; with dilation by balloon, 1 or more strictures      **Global:** 000      **Issue:**      **Screen:** MPC List      **Complete?** No

**Most Recent RUC Meeting:**      **Tab**      **Specialty Developing Recommendation:**      **First Identified:** September 2011      **2012 Est Medicare Utilization:** 2,169      **2007 Work RVU:** 4.57      **2013 Work RVU:** 4.57  
**2007 NF PE RVU:** 12.37      **2013 NF PE RVU:** 15.70  
**2007 Fac PE RVU:** 1.89      **2013 Fac PE RVU:** 2.66

**RUC Recommendation:** Specialty intends on resurveying entire GI endoscopy family.      **CPT Action (if applicable):** October 2013      **Result:**

**Referred to CPT Asst** ☐      **Published in CPT Asst:**

---

**45387** Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic stent placement (includes predilation)      **Global:** 000      **Issue:**      **Screen:** MPC List      **Complete?** No

**Most Recent RUC Meeting:**      **Tab**      **Specialty Developing Recommendation:**      **First Identified:** September 2011      **2012 Est Medicare Utilization:** 664      **2007 Work RVU:** 5.90      **2013 Work RVU:** 5.90  
**2007 NF PE RVU:** NA      **2013 NF PE RVU:** NA  
**2007 Fac PE RVU:** 2.49      **2013 Fac PE RVU:** 3.51

**RUC Recommendation:** Specialty intends on resurveying entire GI endoscopy family.      **CPT Action (if applicable):** October 2013      **Result:**

**Referred to CPT Asst** ☐      **Published in CPT Asst:**

---

## Status Report: CMS Requests and Relativity Assessment Issues

**45391** Colonoscopy, flexible, proximal to splenic flexure; with endoscopic ultrasound examination      **Global:** 000      **Issue:**      **Screen:** MPC List      **Complete?** No

<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 832	<b>2007 Work RVU:</b> 5.09 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU Result:</b> 2.13	<b>2013 Work RVU:</b> 5.09 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 2.99
<b>RUC Recommendation:</b> Specialty intends on resurveying entire GI endoscopy family.			<b>CPT Action (if applicable):</b> October 2013			
			<b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	

**45392** Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)      **Global:** 000      **Issue:**      **Screen:** MPC List      **Complete?** No

<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 115	<b>2007 Work RVU:</b> 6.54 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU Result:</b> 2.65	<b>2013 Work RVU:</b> 6.54 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 3.74
<b>RUC Recommendation:</b> Specialty intends on resurveying entire GI endoscopy family.			<b>CPT Action (if applicable):</b> October 2013			
			<b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	

**46200** Fissurectomy, including sphincterotomy, when performed      **Global:** 090      **Issue:** Fissurectomy      **Screen:** Site of Service Anomaly (99238-Only)      **Complete?** Yes

<b>Most Recent RUC Meeting:</b> September 2007	<b>Tab</b> 16	<b>Specialty Developing Recommendation:</b> ACS	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 1,539	<b>2007 Work RVU:</b> 3.48 <b>2007 NF PE RVU:</b> 4.46 <b>2007 Fac PE RVU Result:</b> 3.08	<b>2013 Work RVU:</b> 3.59 <b>2013 NF PE RVU:</b> 9.36 <b>2013 Fac PE RVU:</b> 5.64
<b>RUC Recommendation:</b> Reduce 99238 to 0.5			<b>CPT Action (if applicable):</b>			
			<b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	



## Status Report: CMS Requests and Relativity Assessment Issues

<b>47011</b>	<b>Hepatotomy; for percutaneous drainage of abscess or cyst, 1 or 2 stages</b>	<b>Global:</b> 000	<b>Issue:</b> Drainage of Abscess	<b>Screen:</b> Codes Reported Together 75% or More-Part2	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> January 2012	<b>2012 Est Medicare Utilization:</b> 3,335	<b>2007 Work RVU:</b> 3.69 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 1.17 <b>2013 Work RVU:</b> 3.69 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 1.29
<b>RUC Recommendation:</b> Deleted from CPT			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>October 2012</b> <b>Published in CPT Asst:</b>	<b>Result:</b> Deleted from CPT
<b>47382</b>	<b>Ablation, 1 or more liver tumor(s), percutaneous, radiofrequency</b>	<b>Global:</b> 010	<b>Issue:</b> Interventional Radiology Procedures	<b>Screen:</b> CMS Request - Practice Expense Review	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2008	<b>Tab</b> 13	<b>Specialty Developing Recommendation:</b> ACR, SIR	<b>First Identified:</b> NA	<b>2012 Est Medicare Utilization:</b> 1,577	<b>2007 Work RVU:</b> 15.19 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 5.83 <b>2013 Work RVU:</b> 15.22 <b>2013 NF PE RVU:</b> 135.85 <b>2013 Fac PE RVU:</b> 5.99
<b>RUC Recommendation:</b> New PE Inputs			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b> PE Only
<b>47490</b>	<b>Cholecystostomy, percutaneous, complete procedure, including imaging guidance, catheter placement, cholecystogram when performed, and radiological supervision and interpretation</b>	<b>Global:</b> 010	<b>Issue:</b> Cholecystostomy	<b>Screen:</b> CMS Fastest Growing	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2009	<b>Tab</b> 04	<b>Specialty Developing Recommendation:</b> ACR	<b>First Identified:</b> October 2008	<b>2012 Est Medicare Utilization:</b> 8,452	<b>2007 Work RVU:</b> 8.05 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 5.32 <b>2013 Work RVU:</b> 4.76 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 4.64
<b>RUC Recommendation:</b> 4.76			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>June 2009</b> <b>Published in CPT Asst:</b>	<b>Result:</b> Decrease

## Status Report: CMS Requests and Relativity Assessment Issues

<b>47500</b>	Injection procedure for percutaneous transhepatic cholangiography	<b>Global:</b> 000	<b>Issue:</b> Introduction of Liver X-ray with Radiological S&I	<b>Screen:</b> Codes Reported Together 75% or More-Part2	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b>	<b>Specialty Developing Recommendation:</b> ACR, SIR	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 5,299	<b>2007 Work RVU:</b> 1.96 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 0.62 <b>2013 Work RVU:</b> 1.96 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 0.68
<b>RUC Recommendation:</b> Refer to CPT to bundle.			<b>CPT Action (if applicable):</b> CPT 2016 cycle <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b>
<hr/>					
<b>47505</b>	Injection procedure for cholangiography through an existing catheter (eg, percutaneous transhepatic or T-tube)	<b>Global:</b> 000	<b>Issue:</b> Introduction of Liver X-ray with Radiological S&I	<b>Screen:</b> Codes Reported Together 75% or More-Part2	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b>	<b>Specialty Developing Recommendation:</b> ACR, SIR	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 16,752	<b>2007 Work RVU:</b> 0.76 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 0.24 <b>2013 Work RVU:</b> 0.76 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 0.26
<b>RUC Recommendation:</b> Refer to CPT to bundle.			<b>CPT Action (if applicable):</b> CPT 2016 cycle <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b>
<hr/>					
<b>47510</b>	Introduction of percutaneous transhepatic catheter for biliary drainage	<b>Global:</b> 090	<b>Issue:</b> Introduction of Liver X-ray with Radiological S&I	<b>Screen:</b> Codes Reported Together 75% or More-Part2	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b>	<b>Specialty Developing Recommendation:</b> ACR, SIR	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 2,069	<b>2007 Work RVU:</b> 7.94 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 4.76 <b>2013 Work RVU:</b> 8.03 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 5.02
<b>RUC Recommendation:</b> Refer to CPT to bundle.			<b>CPT Action (if applicable):</b> CPT 2016 cycle <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b>

## Status Report: CMS Requests and Relativity Assessment Issues

**47511** Introduction of percutaneous transhepatic stent for internal and external biliary drainage      **Global:** 090      **Issue:** Introduction of Liver X-ray with Radiological S&I      **Screen:** Codes Reported Together 75% or More-Part2      **Complete?** No

**Most Recent RUC Meeting:** October 2012

**Tab**

**Specialty Developing Recommendation:** ACR, SIR

**First Identified:**

**2012 Est Medicare Utilization:** 4,964

**2007 Work RVU:** 10.74

**2013 Work RVU:** 10.77

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU:** 4.87

**2013 Fac PE RVU:** 5.17

**RUC Recommendation:** Refer to CPT to bundle.

**CPT Action (if applicable):** CPT 2016 cycle  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

**Result:**

**47525** Change of percutaneous biliary drainage catheter

**Global:** 000

**Issue:** Change Biliary Drainage Catheter

**Screen:** High IWPUP

**Complete?** Yes

**Most Recent RUC Meeting:** October 2008

**Tab 14**

**Specialty Developing Recommendation:** ACR, SIR

**First Identified:** February 2008

**2012 Est Medicare Utilization:** 11,130

**2007 Work RVU:** 5.55

**2013 Work RVU:** 1.54

**2007 NF PE RVU:** 14.8

**2013 NF PE RVU:** 13.35

**2007 Fac PE RVU:** 2.67

**2013 Fac PE RVU:** 0.81

**RUC Recommendation:** 1.54

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

**Result:** Decrease

**47562** Laparoscopy, surgical; cholecystectomy

**Global:** 090

**Issue:** RAW review

**Screen:** CMS High Expenditure Procedural Codes

**Complete?** Yes

**Most Recent RUC Meeting:** January 2012

**Tab 30**

**Specialty Developing Recommendation:**

**First Identified:** September 2011

**2012 Est Medicare Utilization:** 117,601

**2007 Work RVU:** 11.63

**2013 Work RVU:** 10.47

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU:** 5.06

**2013 Fac PE RVU:** 6.81

**RUC Recommendation:** Reaffirmed

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

**Result:** Maintain

# Status Report: CMS Requests and Relativity Assessment Issues

**47563** Laparoscopy, surgical; cholecystectomy with cholangiography

**Global:** 090

**Issue:** RAW review

**Screen:** CMS High Expenditure  
Procedural Codes

**Complete?** Yes

**Most Recent  
RUC Meeting:** January 2012

**Tab** 30

**Specialty Developing  
Recommendation:**

**First  
Identified:** September 2011

**2012 Est  
Medicare  
Utilization:** 56,399

**2007 Work RVU:** 12.03

**2013 Work RVU:** 11.47

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 5.24

**2013 Fac PE RVU:** 7.26

**Result:** Maintain

**RUC Recommendation:** 12.11

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**47600** Cholecystectomy;

**Global:** 090

**Issue:** Cholecystectomy

**Screen:** CMS Request - NPRM  
for 2012

**Complete?** Yes

**Most Recent  
RUC Meeting:** April 2012

**Tab** 36

**Specialty Developing  
Recommendation:** ACS, SAGES

**First  
Identified:** September 2011

**2012 Est  
Medicare  
Utilization:** 14,534

**2007 Work RVU:** 17.35

**2013 Work RVU:** 17.48

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 6.4

**2013 Fac PE RVU:** 10.42

**Result:** Increase

**RUC Recommendation:** 20.00

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**47605** Cholecystectomy; with cholangiography

**Global:** 090

**Issue:** Cholecystectomy

**Screen:** CMS Request - NPRM  
for 2012

**Complete?** Yes

**Most Recent  
RUC Meeting:** April 2012

**Tab** 36

**Specialty Developing  
Recommendation:** ACS, SAGES

**First  
Identified:** September 2011

**2012 Est  
Medicare  
Utilization:** 3,296

**2007 Work RVU:** 15.90

**2013 Work RVU:** 18.48

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 6.47

**2013 Fac PE RVU:** 10.84

**Result:** Increase

**RUC Recommendation:** 21.00

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**48102** Biopsy of pancreas, percutaneous needle

**Global:** 010

**Issue:** Percutaneous Needle  
Biopsy

**Screen:** Site of Service Anomaly  
(99238-Only)

**Complete?** Yes

**Most Recent  
RUC Meeting:** September 2007

**Tab** 16

**Specialty Developing  
Recommendation:** SIR

**First  
Identified:** September 2007

**2012 Est  
Medicare  
Utilization:** 2,025

**2007 Work RVU:** 4.68

**2013 Work RVU:** 4.70

**2007 NF PE RVU:** 8.21

**2013 NF PE RVU:** 10.65

**2007 Fac PE RVU** 1.85

**2013 Fac PE RVU:** 1.94

**Result:** PE Only

**RUC Recommendation:** Reduce 99238 to 0.5

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**48511** External drainage, pseudocyst of pancreas; percutaneous

**Global:** 000

**Issue:** Drainage of Abscess

**Screen:** Codes Reported Together 75% or More-Part2

**Complete?** Yes

**Most Recent RUC Meeting:**

**Tab**

**Specialty Developing Recommendation:**

**First Identified:** January 2012

**2012 Est Medicare Utilization:** 371

**2007 Work RVU:** 3.99

**2013 Work RVU:** 3.99

**2007 NF PE RVU:** 20.43

**2013 NF PE RVU:** 23.64

**2007 Fac PE RVU:** 1.27

**2013 Fac PE RVU:** 1.39

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2012

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**4900X2**

**Global:**

**Issue:** Drainage of Abscess

**Screen:** Codes Reported Together 75% or More-Part2

**Complete?** Yes

**Most Recent RUC Meeting:** January 2013

**Tab** 04

**Specialty Developing Recommendation:** ACR, SIR

**First Identified:** January 2012

**2012 Est Medicare Utilization:**

**2007 Work RVU:**

**2013 Work RVU:**

**2007 NF PE RVU:**

**2013 NF PE RVU:**

**2007 Fac PE RVU**

**2013 Fac PE RVU:**

**RUC Recommendation:** 4.25

**CPT Action (if applicable):** October 2012

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**4900X3**

**Global:**

**Issue:** Drainage of Abscess

**Screen:** Codes Reported Together 75% or More-Part2

**Complete?** Yes

**Most Recent RUC Meeting:** January 2013

**Tab** 04

**Specialty Developing Recommendation:** ACR, SIR

**First Identified:** January 2012

**2012 Est Medicare Utilization:**

**2007 Work RVU:**

**2013 Work RVU:**

**2007 NF PE RVU:**

**2013 NF PE RVU:**

**2007 Fac PE RVU**

**2013 Fac PE RVU:**

**RUC Recommendation:** 4.25

**CPT Action (if applicable):** October 2012

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

# Status Report: CMS Requests and Relativity Assessment Issues

<b>4900X4</b>				<b>Global:</b>	<b>Issue:</b> Drainage of Abscess	<b>Screen:</b> Codes Reported Together 75% or More-Part2	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2013	<b>Tab</b> 04	<b>Specialty Developing Recommendation:</b>	ACR, SIR	<b>First Identified:</b> January 2012	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b>	<b>2013 Work RVU:</b>
<b>RUC Recommendation:</b> 4.50				<b>CPT Action (if applicable):</b>	October 2012	<b>2007 NF PE RVU:</b>	<b>2013 NF PE RVU:</b>
				<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2007 Fac PE RVU Result:</b> Decrease	<b>2013 Fac PE RVU:</b>
<hr/>							
<b>49021</b>	<b>Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; percutaneous</b>			<b>Global:</b> 000	<b>Issue:</b> Drainage of Abscess	<b>Screen:</b> Codes Reported Together 75% or More-Part2	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2013	<b>Tab</b> 04	<b>Specialty Developing Recommendation:</b>	ACR, SIR	<b>First Identified:</b> January 2012	<b>2012 Est Medicare Utilization:</b> 21,996	<b>2007 Work RVU:</b> 3.37	<b>2013 Work RVU:</b> 3.37
<b>RUC Recommendation:</b> Deleted from CPT				<b>CPT Action (if applicable):</b>	October 2012	<b>2007 NF PE RVU:</b> 20.43	<b>2013 NF PE RVU:</b> 22.80
				<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2007 Fac PE RVU</b> 1.07	<b>2013 Fac PE RVU:</b> 1.18
						<b>Result:</b> Deleted from CPT	
<hr/>							
<b>49041</b>	<b>Drainage of subdiaphragmatic or subphrenic abscess; percutaneous</b>			<b>Global:</b> 000	<b>Issue:</b> Drainage of Abscess	<b>Screen:</b> Codes Reported Together 75% or More-Part2	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2013	<b>Tab</b> 04	<b>Specialty Developing Recommendation:</b>	ACR, SIR	<b>First Identified:</b> January 2012	<b>2012 Est Medicare Utilization:</b> 1,166	<b>2007 Work RVU:</b> 3.99	<b>2013 Work RVU:</b> 3.99
<b>RUC Recommendation:</b> Deleted from CPT				<b>CPT Action (if applicable):</b>	October 2012	<b>2007 NF PE RVU:</b> 19.33	<b>2013 NF PE RVU:</b> 23.22
				<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2007 Fac PE RVU</b> 1.27	<b>2013 Fac PE RVU:</b> 1.40
						<b>Result:</b> Deleted from CPT	

# Status Report: CMS Requests and Relativity Assessment Issues

**49061** Drainage of retroperitoneal abscess; percutaneous

**Global:** 000

**Issue:** Drainage of Abscess

**Screen:** Codes Reported Together 75% or More-Part2

**Complete?** Yes

**Most Recent RUC Meeting:** January 2013

**Tab** 04

**Specialty Developing Recommendation:** ACR, SIR

**First Identified:** January 2012

**2012 Est Medicare Utilization:** 7,560

**2007 Work RVU:** 3.69

**2013 Work RVU:** 3.69

**2007 NF PE RVU:** 19.38

**2013 NF PE RVU:** 22.92

**2007 Fac PE RVU** 1.17

**2013 Fac PE RVU:** 1.29

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2012

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**49080** Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); initial

**Global:** 000

**Issue:** Peritoneocentesis

**Screen:** Harvard Valued - Utilization over 100,000

**Complete?** Yes

**Most Recent RUC Meeting:** October 2010

**Tab** 5

**Specialty Developing Recommendation:** ACR, AGA, ASGE, AUR, SIR

**First Identified:** October 2009

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 1.35

**2013 Work RVU:**

**2007 NF PE RVU:** 3.63

**2013 NF PE RVU:**

**2007 Fac PE RVU** 0.45

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** June 2010

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**49081** Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); subsequent

**Global:** 000

**Issue:** Peritoneocentesis

**Screen:** Harvard Valued - Utilization over 100,000

**Complete?** Yes

**Most Recent RUC Meeting:** October 2010

**Tab** 5

**Specialty Developing Recommendation:**

**First Identified:** February 2010

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 1.26

**2013 Work RVU:**

**2007 NF PE RVU:** 2.65

**2013 NF PE RVU:**

**2007 Fac PE RVU** 0.43

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** June 2010

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

---

**49082** Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance      **Global:** 000      **Issue:** Abdominal Paracentesis      **Screen:** Harvard Valued - Utilization over 100,000      **Complete?** Yes

**Most Recent RUC Meeting:** October 2010

**Tab** 05

**Specialty Developing Recommendation:**

ACR, ACS, AGA, ASGE, SIR

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 16,445

**2007 Work RVU:**

**2013 Work RVU:** 1.24

**2007 NF PE RVU:**

**2013 NF PE RVU:** 3.96

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 0.78

**RUC Recommendation:** 1.35

**CPT Action (if applicable):** June 2010

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

---

**49083** Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance      **Global:** 000      **Issue:** Abdominal Paracentesis      **Screen:** Harvard Valued - Utilization over 100,000      **Complete?** Yes

**Most Recent RUC Meeting:** October 2010

**Tab** 05

**Specialty Developing Recommendation:**

ACR, ACS, AGA, ASGE, SIR

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 173,199

**2007 Work RVU:**

**2013 Work RVU:** 2.00

**2007 NF PE RVU:**

**2013 NF PE RVU:** 7.39

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 1.11

**RUC Recommendation:** 2.00

**CPT Action (if applicable):** June 2010

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

---

**49084** Peritoneal lavage, including imaging guidance, when performed      **Global:** 000      **Issue:** Abdominal Paracentesis      **Screen:** Harvard Valued - Utilization over 100,000      **Complete?** Yes

**Most Recent RUC Meeting:** October 2010

**Tab** 05

**Specialty Developing Recommendation:**

ACR, ACS, AGA, ASGE, SIR

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 2,235

**2007 Work RVU:**

**2013 Work RVU:** 2.00

**2007 NF PE RVU:**

**2013 NF PE RVU:** NA

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 0.81

**RUC Recommendation:** 2.50

**CPT Action (if applicable):** June 2010

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Increase



## Status Report: CMS Requests and Relativity Assessment Issues

<b>49418</b>	Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous	<b>Global:</b> 000	<b>Issue:</b> Intraperitoneal Catheter Codes	<b>Screen:</b> Site of Service Anomaly	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab</b> 11	<b>Specialty Developing Recommendation:</b> ACS, ACR, SIR	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 3,297	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease <b>2013 Work RVU:</b> 4.21 <b>2013 NF PE RVU:</b> 39.30 <b>2013 Fac PE RVU:</b> 1.79
<b>RUC Recommendation:</b> 4.21			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	February 2010 <b>Published in CPT Asst:</b>	
<hr/>					
<b>49420</b>	Deleted from CPT	<b>Global:</b> 000	<b>Issue:</b> Insertion of Intraperitoneal Cannula or Catheter	<b>Screen:</b> Site of Service Anomaly	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2009	<b>Tab</b> 40	<b>Specialty Developing Recommendation:</b> ACS	<b>First Identified:</b> April 2008	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> 2.22 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU Result:</b> Deleted from CPT <b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>
<b>RUC Recommendation:</b> Deleted from CPT			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	February 2010 <b>Published in CPT Asst:</b>	
<hr/>					
<b>49421</b>	Insertion of tunneled intraperitoneal catheter for dialysis, open	<b>Global:</b> 000	<b>Issue:</b> Intraperitoneal Catheter Codes	<b>Screen:</b> Site of Service Anomaly	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab</b> 11	<b>Specialty Developing Recommendation:</b> ACS, ACR, SIR	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 4,347	<b>2007 Work RVU:</b> 5.87 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU Result:</b> Decrease <b>2013 Work RVU:</b> 4.21 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 1.73
<b>RUC Recommendation:</b> 4.21			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	February 2010 <b>Published in CPT Asst:</b>	

# Status Report: CMS Requests and Relativity Assessment Issues

**49505** Repair initial inguinal hernia, age 5 years or older; reducible

**Global:** 090

**Issue:** RAW review

**Screen:** CMS High Expenditure  
Procedural Codes

**Complete?** Yes

**Most Recent  
RUC Meeting:** January 2012

**Tab** 30

**Specialty Developing  
Recommendation:**

**First  
Identified:** September 2011

**2012 Est  
Medicare  
Utilization:** 78,138

**2007 Work RVU:** 7.88

**2013 Work RVU:** 7.96

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 3.78

**2013 Fac PE RVU:** 5.83

**Result:** Maintain

**RUC Recommendation:** Reaffirmed

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**49507** Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated

**Global:** 090

**Issue:** Hernia Repair

**Screen:** Site of Service Anomaly

**Complete?** Yes

**Most Recent  
RUC Meeting:** February 2011

**Tab** 29

**Specialty Developing  
Recommendation:** ACS

**First  
Identified:** September 2007

**2012 Est  
Medicare  
Utilization:** 12,126

**2007 Work RVU:** 9.97

**2013 Work RVU:** 9.09

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 4.46

**2013 Fac PE RVU:** 6.36

**Result:** Maintain

**RUC Recommendation:** 10.05

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**49521** Repair recurrent inguinal hernia, any age; incarcerated or strangulated

**Global:** 090

**Issue:** Hernia Repair

**Screen:** Site of Service Anomaly

**Complete?** Yes

**Most Recent  
RUC Meeting:** February 2011

**Tab** 29

**Specialty Developing  
Recommendation:** ACS

**First  
Identified:** September 2007

**2012 Est  
Medicare  
Utilization:** 2,585

**2007 Work RVU:** 12.36

**2013 Work RVU:** 11.48

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 5.18

**2013 Fac PE RVU:** 7.29

**Result:** Maintain

**RUC Recommendation:** 12.44

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**49587** Repair umbilical hernia, age 5 years or older; incarcerated or strangulated

**Global:** 090

**Issue:** Hernia Repair

**Screen:** Site of Service Anomaly

**Complete?** Yes

**Most Recent  
RUC Meeting:** February 2011

**Tab** 29

**Specialty Developing  
Recommendation:** ACS

**First  
Identified:** September 2007

**2012 Est  
Medicare  
Utilization:** 9,365

**2007 Work RVU:** 7.96

**2013 Work RVU:** 7.08

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 3.77

**2013 Fac PE RVU:** 5.58

**Result:** Maintain

**RUC Recommendation:** 8.04

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**49652** Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible **Global:** 090 **Issue:** Laparoscopic Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** February 2011 **Tab** 30 **Specialty Developing Recommendation:** ACS **First Identified:** June 2010 **2012 Est Medicare Utilization:** 7,690 **2007 Work RVU:** **2007 NF PE RVU:** **2007 Fac PE RVU Result:** Maintain **2013 Work RVU:** 11.92 **2013 NF PE RVU:** NA **2013 Fac PE RVU:** 7.61  
**RUC Recommendation:** 12.88 **CPT Action (if applicable):**  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**49653** Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated **Global:** 090 **Issue:** Laparoscopic Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** February 2011 **Tab** 30 **Specialty Developing Recommendation:** ACS **First Identified:** June 2010 **2012 Est Medicare Utilization:** 3,516 **2007 Work RVU:** **2007 NF PE RVU:** **2007 Fac PE RVU Result:** Maintain **2013 Work RVU:** 14.94 **2013 NF PE RVU:** NA **2013 Fac PE RVU:** 9.38  
**RUC Recommendation:** 16.21 **CPT Action (if applicable):**  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**49654** Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible **Global:** 090 **Issue:** Laparoscopic Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** February 2011 **Tab** 30 **Specialty Developing Recommendation:** ACS **First Identified:** June 2010 **2012 Est Medicare Utilization:** 6,691 **2007 Work RVU:** **2007 NF PE RVU:** **2007 Fac PE RVU Result:** Maintain **2013 Work RVU:** 13.76 **2013 NF PE RVU:** NA **2013 Fac PE RVU:** 8.35  
**RUC Recommendation:** 15.03 **CPT Action (if applicable):**  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**49655** Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated **Global:** 090 **Issue:** Laparoscopic Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** February 2011 **Tab** 30 **Specialty Developing Recommendation:** ACS **First Identified:** June 2010 **2012 Est Medicare Utilization:** 3,274 **2007 Work RVU:** **2007 NF PE RVU:** **2007 Fac PE RVU Result:** Maintain **2013 Work RVU:** 16.84 **2013 NF PE RVU:** NA **2013 Fac PE RVU:** 10.13  
**RUC Recommendation:** 18.11 **CPT Action (if applicable):**  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

# Status Report: CMS Requests and Relativity Assessment Issues

50021	Drainage of perirenal or renal abscess; percutaneous			Global:	000	Issue:	Drainage of Abscess		Screen:	Codes Reported Together 75% or More-Part2		Complete?	Yes
Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:		First Identified:	January 2012	2012 Est Medicare Utilization:	792		2007 Work RVU:	3.37		2013 Work RVU:	3.37
									2007 NF PE RVU:	21.23		2013 NF PE RVU:	24.47
									2007 Fac PE RVU	1.07		2013 Fac PE RVU:	1.17
RUC Recommendation:	Deleted from CPT			CPT Action (if applicable): Referred to CPT Asst	<input type="checkbox"/>	October 2012	Published in CPT Asst:		Result:	Deleted from CPT			
50200	Renal biopsy; percutaneous, by trocar or needle			Global:	000	Issue:	Interventional Radiology Procedures		Screen:	CMS Request - Practice Expense Review		Complete?	Yes
Most Recent RUC Meeting:	Tab	13	Specialty Developing Recommendation:	ACR, SIR	First Identified:	NA	2012 Est Medicare Utilization:	31,692	2007 Work RVU:	2.63		2013 Work RVU:	2.63
									2007 NF PE RVU:	NA		2013 NF PE RVU:	14.90
									2007 Fac PE RVU	1.24		2013 Fac PE RVU:	1.28
RUC Recommendation:	New PE Inputs			CPT Action (if applicable): Referred to CPT Asst	<input type="checkbox"/>		Published in CPT Asst:		Result:	PE Only			
50360	Renal allotransplantation, implantation of graft; without recipient nephrectomy			Global:	090	Issue:	Renal Allotransplantation		Screen:	Harvard-Valued Annual Allowed Charges Greater than \$10 million		Complete?	Yes
Most Recent RUC Meeting:	Tab	21	Specialty Developing Recommendation:		First Identified:		2012 Est Medicare Utilization:	9,626	2007 Work RVU:	40.45		2013 Work RVU:	40.90
									2007 NF PE RVU:	NA		2013 NF PE RVU:	NA
									2007 Fac PE RVU	16.32		2013 Fac PE RVU:	26.87
RUC Recommendation:	40.90			CPT Action (if applicable): Referred to CPT Asst	<input type="checkbox"/>		Published in CPT Asst:		Result:	Maintain			

## Status Report: CMS Requests and Relativity Assessment Issues

<b>50392</b>	Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous	<b>Global:</b> 000	<b>Issue:</b> Introduction of Catheter or Stent - Renal	<b>Screen:</b> Codes Reported Together 75% or More-Part2	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b>	<b>Specialty Developing Recommendation:</b> ACR, SIR	<b>First Identified:</b> October 2012	<b>2012 Est Medicare Utilization:</b> 22,032	<b>2007 Work RVU:</b> 3.37 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 1.46 <b>2013 Work RVU:</b> 3.37 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 1.55
<b>RUC Recommendation:</b> Refer to CPT to bundle.			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>CPT 2016 cycle</b> <b>Published in CPT Asst:</b>	<b>Result:</b>
<hr/>					
<b>50393</b>	Introduction of ureteral catheter or stent into ureter through renal pelvis for drainage and/or injection, percutaneous	<b>Global:</b> 000	<b>Issue:</b> Introduction of Catheter or Stent - Renal	<b>Screen:</b> Codes Reported Together 75% or More-Part2	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b>	<b>Specialty Developing Recommendation:</b> ACR, SIR	<b>First Identified:</b> October 2012	<b>2012 Est Medicare Utilization:</b> 12,023	<b>2007 Work RVU:</b> 4.15 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 1.71 <b>2013 Work RVU:</b> 4.15 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 1.82
<b>RUC Recommendation:</b> Refer to CPT to bundle.			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>CPT 2016 cycle</b> <b>Published in CPT Asst:</b>	<b>Result:</b>
<hr/>					
<b>50394</b>	Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter	<b>Global:</b> 000	<b>Issue:</b> Introduction of Catheter or Stent - Renal	<b>Screen:</b> Codes Reported Together 75% or More-Part2	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b>	<b>Specialty Developing Recommendation:</b> ACR, SIR	<b>First Identified:</b> October 2012	<b>2012 Est Medicare Utilization:</b> 29,243	<b>2007 Work RVU:</b> 0.76 <b>2007 NF PE RVU:</b> 2.45 <b>2007 Fac PE RVU:</b> 0.63 <b>2013 Work RVU:</b> 0.76 <b>2013 NF PE RVU:</b> 2.22 <b>2013 Fac PE RVU:</b> 0.64
<b>RUC Recommendation:</b> Refer to CPT to bundle.			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>CPT 2016 cycle</b> <b>Published in CPT Asst:</b>	<b>Result:</b>

## Status Report: CMS Requests and Relativity Assessment Issues

50398	Change of nephrostomy or pyelostomy tube			Global: 000	Issue: Introduction of Catheter or Stent - Renal	Screen: Codes Reported Together 75% or More-Part2	Complete?	No												
Most Recent RUC Meeting:	October 2012	Tab	Specialty Developing Recommendation:	ACR, SIR	First Identified:	October 2012	2012 Est Medicare Utilization:	31,077	2007 Work RVU:	1.46	2013 Work RVU:	1.46	2007 NF PE RVU:	15.06	2013 NF PE RVU:	13.54	2007 Fac PE RVU	0.51	2013 Fac PE RVU:	0.54
RUC Recommendation:				Refer to CPT to bundle.				CPT Action (if applicable): Referred to CPT Asst		<input type="checkbox"/>		CPT 2016 cycle		Published in CPT Asst:		Result:				
50542	Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed			Global: 090	Issue: Laproscopic Procedures	Screen: CMS Fastest Growing	Complete?	Yes												
Most Recent RUC Meeting:	October 2008	Tab 26	Specialty Developing Recommendation:	AUA	First Identified:	October 2008	2012 Est Medicare Utilization:	522	2007 Work RVU:	21.18	2013 Work RVU:	21.36	2007 NF PE RVU:	NA	2013 NF PE RVU:	NA	2007 Fac PE RVU	8.93	2013 Fac PE RVU:	10.22
RUC Recommendation:				Remove from screen				CPT Action (if applicable): Referred to CPT Asst		<input type="checkbox"/>		Published in CPT Asst:		Result:		Remove from Screen				
50548	Laparoscopy, surgical; nephrectomy with total ureterectomy			Global: 090	Issue: Laproscopic Procedures	Screen: CMS Fastest Growing	Complete?	Yes												
Most Recent RUC Meeting:	October 2008	Tab 26	Specialty Developing Recommendation:	AUA	First Identified:	October 2008	2012 Est Medicare Utilization:	1,736	2007 Work RVU:	25.26	2013 Work RVU:	25.36	2007 NF PE RVU:	NA	2013 NF PE RVU:	NA	2007 Fac PE RVU	9.99	2013 Fac PE RVU:	10.98
RUC Recommendation:				Remove from screen				CPT Action (if applicable): Referred to CPT Asst		<input type="checkbox"/>		Published in CPT Asst:		Result:		Remove from Screen				
50590	Lithotripsy, extracorporeal shock wave			Global: 090	Issue: Lithotripsy	Screen: CMS High Expenditure Procedural Codes	Complete?	Yes												
Most Recent RUC Meeting:	April 2012	Tab 42	Specialty Developing Recommendation:	AUA	First Identified:	September 2011	2012 Est Medicare Utilization:	60,188	2007 Work RVU:	9.64	2013 Work RVU:	9.77	2007 NF PE RVU:	13.6	2013 NF PE RVU:	10.27	2007 Fac PE RVU	4.65	2013 Fac PE RVU:	5.73
RUC Recommendation:				9.77				CPT Action (if applicable): Referred to CPT Asst		<input type="checkbox"/>		Published in CPT Asst:		Result:		Maintain				

# Status Report: CMS Requests and Relativity Assessment Issues

## 50605 Ureterotomy for insertion of indwelling stent, all types

Global: 090

Issue: Ureterotomy

Screen: CMS Fastest Growing

Complete? No

**Most Recent**  
**RUC Meeting:** September 2011

**Tab 51**  
**Specialty Developing Recommendation:** AUA, SIR

**First Identified:** October 2008

**2012 Est Medicare Utilization:** 2,835

**2007 Work RVU:** 16.66

**2013 Work RVU:** 16.79

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 7.06

**2013 Fac PE RVU:** 9.18

**Result:**

**RUC Recommendation:** Review September 2014. CPT Assistant article published.

**CPT Action (if applicable):**

**Referred to CPT Asst** ☒

**Published in CPT Asst:** Dec 2009

## 51040 Cystostomy, cystotomy with drainage

Global: 090

Issue: Cystostomy

Screen: Site of Service Anomaly (99238-Only)

Complete? Yes

**Most Recent**  
**RUC Meeting:** September 2007

**Tab 16**  
**Specialty Developing Recommendation:** AUA

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 6,016

**2007 Work RVU:** 4.43

**2013 Work RVU:** 4.49

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 3.01

**2013 Fac PE RVU:** 3.49

**Result:** PE Only

**RUC Recommendation:** Reduce 99238 to 0.5

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## 51102 Aspiration of bladder; with insertion of suprapubic catheter

Global: 000

Issue: Urological Procedures

Screen: Site of Service Anomaly

Complete? Yes

**Most Recent**  
**RUC Meeting:** April 2008

**Tab 45**  
**Specialty Developing Recommendation:** AUA

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 13,873

**2007 Work RVU:**

**2013 Work RVU:** 2.70

**2007 NF PE RVU:**

**2013 NF PE RVU:** 3.70

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 1.23

**Result:** Decrease

**RUC Recommendation:** 2.70

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## 51726 Complex cystometrogram (ie, calibrated electronic equipment);

Global: 000

Issue: Urodynamic Studies

Screen: Codes Reported Together 95% or More

Complete? Yes

**Most Recent**  
**RUC Meeting:** April 2009

**Tab 16**  
**Specialty Developing Recommendation:** AUA, ACOG

**First Identified:** February 2008

**2012 Est Medicare Utilization:** 13,454

**2007 Work RVU:** 1.71

**2013 Work RVU:** 1.71

**2007 NF PE RVU:** 7.41

**2013 NF PE RVU:** 6.00

**2007 Fac PE RVU** 7.41

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** 1.71

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

February 2009

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

---

<b>51727</b>	<b>Complex cystometrogram (ie, calibrated electronic equipment); with urethral pressure profile studies (ie, urethral closure pressure profile), any technique</b>	<b>Global:</b> 000	<b>Issue:</b> Urodynamic Studies	<b>Screen:</b> Codes Reported Together 95% or More	<b>Complete?</b> Yes
--------------	--	--------------------	----------------------------------	--	----------------------

**Most Recent RUC Meeting:** April 2009

**Tab 16 Specialty Developing Recommendation:** AUA, ACOG

**First Identified:**

**2012 Est Medicare Utilization:** 4,025

**2007 Work RVU:**

**2013 Work RVU:** 2.11

**2007 NF PE RVU:**

**2013 NF PE RVU:** 7.09

**2007 Fac PE RVU**

**2013 Fac PE RVU:** NA

**RUC Recommendation:** 2.11

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

---

<b>51728</b>	<b>Complex cystometrogram (ie, calibrated electronic equipment); with voiding pressure studies (ie, bladder voiding pressure), any technique</b>	<b>Global:</b> 000	<b>Issue:</b> Urodynamic Studies	<b>Screen:</b> Codes Reported Together 95% or More	<b>Complete?</b> Yes
--------------	--	--------------------	----------------------------------	--	----------------------

**Most Recent RUC Meeting:** April 2009

**Tab 16 Specialty Developing Recommendation:** AUA, ACOG

**First Identified:**

**2012 Est Medicare Utilization:** 74,267

**2007 Work RVU:**

**2013 Work RVU:** 2.11

**2007 NF PE RVU:**

**2013 NF PE RVU:** 7.08

**2007 Fac PE RVU**

**2013 Fac PE RVU:** NA

**RUC Recommendation:** 2.11

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

---

<b>51729</b>	<b>Complex cystometrogram (ie, calibrated electronic equipment); with voiding pressure studies (ie, bladder voiding pressure) and urethral pressure profile studies (ie, urethral closure pressure profile), any technique</b>	<b>Global:</b> 000	<b>Issue:</b> Urodynamic Studies	<b>Screen:</b> Codes Reported Together 95% or More	<b>Complete?</b> Yes
--------------	--	--------------------	----------------------------------	--	----------------------

**Most Recent RUC Meeting:** April 2009

**Tab 16 Specialty Developing Recommendation:** AUA, ACOG

**First Identified:**

**2012 Est Medicare Utilization:** 96,141

**2007 Work RVU:**

**2013 Work RVU:** 2.51

**2007 NF PE RVU:**

**2013 NF PE RVU:** 7.45

**2007 Fac PE RVU**

**2013 Fac PE RVU:** NA

**RUC Recommendation:** 2.51

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease



## Status Report: CMS Requests and Relativity Assessment Issues

---

**51736** Simple uroflowmetry (UFR) (eg, stop-watch flow rate, mechanical uroflowmeter)      **Global:** XXX      **Issue:** Uroflowmetry      **Screen:** Harvard Valued - Utilization over 100,000      **Complete?** Yes

**Most Recent RUC Meeting:** October 2010      **Tab** 11      **Specialty Developing Recommendation:** AUA      **First Identified:** February 2010      **2012 Est Medicare Utilization:** 10,306      **2007 Work RVU:** 0.61      **2013 Work RVU:** 0.17  
**2007 NF PE RVU:** 0.67      **2013 NF PE RVU:** 0.26  
**2007 Fac PE RVU:** 0.67      **2013 Fac PE RVU:** NA  
**Result:** Decrease

**RUC Recommendation:** 0.17      **CPT Action (if applicable):**  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

---

**51741** Complex uroflowmetry (eg, calibrated electronic equipment)      **Global:** XXX      **Issue:** Uroflowmetry      **Screen:** Harvard Valued - Utilization over 100,000      **Complete?** Yes

**Most Recent RUC Meeting:** October 2010      **Tab** 11      **Specialty Developing Recommendation:** AUA      **First Identified:** October 2009      **2012 Est Medicare Utilization:** 615,158      **2007 Work RVU:** 1.14      **2013 Work RVU:** 0.17  
**2007 NF PE RVU:** 0.91      **2013 NF PE RVU:** 0.27  
**2007 Fac PE RVU:** 0.91      **2013 Fac PE RVU:** NA  
**Result:** Decrease

**RUC Recommendation:** 0.17      **CPT Action (if applicable):**  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

---

**51772** Deleted from CPT      **Global:** 000      **Issue:** Urodynamic Studies      **Screen:** Codes Reported Together 95% or More / CMS Fastest Growing      **Complete?** Yes

**Most Recent RUC Meeting:** April 2009      **Tab** 16      **Specialty Developing Recommendation:** AUA      **First Identified:** February 2008      **2012 Est Medicare Utilization:**      **2007 Work RVU:** 1.61      **2013 Work RVU:**  
**2007 NF PE RVU:** 5.44      **2013 NF PE RVU:**  
**2007 Fac PE RVU:** 5.44      **2013 Fac PE RVU:**  
**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT      **CPT Action (if applicable):** February 2009  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

---

## Status Report: CMS Requests and Relativity Assessment Issues

<b>51784</b>	<b>Electromyography studies (EMG) of anal or urethral sphincter, other than needle, any technique</b>	<b>Global:</b> 000	<b>Issue:</b> Urinary Reflex Studies with EMG	<b>Screen:</b> Codes Reported Together 75% or More-Part2	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b>	<b>Specialty Developing Recommendation:</b> AUA	<b>First Identified:</b> October 2012	<b>2012 Est Medicare Utilization:</b> 186,414	<b>2007 Work RVU:</b> 1.53 <b>2007 NF PE RVU:</b> 3.95 <b>2007 Fac PE RVU</b> 3.95 <b>2013 Work RVU:</b> 1.53 <b>2013 NF PE RVU:</b> 4.06 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Refer to CPT Editorial Panel to add parenthetical and develop CPT assistant article indicating that 51792 and 51784 should not be reported together.			<b>CPT Action (if applicable):</b> 2015 CPT cycle		<b>Result:</b>
			<b>Referred to CPT Asst</b> <input checked="" type="checkbox"/>	<b>Published in CPT Asst:</b>	
<hr/>					
<b>51792</b>	<b>Stimulus evoked response (eg, measurement of bulbocavernosus reflex latency time)</b>	<b>Global:</b> 000	<b>Issue:</b> Urinary Reflex Studies with EMG	<b>Screen:</b> Codes Reported Together 75% or More-Part2	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b>	<b>Specialty Developing Recommendation:</b> AUA	<b>First Identified:</b> October 2012	<b>2012 Est Medicare Utilization:</b> 18,085	<b>2007 Work RVU:</b> 1.10 <b>2007 NF PE RVU:</b> 5.74 <b>2007 Fac PE RVU</b> 5.74 <b>2013 Work RVU:</b> 1.10 <b>2013 NF PE RVU:</b> 5.14 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Refer to CPT Editorial Panel to add parenthetical and develop CPT assistant article indicating that 51792 and 51784 should not be reported together.			<b>CPT Action (if applicable):</b> 2015 CPT cycle		<b>Result:</b>
			<b>Referred to CPT Asst</b> <input checked="" type="checkbox"/>	<b>Published in CPT Asst:</b>	
<hr/>					
<b>51795</b>	<b>Deleted from CPT</b>	<b>Global:</b> 000	<b>Issue:</b> Urology Studies	<b>Screen:</b> Codes Reported Together 95% or More	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2008	<b>Tab</b> S	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> February 2008	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> 1.53 <b>2007 NF PE RVU:</b> 7.15 <b>2007 Fac PE RVU</b> 7.15 <b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>
<b>RUC Recommendation:</b> Deleted from CPT			<b>CPT Action (if applicable):</b> February 2009		<b>Result:</b> Deleted from CPT
			<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	

# Status Report: CMS Requests and Relativity Assessment Issues

**51797** Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal)  
(List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Urology Studies **Screen:** Codes Reported Together 95% or More **Complete?** Yes

**Most Recent RUC Meeting:** February 2008

**Tab** S

**Specialty Developing Recommendation:**

**First Identified:** February 2008

**2012 Est Medicare Utilization:** 152,179

**2007 Work RVU:** 1.60

**2013 Work RVU:** 0.80

**2007 NF PE RVU:** 5.55

**2013 NF PE RVU:** 2.48

**2007 Fac PE RVU** 5.55

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** 0.80

**CPT Action (if applicable):** February 2009

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**52000** Cystourethroscopy (separate procedure)

**Global:** 000

**Issue:**

**Screen:** MPC List

**Complete?** Yes

**Most Recent RUC Meeting:** February 2011

**Tab** 41

**Specialty Developing Recommendation:**

**First Identified:** October 2010

**2012 Est Medicare Utilization:** 945,960

**2007 Work RVU:** 2.23

**2013 Work RVU:** 2.23

**2007 NF PE RVU:** 3.4

**2013 NF PE RVU:** 3.49

**2007 Fac PE RVU** 0.91

**2013 Fac PE RVU:** 1.20

**Result:** Maintain

**RUC Recommendation:** Reaffirmed RUC recommendation

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**52214** Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands

**Global:** 000

**Issue:** Cystourethroscopy

**Screen:** High Volume Growth1

**Complete?** Yes

**Most Recent RUC Meeting:** January 2012

**Tab** 16

**Specialty Developing Recommendation:** AUA

**First Identified:** June 2008

**2012 Est Medicare Utilization:** 20,435

**2007 Work RVU:** 3.70

**2013 Work RVU:** 3.50

**2007 NF PE RVU:** 33.55

**2013 NF PE RVU:** 15.75

**2007 Fac PE RVU** 1.47

**2013 Fac PE RVU:** 1.23

**Result:** Decrease

**RUC Recommendation:** 3.50. CPT Assistant article published.

**CPT Action (if applicable):**

**Referred to CPT Asst** ☒

**Published in CPT Asst:** Oct 2009

**52224** Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy

**Global:** 000

**Issue:** Cystourethroscopy

**Screen:** High Volume Growth1

**Complete?** Yes

**Most Recent RUC Meeting:** January 2012

**Tab** 16

**Specialty Developing Recommendation:** AUA

**First Identified:** February 2008

**2012 Est Medicare Utilization:** 51,482

**2007 Work RVU:** 3.14

**2013 Work RVU:** 4.05

**2007 NF PE RVU:** 32.11

**2013 NF PE RVU:** 16.00

**2007 Fac PE RVU** 1.28

**2013 Fac PE RVU:** 1.42

**Result:** Increase

**RUC Recommendation:** 4.05. CPT Assistant article published.

**CPT Action (if applicable):**

**Referred to CPT Asst** ☒

**Published in CPT Asst:** Oct 2009

## Status Report: CMS Requests and Relativity Assessment Issues

**52234** Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; **SMALL** bladder tumor(s) (0.5 up to 2.0 cm) **Global:** 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

**Most Recent RUC Meeting:** September 2011

**Tab 23 Specialty Developing Recommendation:** AUA

**First Identified:** September 2011

**2012 Est Medicare Utilization:** 27,227

**2007 Work RVU:** 4.62

**2013 Work RVU:** 4.62

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU:** 1.83

**2013 Fac PE RVU:** 2.03

**Result:** Maintain

**RUC Recommendation:** 4.62

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**52235** Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; **MEDIUM** bladder tumor(s) (2.0 to 5.0 cm) **Global:** 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

**Most Recent RUC Meeting:** September 2011

**Tab 23 Specialty Developing Recommendation:** AUA

**First Identified:** April 2011

**2012 Est Medicare Utilization:** 31,849

**2007 Work RVU:** 5.44

**2013 Work RVU:** 5.44

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU:** 2.13

**2013 Fac PE RVU:** 2.36

**Result:** Maintain

**RUC Recommendation:** 5.44

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**52240** Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; **LARGE** bladder tumor(s) **Global:** 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

**Most Recent RUC Meeting:** September 2011

**Tab 23 Specialty Developing Recommendation:** AUA

**First Identified:** September 2011

**2012 Est Medicare Utilization:** 23,620

**2007 Work RVU:** 9.71

**2013 Work RVU:** 7.50

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU:** 3.6

**2013 Fac PE RVU:** 3.08

**Result:** Decrease

**RUC Recommendation:** 8.75

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

<b>52281</b>	<b>Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female</b>	<b>Global:</b> 000	<b>Issue:</b> Cystourethroscopy	<b>Screen:</b> Harvard Valued - Utilization over 100,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab</b> 38 <b>Specialty Developing Recommendation:</b> AUA	<b>First Identified:</b> October 2009	<b>2012 Est Medicare Utilization:</b> 99,619	<b>2007 Work RVU:</b> 2.80 <b>2007 NF PE RVU:</b> 6.65 <b>2007 Fac PE RVU</b> 1.21 <b>Result:</b> Maintain	<b>2013 Work RVU:</b> 2.75 <b>2013 NF PE RVU:</b> 4.92 <b>2013 Fac PE RVU:</b> 1.38
<b>RUC Recommendation:</b> 2.80		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		
<hr/>					
<b>52332</b>	<b>Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)</b>	<b>Global:</b> 000	<b>Issue:</b> Cystourethroscopy	<b>Screen:</b> Harvard Valued - Utilization over 100,000 / Codes Reported Together 75% or More-Part2	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 13 <b>Specialty Developing Recommendation:</b> AUA	<b>First Identified:</b> October 2009	<b>2012 Est Medicare Utilization:</b> 161,732	<b>2007 Work RVU:</b> 2.83 <b>2007 NF PE RVU:</b> 7.42 <b>2007 Fac PE RVU</b> 1.19 <b>Result:</b> Maintain	<b>2013 Work RVU:</b> 2.82 <b>2013 NF PE RVU:</b> 11.97 <b>2013 Fac PE RVU:</b> 1.40
<b>RUC Recommendation:</b> 2.82		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b> February 2013		
<hr/>					
<b>52341</b>	<b>Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)</b>	<b>Global:</b> 000	<b>Issue:</b> Urological Procedures	<b>Screen:</b> Site of Service Anomaly	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2010	<b>Tab</b> 65 <b>Specialty Developing Recommendation:</b> AUA	<b>First Identified:</b> April 2008	<b>2012 Est Medicare Utilization:</b> 2,470	<b>2007 Work RVU:</b> 6.11 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU</b> 2.44 <b>Result:</b> Decrease	<b>2013 Work RVU:</b> 5.35 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 2.48
<b>RUC Recommendation:</b> 5.35		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

## Status Report: CMS Requests and Relativity Assessment Issues

**52342** Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision) **Global:** 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent** **Tab** 65 **Specialty Developing** AUA  
**RUC Meeting:** October 2010 **Recommendation:**

**First Identified:** April 2008

**2012 Est Medicare Utilization:** 288

**2007 Work RVU:** 6.61

**2013 Work RVU:** 5.85

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 2.59

**2013 Fac PE RVU:** 2.66

**Result:** Decrease

**RUC Recommendation:** 5.85

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**52343** Cystourethroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision) **Global:** 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent** **Tab** 65 **Specialty Developing** AUA  
**RUC Meeting:** October 2010 **Recommendation:**

**First Identified:** April 2008

**2012 Est Medicare Utilization:** 29

**2007 Work RVU:** 7.31

**2013 Work RVU:** 6.55

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 2.84

**2013 Fac PE RVU:** 2.90

**Result:** Decrease

**RUC Recommendation:** 6.55

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**52344** Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision) **Global:** 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent** **Tab** 65 **Specialty Developing** AUA  
**RUC Meeting:** October 2010 **Recommendation:**

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 2,895

**2007 Work RVU:** 7.81

**2013 Work RVU:** 7.05

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 3.09

**2013 Fac PE RVU:** 3.24

**Result:** Decrease

**RUC Recommendation:** 7.05

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**52345** Cystourethroscopy with ureteroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision) **Global:** 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent** **Tab** 65 **Specialty Developing** AUA  
**RUC Meeting:** October 2010 **Recommendation:**

**First Identified:** April 2008

**2012 Est Medicare Utilization:** 564

**2007 Work RVU:** 8.31

**2013 Work RVU:** 7.55

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 3.27

**2013 Fac PE RVU:** 3.42

**Result:** Decrease

**RUC Recommendation:** 7.55

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**52346** Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision) **Global:** 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent** **Tab** 65 **Specialty Developing** AUA  
**RUC Meeting:** October 2010 **Recommendation:**

**First**  
**Identified:** April 2008

**2012 Est**  
**Medicare**  
**Utilization:** 249

**2007 Work RVU:** 9.34

**2013 Work RVU:** 8.58

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 3.62

**2013 Fac PE RVU:** 3.80

**Result:** Decrease

**RUC Recommendation:** 8.58

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**52351** Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic

**Global:** 000

**Issue:** Cystourethroscopy and Ureteroscopy

**Screen:** Harvard Valued - Utilization over 30,000

**Complete?** Yes

**Most Recent** **Tab** 23 **Specialty Developing** AUA  
**RUC Meeting:** September 2011 **Recommendation:**

**First**  
**Identified:** September 2011

**2012 Est**  
**Medicare**  
**Utilization:** 20,605

**2007 Work RVU:** 5.85

**2013 Work RVU:** 5.75

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 2.36

**2013 Fac PE RVU:** 2.62

**Result:** Decrease

**RUC Recommendation:** 5.75

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**52352** Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)

**Global:** 000

**Issue:** Cystourethroscopy and Ureteroscopy

**Screen:** Harvard Valued - Utilization over 30,000

**Complete?** Yes

**Most Recent** **Tab** 23 **Specialty Developing** AUA  
**RUC Meeting:** September 2011 **Recommendation:**

**First**  
**Identified:** September 2011

**2012 Est**  
**Medicare**  
**Utilization:** 19,442

**2007 Work RVU:** 6.87

**2013 Work RVU:** 6.75

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 2.77

**2013 Fac PE RVU:** 3.07

**Result:** Decrease

**RUC Recommendation:** 6.75

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

<b>52353</b>	<b>Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)</b>	<b>Global:</b> 000	<b>Issue:</b> Cystourethroscopy	<b>Screen:</b> Harvard Valued - Utilization over 30,000 / Harvard-Valued Annual Allowed Charges Greater than \$10 million / Codes Reported Together 75% or More-Part2	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 13 <b>Specialty Developing Recommendation:</b> AUA	<b>First Identified:</b> April 2011	<b>2012 Est Medicare Utilization:</b> 44,968	<b>2007 Work RVU:</b> 7.96 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 3.14 <b>Result:</b> Decrease	<b>2013 Work RVU:</b> 7.50 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 3.33
<b>RUC Recommendation:</b> 7.50		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b> February 2013		
<b>52354</b>	<b>Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with biopsy and/or fulguration of ureteral or renal pelvic lesion</b>	<b>Global:</b> 000	<b>Issue:</b> Cystourethroscopy and Ureteroscopy	<b>Screen:</b> Harvard Valued - Utilization over 30,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> September 2011	<b>Tab</b> 23 <b>Specialty Developing Recommendation:</b> AUA	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 7,508	<b>2007 Work RVU:</b> 7.33 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 2.94 <b>Result:</b> Increase	<b>2013 Work RVU:</b> 8.00 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 3.51
<b>RUC Recommendation:</b> 8.58		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		
<b>52355</b>	<b>Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic tumor</b>	<b>Global:</b> 000	<b>Issue:</b> Cystourethroscopy and Ureteroscopy	<b>Screen:</b> Harvard Valued - Utilization over 30,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> September 2011	<b>Tab</b> 23 <b>Specialty Developing Recommendation:</b> AUA	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 1,035	<b>2007 Work RVU:</b> 8.81 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 3.44 <b>Result:</b> Increase	<b>2013 Work RVU:</b> 9.00 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 3.86
<b>RUC Recommendation:</b> 10.00		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		



# Status Report: CMS Requests and Relativity Assessment Issues

**52400** Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent** **Tab** 65 **Specialty Developing** AUA  
**RUC Meeting:** October 2010 **Recommendation:**

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 441

**2007 Work RVU:** 10.06 **2013 Work RVU:** 8.69  
**2007 NF PE RVU:** NA **2013 NF PE RVU:** NA  
**2007 Fac PE RVU:** 4.18 **2013 Fac PE RVU:** 4.28  
**Result:** Decrease

**RUC Recommendation:** 8.69

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**52500** Transurethral resection of bladder neck (separate procedure)

**Global:** 090 **Issue:** Urological Procedures

**Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent** **Tab** 65 **Specialty Developing** AUA  
**RUC Meeting:** October 2010 **Recommendation:**

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 4,550

**2007 Work RVU:** 9.39 **2013 Work RVU:** 8.14  
**2007 NF PE RVU:** NA **2013 NF PE RVU:** NA  
**2007 Fac PE RVU:** 4.52 **2013 Fac PE RVU:** 5.22  
**Result:** Decrease

**RUC Recommendation:** 8.14

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**52640** Transurethral resection; of postoperative bladder neck contracture

**Global:** 090 **Issue:** Urological Procedures

**Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent** **Tab** 45 **Specialty Developing** AUA  
**RUC Meeting:** April 2008 **Recommendation:**

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 1,876

**2007 Work RVU:** 6.89 **2013 Work RVU:** 4.79  
**2007 NF PE RVU:** NA **2013 NF PE RVU:** NA  
**2007 Fac PE RVU:** 3.35 **2013 Fac PE RVU:** 3.93  
**Result:** Decrease

**RUC Recommendation:** 4.79

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**52648** Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)

**Global:** 090 **Issue:** Laser Surgery of Prostate

**Screen:** High Volume Growth1 **Complete?** Yes

**Most Recent** **Tab** 57 **Specialty Developing** AUA  
**RUC Meeting:** April 2008 **Recommendation:**

**First Identified:** February 2008

**2012 Est Medicare Utilization:** 27,775

**2007 Work RVU:** 12.00 **2013 Work RVU:** 12.15  
**2007 NF PE RVU:** 66.1 **2013 NF PE RVU:** 40.98  
**2007 Fac PE RVU:** 5.44 **2013 Fac PE RVU:** 6.63  
**Result:** Remove from Screen

**RUC Recommendation:** Remove from screen

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

53256X

Global: 000

Issue: Cystourethroscopy

Screen: Codes Reported Together 75% or More-Part2

Complete? Yes

Most Recent  
RUC Meeting: April 2013

Tab 13

Specialty Developing  
Recommendation: AUA

First  
Identified: January 2013

2012 Est  
Medicare  
Utilization:

2007 Work RVU:

2013 Work RVU:

2007 NF PE RVU:

2013 NF PE RVU:

2007 Fac PE RVU

2013 Fac PE RVU:

Result: Decrease

RUC Recommendation: 8.00

CPT Action (if applicable):

Referred to CPT Asst ☐

Published in CPT Asst:

53445 Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff

Global: 090

Issue: Urological Procedures

Screen: Site of Service Anomaly

Complete? Yes

Most Recent  
RUC Meeting: February 2011

Tab 31

Specialty Developing  
Recommendation: AUA

First  
Identified: September 2007

2012 Est  
Medicare  
Utilization: 1,973

2007 Work RVU: 15.21

2013 Work RVU: 13.00

2007 NF PE RVU: NA

2013 NF PE RVU: NA

2007 Fac PE RVU 7.55

2013 Fac PE RVU: 7.52

Result: Decrease

RUC Recommendation: 13.00

CPT Action (if applicable):

Referred to CPT Asst ☐

Published in CPT Asst:

53850 Transurethral destruction of prostate tissue; by microwave thermotherapy

Global: 090

Issue: Transurethral Destruction of Prostate Tissue

Screen: CMS High Expenditure Procedural Codes

Complete? Yes

Most Recent  
RUC Meeting: April 2012

Tab 43

Specialty Developing  
Recommendation: AUA

First  
Identified: September 2011

2012 Est  
Medicare  
Utilization: 11,808

2007 Work RVU: 9.98

2013 Work RVU: 10.08

2007 NF PE RVU: 82.87

2013 NF PE RVU: 50.70

2007 Fac PE RVU 4.46

2013 Fac PE RVU: 6.55

Result: Maintain

RUC Recommendation: 10.08

CPT Action (if applicable):

Referred to CPT Asst ☐

Published in CPT Asst:

## Status Report: CMS Requests and Relativity Assessment Issues

**54405** Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent** **Tab** 45 **Specialty Developing** AUA  
**RUC Meeting:** April 2008 **Recommendation:**

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 5,321

**2007 Work RVU:** 14.39

**2013 Work RVU:** 14.52

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 6.51

**2013 Fac PE RVU:** 7.42

**Result:** Maintain

**RUC Recommendation:** 14.39

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**54410** Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent** **Tab** 31 **Specialty Developing** AUA  
**RUC Meeting:** February 2011 **Recommendation:**

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 1,296

**2007 Work RVU:** 16.48

**2013 Work RVU:** 15.18

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 7.35

**2013 Fac PE RVU:** 8.19

**Result:** Decrease

**RUC Recommendation:** 15.18

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**54520** Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach **Global:** 090 **Issue:** Removal of Testical **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

**Most Recent** **Tab** 16 **Specialty Developing** AUA  
**RUC Meeting:** September 2007 **Recommendation:**

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 3,497

**2007 Work RVU:** 5.25

**2013 Work RVU:** 5.30

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 3.03

**2013 Fac PE RVU:** 3.62

**Result:** PE Only

**RUC Recommendation:** Reduce 99238 to 0.5

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**54530** Orchiectomy, radical, for tumor; inguinal approach **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent** **Tab** 65 **Specialty Developing** AUA  
**RUC Meeting:** October 2010 **Recommendation:**

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 1,264

**2007 Work RVU:** 9.31

**2013 Work RVU:** 8.46

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 4.72

**2013 Fac PE RVU:** 5.36

**Result:** Decrease

**RUC Recommendation:** 8.46

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

# Status Report: CMS Requests and Relativity Assessment Issues

<b>55866</b>	<b>Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed</b>	<b>Global:</b> 090	<b>Issue:</b> Lap Radical Prostatectomy	<b>Screen:</b> New Technology / CMS Fastest Growing	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2009	<b>Tab</b> 14 <b>Specialty Developing Recommendation:</b> AUA	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 13,555	<b>2007 Work RVU:</b> 32.25 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 12.87 <b>Result:</b> Decrease	<b>2013 Work RVU:</b> 32.06 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 14.88
<b>RUC Recommendation:</b> 32.06		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		
<hr/>					
<b>55873</b>	<b>Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)</b>	<b>Global:</b> 090	<b>Issue:</b> Cryoablation of Prostate	<b>Screen:</b> CMS Request - Practice Expense Review	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2009	<b>Tab</b> 25 <b>Specialty Developing Recommendation:</b> AUA	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 2,435	<b>2007 Work RVU:</b> 20.25 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 9.59 <b>Result:</b> Decrease	<b>2013 Work RVU:</b> 13.60 <b>2013 NF PE RVU:</b> 192.13 <b>2013 Fac PE RVU:</b> 7.17
<b>RUC Recommendation:</b> 13.45		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		
<hr/>					
<b>56515</b>	<b>Destruction of lesion(s), vulva; extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)</b>	<b>Global:</b> 010	<b>Issue:</b> Destruction of Lesions	<b>Screen:</b> Site of Service Anomaly (99238-Only)	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> September 2007	<b>Tab</b> 16 <b>Specialty Developing Recommendation:</b> ACOG	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 1,973	<b>2007 Work RVU:</b> 3.03 <b>2007 NF PE RVU:</b> 2.5 <b>2007 Fac PE RVU:</b> 1.79 <b>Result:</b> PE Only	<b>2013 Work RVU:</b> 3.08 <b>2013 NF PE RVU:</b> 3.14 <b>2013 Fac PE RVU:</b> 2.39
<b>RUC Recommendation:</b> Reduce 99238 to 0.5		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		
<hr/>					
<b>56620</b>	<b>Vulvectomy simple; partial</b>	<b>Global:</b> 090	<b>Issue:</b> Partial Removal of Vulva	<b>Screen:</b> Site of Service Anomaly	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2008	<b>Tab</b> D <b>Specialty Developing Recommendation:</b> ACOG	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 2,697	<b>2007 Work RVU:</b> 8.44 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 4.7 <b>Result:</b> Decrease	<b>2013 Work RVU:</b> 7.53 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 6.45
<b>RUC Recommendation:</b> 7.35		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

# Status Report: CMS Requests and Relativity Assessment Issues

**57155** Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy **Global:** 000 **Issue:** Vaginal Radiation Afterloading Apparatus for Clinical Brachytherapy **Screen:** Site of Service Anomaly / Different Performing Specialty from Survey **Complete?** Yes

**Most Recent RUC Meeting:** February 2010

**Tab** 12

**Specialty Developing Recommendation:** ACOG, ASTRO

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 3,635

**2007 Work RVU:** 6.79

**2013 Work RVU:** 5.40

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** 7.18

**2007 Fac PE RVU:** 4.3

**2013 Fac PE RVU:** 2.41

**RUC Recommendation:** 5.40

**CPT Action (if applicable):** October 2009  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Decrease

**57156** Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy **Global:** 000 **Issue:** Vaginal Radiation Afterloading Apparatus for Clinical Brachytherapy **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** February 2010

**Tab** 12

**Specialty Developing Recommendation:** ACOG, ASTRO

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 8,746

**2007 Work RVU:**

**2013 Work RVU:** 2.69

**2007 NF PE RVU:**

**2013 NF PE RVU:** 2.78

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 1.27

**RUC Recommendation:** 2.69

**CPT Action (if applicable):** October 2009  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Decrease

**57287** Removal or revision of sling for stress incontinence (eg, fascia or synthetic) **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** February 2008

**Tab** C

**Specialty Developing Recommendation:** AUA

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 2,887

**2007 Work RVU:** 11.49

**2013 Work RVU:** 11.15

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 5.73

**2013 Fac PE RVU:** 7.42

**RUC Recommendation:** 10.97

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Decrease

**57288** Sling operation for stress incontinence (eg, fascia or synthetic) **Global:** 090 **Issue:** Sling Operation for Stress Incontinence **Screen:** New Technology **Complete?** Yes

**Most Recent RUC Meeting:** February 2008

**Tab** O

**Specialty Developing Recommendation:** ACOG, AUA

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 34,970

**2007 Work RVU:** 14.01

**2013 Work RVU:** 12.13

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 6.21

**2013 Fac PE RVU:** 7.28

**RUC Recommendation:** 12.00

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Decrease

# Status Report: CMS Requests and Relativity Assessment Issues

<b>58555</b>	<b>Hysteroscopy, diagnostic (separate procedure)</b>		<b>Global:</b> 000	<b>Issue:</b> Hysteroscopy	<b>Screen:</b> CMS Request - Practice Expense Review	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2009	<b>Tab</b> 26	<b>Specialty Developing Recommendation:</b>	ACOG	<b>First Identified:</b> NA	<b>2012 Est Medicare Utilization:</b> 1,829	<b>2007 Work RVU:</b> 3.33 <b>2007 NF PE RVU:</b> 2.32 <b>2007 Fac PE RVU:</b> 1.47 <b>Result:</b> PE Only
<b>RUC Recommendation:</b> New PE inputs				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 3.33 <b>2013 NF PE RVU:</b> 5.26 <b>2013 Fac PE RVU:</b> 1.79

<b>58558</b>	<b>Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D &amp; C</b>		<b>Global:</b> 000	<b>Issue:</b> Hysteroscopy	<b>Screen:</b> CMS Request - Practice Expense Review	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2009	<b>Tab</b> 26	<b>Specialty Developing Recommendation:</b>	ACOG	<b>First Identified:</b> NA	<b>2012 Est Medicare Utilization:</b> 40,848	<b>2007 Work RVU:</b> 4.74 <b>2007 NF PE RVU:</b> 2.52 <b>2007 Fac PE RVU:</b> 2.05 <b>Result:</b> PE Only
<b>RUC Recommendation:</b> New PE inputs				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 4.74 <b>2013 NF PE RVU:</b> 6.39 <b>2013 Fac PE RVU:</b> 2.43

<b>58562</b>	<b>Hysteroscopy, surgical; with removal of impacted foreign body</b>		<b>Global:</b> 000	<b>Issue:</b> Hysteroscopy	<b>Screen:</b> CMS Request - Practice Expense Review	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2009	<b>Tab</b> 26	<b>Specialty Developing Recommendation:</b>	ACOG	<b>First Identified:</b> NA	<b>2012 Est Medicare Utilization:</b> 167	<b>2007 Work RVU:</b> 5.20 <b>2007 NF PE RVU:</b> 2.63 <b>2007 Fac PE RVU:</b> 2.21 <b>Result:</b> PE Only
<b>RUC Recommendation:</b> New PE inputs				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 5.20 <b>2013 NF PE RVU:</b> 6.27 <b>2013 Fac PE RVU:</b> 2.59

<b>58563</b>	<b>Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)</b>		<b>Global:</b> 000	<b>Issue:</b> Hysteroscopy	<b>Screen:</b> CMS Request - Practice Expense Review	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2009	<b>Tab</b> 26	<b>Specialty Developing Recommendation:</b>	ACOG	<b>First Identified:</b> NA	<b>2012 Est Medicare Utilization:</b> 6,102	<b>2007 Work RVU:</b> 6.16 <b>2007 NF PE RVU:</b> 51.38 <b>2007 Fac PE RVU:</b> 2.58 <b>Result:</b> PE Only
<b>RUC Recommendation:</b> New PE inputs				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 6.16 <b>2013 NF PE RVU:</b> 43.80 <b>2013 Fac PE RVU:</b> 3.03

58660	Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)			Global: 090	Issue: Laproscopic Procedures	Screen: Site of Service Anomaly (99238-Only)	Complete? Yes	
Most Recent RUC Meeting:	September 2007	Tab 16	Specialty Developing Recommendation:	AUA, ACOG	First Identified: September 2007	2012 Est Medicare Utilization: 1,759	2007 Work RVU: 11.54 2007 NF PE RVU: NA 2007 Fac PE RVU 5.07 Result: PE Only	2013 Work RVU: 11.59 2013 NF PE RVU: NA 2013 Fac PE RVU: 6.49
RUC Recommendation: Reduce 99238 to 0.5				CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:		
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)			Global: 010	Issue: Laproscopic Procedures	Screen: Site of Service Anomaly (99238-Only)	Complete? Yes	
Most Recent RUC Meeting:	September 2007	Tab 16	Specialty Developing Recommendation:	ACOG	First Identified: September 2007	2012 Est Medicare Utilization: 10,965	2007 Work RVU: 11.30 2007 NF PE RVU: NA 2007 Fac PE RVU 4.84 Result: PE Only	2013 Work RVU: 11.35 2013 NF PE RVU: NA 2013 Fac PE RVU: 5.95
RUC Recommendation: Reduce 99238 to 0.5				CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:		
58823	Drainage of pelvic abscess, transvaginal or transrectal approach, percutaneous (eg, ovarian, pericolic)			Global: 000	Issue: Drainage of Abscess	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes	
Most Recent RUC Meeting:		Tab	Specialty Developing Recommendation:		First Identified: January 2012	2012 Est Medicare Utilization: 316	2007 Work RVU: 3.37 2007 NF PE RVU: 20.75 2007 Fac PE RVU 1.08 Result: Deleted from CPT	2013 Work RVU: 3.37 2013 NF PE RVU: 23.33 2013 Fac PE RVU: 1.19
RUC Recommendation: Deleted from CPT				CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:		

## Status Report: CMS Requests and Relativity Assessment Issues

<b>59400</b>	<b>Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care</b>	<b>Global:</b> MMM	<b>Issue:</b> Obstetrical Care	<b>Screen:</b> High IWPUT	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2009	<b>Tab 15</b>	<b>Specialty Developing Recommendation:</b> ACOG, AAFP	<b>First Identified:</b> February 2008	<b>2012 Est Medicare Utilization:</b> 4,365	<b>2007 Work RVU:</b> 26.80 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU Result:</b> Increase <b>2013 Work RVU:</b> 32.16 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 22.09
<b>RUC Recommendation:</b> 32.69			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	
<hr/>					
<b>59409</b>	<b>Vaginal delivery only (with or without episiotomy and/or forceps);</b>	<b>Global:</b> MMM	<b>Issue:</b> Obstetrical Care	<b>Screen:</b> High IWPUT	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2009	<b>Tab 15</b>	<b>Specialty Developing Recommendation:</b> ACOG, AAFP	<b>First Identified:</b> February 2008	<b>2012 Est Medicare Utilization:</b> 1,715	<b>2007 Work RVU:</b> 13.48 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU Result:</b> Increase <b>2013 Work RVU:</b> 14.37 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 6.23
<b>RUC Recommendation:</b> 14.37			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	
<hr/>					
<b>59410</b>	<b>Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care</b>	<b>Global:</b> MMM	<b>Issue:</b> Obstetrical Care	<b>Screen:</b> High IWPUT	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2009	<b>Tab 15</b>	<b>Specialty Developing Recommendation:</b> ACOG, AAFP	<b>First Identified:</b> February 2008	<b>2012 Est Medicare Utilization:</b> 1,483	<b>2007 Work RVU:</b> 15.29 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU Result:</b> Increase <b>2013 Work RVU:</b> 18.01 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 8.34
<b>RUC Recommendation:</b> 18.54			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	
<hr/>					
<b>59412</b>	<b>External cephalic version, with or without tocolysis</b>	<b>Global:</b> MMM	<b>Issue:</b> Obstetrical Care	<b>Screen:</b> High IWPUT	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2009	<b>Tab 15</b>	<b>Specialty Developing Recommendation:</b> ACOG, AAFP	<b>First Identified:</b> April 2008	<b>2012 Est Medicare Utilization:</b> 42	<b>2007 Work RVU:</b> 1.71 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU Result:</b> Maintain <b>2013 Work RVU:</b> 1.71 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 0.92
<b>RUC Recommendation:</b> 1.71			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	



## Status Report: CMS Requests and Relativity Assessment Issues

---

<b>59414</b>	<b>Delivery of placenta (separate procedure)</b>		<b>Global:</b> MMM	<b>Issue:</b> Obstetrical Care	<b>Screen:</b> High IWPUT	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2009	<b>Tab</b> 15	<b>Specialty Developing Recommendation:</b> ACOG, AAFP	<b>First Identified:</b> April 2008	<b>2012 Est Medicare Utilization:</b> 57	<b>2007 Work RVU:</b> 1.61 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU</b> 0.59 <b>Result:</b> Maintain	<b>2013 Work RVU:</b> 1.61 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 0.69
<b>RUC Recommendation:</b> 1.61			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

---

<b>59425</b>	<b>Antepartum care only; 4-6 visits</b>		<b>Global:</b> MMM	<b>Issue:</b> Obstetrical Care	<b>Screen:</b> High IWPUT	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2009	<b>Tab</b> 15	<b>Specialty Developing Recommendation:</b> ACOG, AAFP	<b>First Identified:</b> April 2008	<b>2012 Est Medicare Utilization:</b> 853	<b>2007 Work RVU:</b> 6.22 <b>2007 NF PE RVU:</b> 4.21 <b>2007 Fac PE RVU</b> 1.81 <b>Result:</b> Decrease	<b>2013 Work RVU:</b> 6.31 <b>2013 NF PE RVU:</b> 5.75 <b>2013 Fac PE RVU:</b> 2.70
<b>RUC Recommendation:</b> 6.31			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

---

<b>59426</b>	<b>Antepartum care only; 7 or more visits</b>		<b>Global:</b> MMM	<b>Issue:</b> Obstetrical Care	<b>Screen:</b> High IWPUT	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2009	<b>Tab</b> 15	<b>Specialty Developing Recommendation:</b> ACOG, AAFP	<b>First Identified:</b> April 2008	<b>2012 Est Medicare Utilization:</b> 834	<b>2007 Work RVU:</b> 11.04 <b>2007 NF PE RVU:</b> 7.6 <b>2007 Fac PE RVU</b> 3.17 <b>Result:</b> Decrease	<b>2013 Work RVU:</b> 11.16 <b>2013 NF PE RVU:</b> 10.52 <b>2013 Fac PE RVU:</b> 4.78
<b>RUC Recommendation:</b> 11.16			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

---

<b>59430</b>	<b>Postpartum care only (separate procedure)</b>		<b>Global:</b> MMM	<b>Issue:</b> Obstetrical Care	<b>Screen:</b> High IWPUT	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2009	<b>Tab</b> 15	<b>Specialty Developing Recommendation:</b> ACOG, AAFP	<b>First Identified:</b> April 2008	<b>2012 Est Medicare Utilization:</b> 1,604	<b>2007 Work RVU:</b> 2.13 <b>2007 NF PE RVU:</b> 1.19 <b>2007 Fac PE RVU</b> 0.88 <b>Result:</b> Increase	<b>2013 Work RVU:</b> 2.47 <b>2013 NF PE RVU:</b> 2.46 <b>2013 Fac PE RVU:</b> 1.06
<b>RUC Recommendation:</b> 2.47			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

---

## Status Report: CMS Requests and Relativity Assessment Issues

---

**59510** Routine obstetric care including antepartum care, cesarean delivery, and postpartum care      **Global:** MMM    **Issue:** Obstetrical Care      **Screen:** High IWPUT      **Complete?** Yes

**Most Recent RUC Meeting:** October 2009      **Tab** 15      **Specialty Developing Recommendation:** ACOG, AAFP      **First Identified:** February 2008      **2012 Est Medicare Utilization:** 3,584      **2007 Work RVU:** 30.34      **2013 Work RVU:** 35.64  
**2007 NF PE RVU:** NA      **2013 NF PE RVU:** NA  
**2007 Fac PE RVU:** 16.92      **2013 Fac PE RVU:** 24.08  
**Result:** Increase

**RUC Recommendation:** 36.17      **CPT Action (if applicable):**  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

---

**59514** Cesarean delivery only;      **Global:** MMM    **Issue:** Obstetrical Care      **Screen:** High IWPUT      **Complete?** Yes

**Most Recent RUC Meeting:** October 2009      **Tab** 15      **Specialty Developing Recommendation:** ACOG, AAFP      **First Identified:**      **2012 Est Medicare Utilization:** 1,452      **2007 Work RVU:** 15.95      **2013 Work RVU:** 16.13  
**2007 NF PE RVU:** NA      **2013 NF PE RVU:** NA  
**2007 Fac PE RVU:** 5.78      **2013 Fac PE RVU:** 6.96  
**Result:** Increase

**RUC Recommendation:** 16.13      **CPT Action (if applicable):**  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

---

**59515** Cesarean delivery only; including postpartum care      **Global:** MMM    **Issue:** Obstetrical Care      **Screen:** High IWPUT      **Complete?** Yes

**Most Recent RUC Meeting:** October 2009      **Tab** 15      **Specialty Developing Recommendation:** ACOG, AAFP      **First Identified:** April 2008      **2012 Est Medicare Utilization:** 1,176      **2007 Work RVU:** 18.26      **2013 Work RVU:** 21.47  
**2007 NF PE RVU:** NA      **2013 NF PE RVU:** NA  
**2007 Fac PE RVU:** 7.43      **2013 Fac PE RVU:** 10.45  
**Result:** Increase

**RUC Recommendation:** 22.00      **CPT Action (if applicable):**  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

---

**59610** Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery      **Global:** MMM    **Issue:** Obstetrical Care      **Screen:** High IWPUT      **Complete?** Yes

**Most Recent RUC Meeting:** October 2009      **Tab** 15      **Specialty Developing Recommendation:** ACOG, AAFP      **First Identified:** April 2008      **2012 Est Medicare Utilization:** 89      **2007 Work RVU:** 28.21      **2013 Work RVU:** 33.87  
**2007 NF PE RVU:** NA      **2013 NF PE RVU:** NA  
**2007 Fac PE RVU:** 15.52      **2013 Fac PE RVU:** 22.63  
**Result:** Increase

**RUC Recommendation:** 34.40      **CPT Action (if applicable):**  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

---

# Status Report: CMS Requests and Relativity Assessment Issues

**59612** Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

**Most Recent RUC Meeting:** October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2012 Est Medicare Utilization:** 45 **2007 Work RVU:** 15.04 **2013 Work RVU:** 16.09 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 5.6 **2013 Fac PE RVU:** 6.88 **Result:** Increase

**RUC Recommendation:** 16.09 **CPT Action (if applicable):** Referred to CPT Asst ☐ **Published in CPT Asst:**

**59614** Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

**Most Recent RUC Meeting:** October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2012 Est Medicare Utilization:** 41 **2007 Work RVU:** 16.59 **2013 Work RVU:** 19.73 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 6.49 **2013 Fac PE RVU:** 8.94 **Result:** Increase

**RUC Recommendation:** 20.26 **CPT Action (if applicable):** Referred to CPT Asst ☐ **Published in CPT Asst:**

**59618** Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

**Most Recent RUC Meeting:** October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2012 Est Medicare Utilization:** 26 **2007 Work RVU:** 31.78 **2013 Work RVU:** 36.16 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 17.74 **2013 Fac PE RVU:** 24.25 **Result:** Increase

**RUC Recommendation:** 36.69 **CPT Action (if applicable):** Referred to CPT Asst ☐ **Published in CPT Asst:**

**59620** Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

**Most Recent RUC Meeting:** October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2012 Est Medicare Utilization:** 21 **2007 Work RVU:** 17.50 **2013 Work RVU:** 16.66 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 6.27 **2013 Fac PE RVU:** 7.12 **Result:** Decrease

**RUC Recommendation:** 16.66 **CPT Action (if applicable):** Referred to CPT Asst ☐ **Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**59622** Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

**Most Recent RUC Meeting:** October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2012 Est Medicare Utilization:** 10 **2007 Work RVU:** 19.70 **2013 Work RVU:** 22.00 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 8.14 **2013 Fac PE RVU:** 10.72 **RUC Recommendation:** 22.53 **CPT Action (if applicable):** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Increase

**60220** Total thyroid lobectomy, unilateral; with or without isthmusectomy **Global:** 090 **Issue:** Total Thyroid Lobectomy **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** April 2008 **Tab** 46 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2012 Est Medicare Utilization:** 8,774 **2007 Work RVU:** 12.29 **2013 Work RVU:** 11.19 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 5.96 **2013 Fac PE RVU:** 7.97 **RUC Recommendation:** 12.29 **CPT Action (if applicable):** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Maintain

**60225** Total thyroid lobectomy, unilateral; with contralateral subtotal lobectomy, including isthmusectomy **Global:** 090 **Issue:** Total Thyroid Lobectomy **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** April 2008 **Tab** 46 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2012 Est Medicare Utilization:** 660 **2007 Work RVU:** 14.67 **2013 Work RVU:** 14.79 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 7.22 **2013 Fac PE RVU:** 10.32 **RUC Recommendation:** 14.67 **CPT Action (if applicable):** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Maintain

## Status Report: CMS Requests and Relativity Assessment Issues

---

<b>60520</b>	<b>Thymectomy, partial or total; transcervical approach (separate procedure)</b>	<b>Global:</b> 090	<b>Issue:</b> RAW Review	<b>Screen:</b> CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request Final Rule for 2013	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2013	<b>Tab</b> 34 <b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> November 2011	<b>2012 Est Medicare Utilization:</b> 320	<b>2007 Work RVU:</b> 17.07 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 7.95 <b>Result:</b> Remove from Screen	<b>2013 Work RVU:</b> 17.16 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 10.17
<b>RUC Recommendation:</b> No reliable way to determine an incremental difference from open thoracotomy to thoracoscopic procedures.		<b>CPT Action (if applicable):</b>			
		<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

---

<b>60521</b>	<b>Thymectomy, partial or total; sternal split or transthoracic approach, without radical mediastinal dissection (separate procedure)</b>	<b>Global:</b> 090	<b>Issue:</b> RAW Review	<b>Screen:</b> CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request Final Rule for 2013	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2013	<b>Tab</b> 34 <b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> November 2011	<b>2012 Est Medicare Utilization:</b> 339	<b>2007 Work RVU:</b> 19.11 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 9.22 <b>Result:</b> Remove from Screen	<b>2013 Work RVU:</b> 19.18 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 9.88
<b>RUC Recommendation:</b> No reliable way to determine an incremental difference from open thoracotomy to thoracoscopic procedures.		<b>CPT Action (if applicable):</b>			
		<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

---

## Status Report: CMS Requests and Relativity Assessment Issues

<b>60522</b>	Thymectomy, partial or total; sternal split or transthoracic approach, with radical mediastinal dissection (separate procedure)	<b>Global:</b> 090	<b>Issue:</b> RAW Review	<b>Screen:</b> CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request Final Rule for 2013	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2013	<b>Tab</b> 34	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> November 2011	<b>2012 Est Medicare Utilization:</b> 137	<b>2007 Work RVU:</b> 23.37 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 10.89 <b>2013 Work RVU:</b> 23.48 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 11.95 <b>Result:</b> Remove from Screen
<b>RUC Recommendation:</b>	No reliable way to determine an incremental difference from open thoracotomy to thoracoscopic procedures.		<b>CPT Action (if applicable):</b>		
	<b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>		
<b>61781</b>	Stereotactic computer-assisted (navigational) procedure; cranial, intradural (List separately in addition to code for primary procedure)	<b>Global:</b> ZZZ	<b>Issue:</b> Stereotactic Computer-Assisted Volumetric Navigational Procedures	<b>Screen:</b> CMS Fastest Growing	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2010	<b>Tab</b> 13	<b>Specialty Developing Recommendation:</b> NASS, AANS/CNS	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 11,790	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU:</b> <b>2013 Work RVU:</b> 3.75 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 1.90 <b>Result:</b> Decrease
<b>RUC Recommendation:</b> 3.75			<b>CPT Action (if applicable):</b>	October 2009	
	<b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>		
<b>61782</b>	Stereotactic computer-assisted (navigational) procedure; cranial, extradural (List separately in addition to code for primary procedure)	<b>Global:</b> ZZZ	<b>Issue:</b> Stereotactic Computer-Assisted Volumetric Navigational Procedures	<b>Screen:</b> CMS Fastest Growing	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2010	<b>Tab</b> 13	<b>Specialty Developing Recommendation:</b> NASS, AANS/CNS, AAO-HNS	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 9,640	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU:</b> <b>2013 Work RVU:</b> 3.18 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 1.59 <b>Result:</b> Decrease
<b>RUC Recommendation:</b> 3.18			<b>CPT Action (if applicable):</b>	October 2009	
	<b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>		

## Status Report: CMS Requests and Relativity Assessment Issues

**61783** Stereotactic computer-assisted (navigational) procedure; spinal (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Stereotactic Computer-Assisted Volumetric Navigational Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent RUC Meeting:** February 2010 **Tab** 13 **Specialty Developing Recommendation:** NASS, AANS/CNS **First Identified:** **2012 Est Medicare Utilization:** 3,618 **2007 Work RVU:** **2013 Work RVU:** 3.75 **2007 NF PE RVU:** **2013 NF PE RVU:** NA **2007 Fac PE RVU** **2013 Fac PE RVU:** 1.91 **RUC Recommendation:** 3.75 **CPT Action (if applicable):** October 2009 **Published in CPT Asst:** **Referred to CPT Asst** ☐

**61793** Deleted from CPT **Global:** 090 **Issue:** Stereotactic Radiosurgery **Screen:** CMS Fastest Growing, Site of Service Anomaly (99238-Only) **Complete?** Yes

**Most Recent RUC Meeting:** October 2008 **Tab** 26 **Specialty Developing Recommendation:** AANS **First Identified:** September 2007 **2012 Est Medicare Utilization:** **2007 Work RVU:** 17.75 **2013 Work RVU:** **2007 NF PE RVU:** NA **2013 NF PE RVU:** **2007 Fac PE RVU** 10.08 **2013 Fac PE RVU:** **RUC Recommendation:** Deleted from CPT **CPT Action (if applicable):** February 2008 **Published in CPT Asst:** **Referred to CPT Asst** ☐

**61795** Deleted from CPT **Global:** ZZZ **Issue:** Stereotactic Radiosurgery **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent RUC Meeting:** February 2009 **Tab** 38 **Specialty Developing Recommendation:** NASS, AAO-HNS, AANS **First Identified:** October 2008 **2012 Est Medicare Utilization:** **2007 Work RVU:** 4.03 **2013 Work RVU:** **2007 NF PE RVU:** NA **2013 NF PE RVU:** **2007 Fac PE RVU** 1.87 **2013 Fac PE RVU:** **RUC Recommendation:** Deleted from CPT **CPT Action (if applicable):** October 2009 **Published in CPT Asst:** **Referred to CPT Asst** ☐

## Status Report: CMS Requests and Relativity Assessment Issues

---

<b>61796</b>	<b>Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 simple cranial lesion</b>	<b>Global:</b> 090	<b>Issue:</b> Stereotactic Radiosurgery	<b>Screen:</b> CMS Request - 2009 Final Rule	<b>Complete?</b> Yes
--------------	---	--------------------	---	--	----------------------

**Most Recent RUC Meeting:** February 2009

**Tab** 38

**Specialty Developing Recommendation:**

**First Identified:** NA

**2012 Est Medicare Utilization:** 5,144

**2007 Work RVU:**

**2013 Work RVU:** 13.93

**2007 NF PE RVU:**

**2013 NF PE RVU:** NA

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 11.32

**RUC Recommendation:** 15.50

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

---

<b>61797</b>	<b>Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, simple (List separately in addition to code for primary procedure)</b>	<b>Global:</b> ZZZ	<b>Issue:</b> Stereotactic Radiosurgery	<b>Screen:</b> CMS Request - 2009 Final Rule	<b>Complete?</b> Yes
--------------	--	--------------------	---	--	----------------------

**Most Recent RUC Meeting:** February 2009

**Tab** 38

**Specialty Developing Recommendation:**

**First Identified:** NA

**2012 Est Medicare Utilization:** 3,984

**2007 Work RVU:**

**2013 Work RVU:** 3.48

**2007 NF PE RVU:**

**2013 NF PE RVU:** NA

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 1.77

**RUC Recommendation:** 3.48

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

---

<b>61798</b>	<b>Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 complex cranial lesion</b>	<b>Global:</b> 090	<b>Issue:</b> Stereotactic Radiosurgery	<b>Screen:</b> CMS Request - 2009 Final Rule	<b>Complete?</b> Yes
--------------	--	--------------------	---	--	----------------------

**Most Recent RUC Meeting:** February 2009

**Tab** 38

**Specialty Developing Recommendation:**

**First Identified:** NA

**2012 Est Medicare Utilization:** 3,379

**2007 Work RVU:**

**2013 Work RVU:** 19.85

**2007 NF PE RVU:**

**2013 NF PE RVU:** NA

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 14.28

**RUC Recommendation:** 19.75

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease



## Status Report: CMS Requests and Relativity Assessment Issues

**61799** Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, complex (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

**Most Recent RUC Meeting:** February 2009

**Tab** 38

**Specialty Developing Recommendation:**

**First Identified:** NA

**2012 Est Medicare Utilization:** 615

**2007 Work RVU:**

**2013 Work RVU:** 4.81

**2007 NF PE RVU:**

**2013 NF PE RVU:** NA

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 2.45

**RUC Recommendation:** 4.81

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**61800** Application of stereotactic headframe for stereotactic radiosurgery (List separately in addition to code for primary procedure)

**Global:** ZZZ

**Issue:** Stereotactic Radiosurgery

**Screen:** CMS Fastest Growing, Site of Service Anomaly (99238-Only)

**Complete?** Yes

**Most Recent RUC Meeting:** April 2008

**Tab** 16

**Specialty Developing Recommendation:**

**First Identified:**

**2012 Est Medicare Utilization:** 5,296

**2007 Work RVU:**

**2013 Work RVU:** 2.25

**2007 NF PE RVU:**

**2013 NF PE RVU:** NA

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 1.53

**RUC Recommendation:** 2.25

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**61885** Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array

**Global:** 090

**Issue:** Vagal Nerve Stimulator

**Screen:** Site of Service Anomaly

**Complete?** Yes

**Most Recent RUC Meeting:** February 2010

**Tab** 14

**Specialty Developing Recommendation:** AANS/CNS

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 5,469

**2007 Work RVU:** 7.37

**2013 Work RVU:** 6.05

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 5.85

**2013 Fac PE RVU:** 7.51

**RUC Recommendation:** 6.44

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

October 2009

**Published in CPT Asst:**

**Result:** Decrease

## Status Report: CMS Requests and Relativity Assessment Issues

<b>62263</b>	Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days	<b>Global:</b> 010	<b>Issue:</b> Epidural Lysis	<b>Screen:</b> Site of Service Anomaly	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2010	<b>Tab</b> 66	<b>Specialty Developing Recommendation:</b> AAPM, AANS/CNS, ASA, NASS	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 953	<b>2007 Work RVU:</b> 6.41 <b>2007 NF PE RVU:</b> 11.78 <b>2007 Fac PE RVU:</b> 3.11 <b>2013 Work RVU:</b> 5.00 <b>2013 NF PE RVU:</b> 15.90 <b>2013 Fac PE RVU:</b> 5.13
<b>RUC Recommendation:</b> 6.54			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b> Maintain
<b>62281</b>	Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, cervical or thoracic	<b>Global:</b> 010	<b>Issue:</b> Injection of Neurolytic Agent	<b>Screen:</b> Site of Service Anomaly (99238-Only)	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> September 2007	<b>Tab</b> 16	<b>Specialty Developing Recommendation:</b> ASA	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 710	<b>2007 Work RVU:</b> 2.66 <b>2007 NF PE RVU:</b> 5.16 <b>2007 Fac PE RVU:</b> 0.89 <b>2013 Work RVU:</b> 2.66 <b>2013 NF PE RVU:</b> 4.44 <b>2013 Fac PE RVU:</b> 1.82
<b>RUC Recommendation:</b> Remove 99238			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input checked="" type="checkbox"/>	<b>Published in CPT Asst:</b> Q&A May 2010	<b>Result:</b> PE Only
<b>62284</b>	Injection procedure for myelography and/or computed tomography, spinal (other than C1-C2 and posterior fossa)	<b>Global:</b> 000	<b>Issue:</b> Myelography with Injection	<b>Screen:</b> Codes Reported Together 75% or More-Part2	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b>	<b>Specialty Developing Recommendation:</b> ACR, ASNR	<b>First Identified:</b> October 2012	<b>2012 Est Medicare Utilization:</b> 57,956	<b>2007 Work RVU:</b> 1.54 <b>2007 NF PE RVU:</b> 4.62 <b>2007 Fac PE RVU:</b> 0.67 <b>2013 Work RVU:</b> 1.54 <b>2013 NF PE RVU:</b> 4.04 <b>2013 Fac PE RVU:</b> 0.79
<b>RUC Recommendation:</b> Refer to CPT to bundle.			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b> CPT 2015 cycle	<b>Result:</b>

## Status Report: CMS Requests and Relativity Assessment Issues

**62287** Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with the use of an endoscope, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar

**Global:** 090 **Issue:** Percutaneous Discectomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

**Most Recent RUC Meeting:** September 2007 **Tab** 16 **Specialty Developing Recommendation:** ASA **First Identified:** September 2007 **2012 Est Medicare Utilization:** 472

**2007 Work RVU:** 8.88 **2013 Work RVU:** 9.03  
**2007 NF PE RVU:** NA **2013 NF PE RVU:** NA  
**2007 Fac PE RVU:** 5.18 **2013 Fac PE RVU:** 6.92  
**Result:** PE Only

**RUC Recommendation:** Reduce 99238 to 0.5

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**62290** Injection procedure for discography, each level; lumbar

**Global:** 000 **Issue:** Injection for discography **Screen:** Different Performing Specialty from Survey **Complete?** Yes

**Most Recent RUC Meeting:** April 2010 **Tab** 45 **Specialty Developing Recommendation:** ASA, AAPM, AAMPR, AUR, NASS, ACR, ASNR, ISIS, AANS **First Identified:** October 2009 **2012 Est Medicare Utilization:** 15,691

**2007 Work RVU:** 3.00 **2013 Work RVU:** 3.00  
**2007 NF PE RVU:** 6.43 **2013 NF PE RVU:** 6.95  
**2007 Fac PE RVU:** 1.31 **2013 Fac PE RVU:** 1.88

**RUC Recommendation:** 3.00, CPT Assistant article published.

**CPT Action (if applicable):**

**Referred to CPT Asst** ☒

**Published in CPT Asst:** Mar 2011

**Result:** Maintain

**62310** Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic

**Global:** 000 **Issue:** Spine Injections **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

**Most Recent RUC Meeting:** October 2012 **Tab** 18 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, ISIS, NASS, ASNR, ASIPP **First Identified:** January 2012 **2012 Est Medicare Utilization:** 216,069

**2007 Work RVU:** 1.91 **2013 Work RVU:** 1.91  
**2007 NF PE RVU:** 4.35 **2013 NF PE RVU:** 5.37  
**2007 Fac PE RVU:** 0.63 **2013 Fac PE RVU:** 1.18

**RUC Recommendation:** 1.68

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

## Status Report: CMS Requests and Relativity Assessment Issues

---

<b>62311</b>	Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)	<b>Global:</b> 000	<b>Issue:</b> Spine Injections	<b>Screen:</b> CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
--------------	---	--------------------	--------------------------------	--	----------------------

<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b> 18	<b>Specialty Developing Recommendation:</b>	AAPM, AAPMR, ASA, ISIS, NASS, ASNR, ASIPP	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 939,728	<b>2007 Work RVU:</b> 1.54	<b>2013 Work RVU:</b> 1.54
						<b>2007 NF PE RVU:</b> 4.35	<b>2013 NF PE RVU:</b> 4.61
						<b>2007 Fac PE RVU</b> 0.58	<b>2013 Fac PE RVU:</b> 0.99

**RUC Recommendation:** 1.54

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Maintain

---

<b>62318</b>	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic	<b>Global:</b> 000	<b>Issue:</b> Spine Injections	<b>Screen:</b> CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
--------------	--	--------------------	--------------------------------	--	----------------------

<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b> 18	<b>Specialty Developing Recommendation:</b>	AAPM, AAPMR, ASA, ISIS, NASS, ASNR, ASIPP	<b>First Identified:</b> January 2012	<b>2012 Est Medicare Utilization:</b> 38,697	<b>2007 Work RVU:</b> 2.04	<b>2013 Work RVU:</b> 2.04
						<b>2007 NF PE RVU:</b> 5.09	<b>2013 NF PE RVU:</b> 4.99
						<b>2007 Fac PE RVU</b> 0.61	<b>2013 Fac PE RVU:</b> 0.77

**RUC Recommendation:** 2.04

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Maintain

## Status Report: CMS Requests and Relativity Assessment Issues

**62319** Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal) **Global:** 000 **Issue:** Spine Injections **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

**Most Recent RUC Meeting:** October 2012 **Tab** 18 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, ISIS, NASS, ASNR, ASIPP **First Identified:** January 2012 **2012 Est Medicare Utilization:** 29,052 **2007 Work RVU:** 1.87 **2013 Work RVU:** 1.87 **2007 NF PE RVU:** 4.45 **2013 NF PE RVU:** 3.14 **2007 Fac PE RVU:** 0.58 **2013 Fac PE RVU:** 0.84

**RUC Recommendation:** 1.87

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Maintain

**62350** Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy **Global:** 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** October 2010 **Tab** 67 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2012 Est Medicare Utilization:** 6,892 **2007 Work RVU:** 8.04 **2013 Work RVU:** 6.05 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 4 **2013 Fac PE RVU:** 4.93

**RUC Recommendation:** 6.05

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**62355** Removal of previously implanted intrathecal or epidural catheter **Global:** 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** October 2010 **Tab** 67 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2012 Est Medicare Utilization:** 1,337 **2007 Work RVU:** 6.60 **2013 Work RVU:** 3.55 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 3.27 **2013 Fac PE RVU:** 3.74

**RUC Recommendation:** 4.35

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

## Status Report: CMS Requests and Relativity Assessment Issues

**62360** Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir **Global:** 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** October 2010

**Tab** 67

**Specialty Developing Recommendation:** AAPMR, ASA, NASS, AAPM, AANS/CNS

**First Identified:** April 2008

**2012 Est Medicare Utilization:** 602

**2007 Work RVU:** 3.68

**2013 Work RVU:** 4.33

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 2.87

**2013 Fac PE RVU:** 4.12

**RUC Recommendation:** 4.33

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**62361** Implantation or replacement of device for intrathecal or epidural drug infusion; nonprogrammable pump **Global:** 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** October 2010

**Tab** 67

**Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS

**First Identified:** April 2008

**2012 Est Medicare Utilization:** 88

**2007 Work RVU:** 6.59

**2013 Work RVU:** 5.00

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 3.94

**2013 Fac PE RVU:** 3.89

**RUC Recommendation:** 5.65

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**62362** Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming **Global:** 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** October 2010

**Tab** 67

**Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 7,805

**2007 Work RVU:** 8.58

**2013 Work RVU:** 5.60

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 4.46

**2013 Fac PE RVU:** 4.90

**RUC Recommendation:** 6.10

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

## Status Report: CMS Requests and Relativity Assessment Issues

**62365** Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion **Global:** 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** October 2010

**Tab 67 Specialty Developing Recommendation:** AAPMR, ASA, NASS, AAPM, AANS/CNS

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 1,282

**2007 Work RVU:** 6.57

**2013 Work RVU:** 3.93

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU:** 3.65

**2013 Fac PE RVU:** 4.13

**RUC Recommendation:** 4.65

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**62367** Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming or refill

**Global:** XXX

**Issue:** Electronic Analysis Implanted Pump

**Screen:** Different Performing Specialty from Survey

**Complete?** Yes

**Most Recent RUC Meeting:** February 2011

**Tab 07 Specialty Developing Recommendation:** ASA, AAPM, NASS, AAMP&R, AANS/CNS, ISIS

**First Identified:** October 2009

**2012 Est Medicare Utilization:** 7,325

**2007 Work RVU:** 0.48

**2013 Work RVU:** 0.48

**2007 NF PE RVU:** 0.56

**2013 NF PE RVU:** 0.73

**2007 Fac PE RVU:** 0.10

**2013 Fac PE RVU:** 0.22

**RUC Recommendation:** 0.48

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**October 2010**  
**Published in CPT Asst:**

**Result:** Maintain

**62368** Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming

**Global:** XXX

**Issue:** Electronic Analysis Implanted Pump

**Screen:** Different Performing Specialty from Survey / Codes Reported Together 75% or More-Part1

**Complete?** Yes

**Most Recent RUC Meeting:** February 2011

**Tab 07 Specialty Developing Recommendation:** ASA, AAPM, NASS, AAMP&R, AANS/CNS, ISIS

**First Identified:** October 2009

**2012 Est Medicare Utilization:** 53,939

**2007 Work RVU:** 0.75

**2013 Work RVU:** 0.67

**2007 NF PE RVU:** 0.67

**2013 NF PE RVU:** 0.98

**2007 Fac PE RVU:** 0.17

**2013 Fac PE RVU:** 0.31

**RUC Recommendation:** 0.67

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**October 2010**  
**Published in CPT Asst:**

**Result:** Decrease

## Status Report: CMS Requests and Relativity Assessment Issues

**62369** Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill **Global:** XXX **Issue:** Electronic Analysis Implanted Pump **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

**Most Recent RUC Meeting:** February 2011

**Tab** 07

**Specialty Developing Recommendation:**

ASA, AAPM, NASS, AAMP&R, AANS/CNS, ISIS

**First Identified:**

**2012 Est Medicare Utilization:** 48,051

**2007 Work RVU:**  
**2007 NF PE RVU:**  
**2007 Fac PE RVU**

**2013 Work RVU:** 0.67  
**2013 NF PE RVU:** 3.08  
**2013 Fac PE RVU:** 0.31

**RUC Recommendation:** 0.67

**CPT Action (if applicable):** October 2010  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Decrease

**62370** Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring skill of a physician or other qualified health care professional) **Global:** XXX **Issue:** Electronic Analysis Implanted Pump **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

**Most Recent RUC Meeting:** February 2011

**Tab** 07

**Specialty Developing Recommendation:**

ASA, AAPM, NASS, AAMP&R, AANS/CNS, ISIS

**First Identified:**

**2012 Est Medicare Utilization:** 63,529

**2007 Work RVU:**  
**2007 NF PE RVU:**  
**2007 Fac PE RVU**

**2013 Work RVU:** 0.90  
**2013 NF PE RVU:** 2.99  
**2013 Fac PE RVU:** 0.42

**RUC Recommendation:** 1.10

**CPT Action (if applicable):** October 2010  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Decrease

**63047** Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar **Global:** 090 **Issue:** Laminectomy **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

**Most Recent RUC Meeting:** January 2013

**Tab** 24

**Specialty Developing Recommendation:**

**First Identified:** September 2011

**2012 Est Medicare Utilization:** 91,477

**2007 Work RVU:** 15.22  
**2007 NF PE RVU:** NA  
**2007 Fac PE RVU** 9.79

**2013 Work RVU:** 15.37  
**2013 NF PE RVU:** NA  
**2013 Fac PE RVU:** 13.12

**RUC Recommendation:** 15.37

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Maintain



# Status Report: CMS Requests and Relativity Assessment Issues

<b>63048</b>	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)	<b>Global:</b> ZZZ	<b>Issue:</b> Laminectomy	<b>Screen:</b> CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2013	<b>Tab</b> 24	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> January 2012	<b>2012 Est Medicare Utilization:</b> 129,771	<b>2007 Work RVU:</b> 3.47 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 1.58 <b>Result:</b> Maintain
<b>RUC Recommendation:</b> 3.47			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 3.47 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 1.80
<b>63056</b>	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disc)	<b>Global:</b> 090	<b>Issue:</b> RAW	<b>Screen:</b> CMS Fastest Growing	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b> 27	<b>Specialty Developing Recommendation:</b> NASS, AANS	<b>First Identified:</b> October 2008	<b>2012 Est Medicare Utilization:</b> 7,724	<b>2007 Work RVU:</b> 21.73 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 12.31 <b>Result:</b>
<b>RUC Recommendation:</b> Review in October 2014.			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input checked="" type="checkbox"/>	<b>Published in CPT Asst:</b> February 2010 Oct 2009	<b>2013 Work RVU:</b> 21.86 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 15.98
<b>63075</b>	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctomy; cervical, single interspace	<b>Global:</b> 090	<b>Issue:</b> Arthrodesis Including Discectomy	<b>Screen:</b> Codes Reported Together 95% or More	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2010	<b>Tab</b> 5	<b>Specialty Developing Recommendation:</b> NASS, AANS/CNS	<b>First Identified:</b> February 2008	<b>2012 Est Medicare Utilization:</b> 2,202	<b>2007 Work RVU:</b> 19.47 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 11.87 <b>Result:</b> Maintain
<b>RUC Recommendation:</b> 17.69			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b> October 2009	<b>2013 Work RVU:</b> 19.60 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 15.05

## Status Report: CMS Requests and Relativity Assessment Issues

**63076** Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Arthrodesis Including Discectomy **Screen:** Codes Reported Together 95% or More **Complete?** Yes

**Most Recent RUC Meeting:** February 2010

**Tab** 5

**Specialty Developing Recommendation:** NASS, AANS/CNS

**First Identified:**

**2012 Est Medicare Utilization:** 1,541

**2007 Work RVU:** 4.04

**2013 Work RVU:** 4.04

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU:** 1.93

**2013 Fac PE RVU:** 2.08

**RUC Recommendation:** 19.60

**CPT Action (if applicable):** October 2009  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Maintain

**63620** Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion **Global:** 090 **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

**Most Recent RUC Meeting:** February 2009

**Tab** 38

**Specialty Developing Recommendation:**

**First Identified:** NA

**2012 Est Medicare Utilization:** 406

**2007 Work RVU:**

**2013 Work RVU:** 15.60

**2007 NF PE RVU:**

**2013 NF PE RVU:** NA

**2007 Fac PE RVU:**

**2013 Fac PE RVU:** 12.13

**RUC Recommendation:** 15.50

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Decrease

**63621** Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional spinal lesion (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

**Most Recent RUC Meeting:** February 2009

**Tab** 38

**Specialty Developing Recommendation:**

**First Identified:** NA

**2012 Est Medicare Utilization:** 49

**2007 Work RVU:**

**2013 Work RVU:** 4.00

**2007 NF PE RVU:**

**2013 NF PE RVU:** NA

**2007 Fac PE RVU:**

**2013 Fac PE RVU:** 2.03

**RUC Recommendation:** 4.00

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Decrease

## Status Report: CMS Requests and Relativity Assessment Issues

<b>63650</b>	<b>Percutaneous implantation of neurostimulator electrode array, epidural</b>	<b>Global:</b> 010	<b>Issue:</b> Percutaneous implantation of neurostimulator	<b>Screen:</b> Site of Service Anomaly / CMS Fastest Growing / CMS Request Final Rule for 2013	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 22	<b>Specialty Developing Recommendation:</b> AAPM, AANS/CNS, ASA, ISIS, NASS	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 46,347	<b>2007 Work RVU:</b> 7.57 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 3.11 <b>2013 Work RVU:</b> 7.15 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 5.11
<b>RUC Recommendation:</b> 7.20. New PE Inputs			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b> Decrease
<hr/>					
<b>63655</b>	<b>Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural</b>	<b>Global:</b> 090	<b>Issue:</b> Neurostimulator (Spinal)	<b>Screen:</b> CMS Fastest Growing	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2009	<b>Tab</b> 17	<b>Specialty Developing Recommendation:</b> NASS, AANS	<b>First Identified:</b> October 2008	<b>2012 Est Medicare Utilization:</b> 6,675	<b>2007 Work RVU:</b> 11.43 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 7.15 <b>2013 Work RVU:</b> 10.92 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 10.42
<b>RUC Recommendation:</b> 11.43			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b> Maintain
<hr/>					
<b>63660</b>	<b>Deleted from CPT</b>	<b>Global:</b> 090	<b>Issue:</b> Neurostimulator (Spinal)	<b>Screen:</b> Site of Service Anomaly / CMS Fastest Growing	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2009	<b>Tab</b> 17	<b>Specialty Developing Recommendation:</b> AAPM, AANS/CNS, ASA, ISIS, NASS	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> 6.87 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 3.54 <b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>
<b>RUC Recommendation:</b> Deleted from CPT			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b> Deleted from CPT

## Status Report: CMS Requests and Relativity Assessment Issues

**63661** Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed

**Global:** 010

**Issue:** Neurostimulator (Spinal)

**Screen:** Site of Service Anomaly / CMS Fastest Growing

**Complete?** Yes

**Most Recent RUC Meeting:** April 2009

**Tab** 17

**Specialty Developing Recommendation:** ISIS, NASS, AANS/CNS, ASA, AAPM

**First Identified:**

**2012 Est Medicare Utilization:** 3,661

**2007 Work RVU:**

**2013 Work RVU:** 5.08

**2007 NF PE RVU:**

**2013 NF PE RVU:** 11.83

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 3.82

**RUC Recommendation:** 5.02

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**63662** Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed

**Global:** 090

**Issue:** Neurostimulator (Spinal)

**Screen:** Site of Service Anomaly / CMS Fastest Growing

**Complete?** Yes

**Most Recent RUC Meeting:** April 2009

**Tab** 17

**Specialty Developing Recommendation:** ISIS, NASS, AANS/CNS, ASA, AAPM

**First Identified:**

**2012 Est Medicare Utilization:** 1,358

**2007 Work RVU:**

**2013 Work RVU:** 11.00

**2007 NF PE RVU:**

**2013 NF PE RVU:** NA

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 10.60

**RUC Recommendation:** 10.84

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**63663** Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed

**Global:** 010

**Issue:** Neurostimulator (Spinal)

**Screen:** Site of Service Anomaly / CMS Fastest Growing

**Complete?** Yes

**Most Recent RUC Meeting:** April 2009

**Tab** 17

**Specialty Developing Recommendation:** ISIS, NASS, AANS/CNS, ASA, AAPM

**First Identified:**

**2012 Est Medicare Utilization:** 1,196

**2007 Work RVU:**

**2013 Work RVU:** 7.75

**2007 NF PE RVU:**

**2013 NF PE RVU:** 15.91

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 5.09

**RUC Recommendation:** 7.68

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

## Status Report: CMS Requests and Relativity Assessment Issues

**63664** Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed **Global:** 090 **Issue:** Neurostimulator (Spinal) **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

**Most Recent RUC Meeting:** April 2009 **Tab** 17 **Specialty Developing Recommendation:** ISIS, NASS, AANS/CNS, ASA, AAPM **First Identified:** **2012 Est Medicare Utilization:** 666 **2007 Work RVU:** **2013 Work RVU:** 11.52 **2007 NF PE RVU:** **2013 NF PE RVU:** NA **2007 Fac PE RVU Result:** Decrease **2013 Fac PE RVU:** 10.57

**RUC Recommendation:** 11.34 **CPT Action (if applicable):** Referred to CPT Asst ☐ **Published in CPT Asst:**

**63685** Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling **Global:** 010 **Issue:** Neurostimulators **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

**Most Recent RUC Meeting:** October 2010 **Tab** 68 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2012 Est Medicare Utilization:** 14,291 **2007 Work RVU:** 7.87 **2013 Work RVU:** 5.19 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 4.03 **2013 Fac PE RVU:** 4.77

**RUC Recommendation:** 6.05 **CPT Action (if applicable):** Referred to CPT Asst ☐ **Published in CPT Asst:** **Result:** Decrease

**63688** Revision or removal of implanted spinal neurostimulator pulse generator or receiver **Global:** 010 **Issue:** Neurostimulators **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** February 2008 **Tab** I **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2012 Est Medicare Utilization:** 5,621 **2007 Work RVU:** 6.10 **2013 Work RVU:** 5.30 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 3.56 **2013 Fac PE RVU:** 4.72

**RUC Recommendation:** 5.25 **CPT Action (if applicable):** Referred to CPT Asst ☐ **Published in CPT Asst:** **Result:** Decrease

## Status Report: CMS Requests and Relativity Assessment Issues

<b>64412</b>	Injection, anesthetic agent; spinal accessory nerve	<b>Global:</b>	<b>Issue:</b> RAW	<b>Screen:</b> High Volume Growth2	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> April 2013	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b>
<b>RUC Recommendation:</b>	Review Action Plan		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>

<b>64415</b>	Injection, anesthetic agent; brachial plexus, single	<b>Global:</b> 000	<b>Issue:</b> RAW	<b>Screen:</b> CMS Fastest Growing	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b>	<b>Tab</b> 27	<b>Specialty Developing Recommendation:</b> AAPM, ASA	<b>First Identified:</b> October 2008	<b>2012 Est Medicare Utilization:</b> 138,290	<b>2007 Work RVU:</b> 1.48 <b>2007 NF PE RVU:</b> 2.47 <b>2007 Fac PE RVU</b> 0.43
<b>RUC Recommendation:</b>	1.48, Review in October 2014		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input checked="" type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 1.48 <b>2013 NF PE RVU:</b> 1.97 <b>2013 Fac PE RVU:</b> 0.30

<b>64416</b>	Injection, anesthetic agent; brachial plexus, continuous infusion by catheter (including catheter placement)	<b>Global:</b> 000	<b>Issue:</b> Anesthetic Agent Nerve Injection	<b>Screen:</b> Site of Service Anomaly / High Volume Growth2	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b>	<b>Tab</b> 19	<b>Specialty Developing Recommendation:</b> ASA	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 15,628	<b>2007 Work RVU:</b> 3.85 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU</b> 0.74
<b>RUC Recommendation:</b>	Review action plan. 1.81		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 1.81 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 0.35

<b>64445</b>	Injection, anesthetic agent; sciatic nerve, single	<b>Global:</b> 000	<b>Issue:</b> RAW	<b>Screen:</b> CMS Fastest Growing	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b>	<b>Tab</b> 27	<b>Specialty Developing Recommendation:</b> AAPM, ASA	<b>First Identified:</b> October 2008	<b>2012 Est Medicare Utilization:</b> 107,899	<b>2007 Work RVU:</b> 1.48 <b>2007 NF PE RVU:</b> 2.42 <b>2007 Fac PE RVU</b> 0.51
<b>RUC Recommendation:</b>	1.48, Review in October 2014.		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input checked="" type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 1.48 <b>2013 NF PE RVU:</b> 2.45 <b>2013 Fac PE RVU:</b> 0.48

## Status Report: CMS Requests and Relativity Assessment Issues

**64446** Injection, anesthetic agent; sciatic nerve, continuous infusion by catheter (including catheter placement) **Global:** 000 **Issue:** Anesthetic Agent Nerve Injection **Screen:** Site of Service Anomaly / High Volume Growth1 **Complete?** Yes

**Most Recent** **Tab** 19 **Specialty Developing** ASA  
**RUC Meeting:** April 2008 **Recommendation:**

**First Identified:** February 2008

**2012 Est Medicare Utilization:** 7,085

**2007 Work RVU:** 3.61 **2013 Work RVU:** 1.81  
**2007 NF PE RVU:** NA **2013 NF PE RVU:** NA  
**2007 Fac PE RVU** 0.90 **2013 Fac PE RVU:** 0.36  
**Result:** Decrease

**RUC Recommendation:** 1.81

**CPT Action (if applicable):** February 2008  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**64447** Injection, anesthetic agent; femoral nerve, single

**Global:** 000 **Issue:** RAW

**Screen:** CMS Fastest Growing **Complete?** No

**Most Recent** **Tab** 27 **Specialty Developing** AAPM, ASA  
**RUC Meeting:** October 2012 **Recommendation:**

**First Identified:** October 2008

**2012 Est Medicare Utilization:** 120,863

**2007 Work RVU:** 1.50 **2013 Work RVU:** 1.50  
**2007 NF PE RVU:** NA **2013 NF PE RVU:** 1.96  
**2007 Fac PE RVU** 0.38 **2013 Fac PE RVU:** 0.30  
**Result:**

**RUC Recommendation:** 1.50, Review October 2014.

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☒ **Published in CPT Asst:** Dec 2011 & Apr 20

**64448** Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement)

**Global:** 000 **Issue:** Anesthetic Agent Nerve Injection

**Screen:** Site of Service Anomaly / High Volume Growth1 / CMS Fastest Growing / High Volume Growth2 **Complete?** No

**Most Recent** **Tab** 19 **Specialty Developing** ASA  
**RUC Meeting:** April 2008 **Recommendation:**

**First Identified:** February 2008

**2012 Est Medicare Utilization:** 71,006

**2007 Work RVU:** 3.36 **2013 Work RVU:** 1.63  
**2007 NF PE RVU:** NA **2013 NF PE RVU:** NA  
**2007 Fac PE RVU** 0.73 **2013 Fac PE RVU:** 0.32  
**Result:** Decrease

**RUC Recommendation:** Review action plan. 1.63

**CPT Action (if applicable):** February 2008  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**64449** Injection, anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement) **Global:** 000 **Issue:** Anesthetic Agent Nerve Injection **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** April 2008

**Tab** 19 **Specialty Developing Recommendation:** ASA

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 5,829

**2007 Work RVU:** 3.24

**2013 Work RVU:** 1.81

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU:** 0.84

**2013 Fac PE RVU:** 0.47

**RUC Recommendation:** 1.81

**CPT Action (if applicable):** February 2008

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**64450** Injection, anesthetic agent; other peripheral nerve or branch

**Global:** 000

**Issue:** Injection - Anesthetic Agent

**Screen:** Harvard Valued - Utilization over 100,000 / Harvard-Valued Annual Allowed Charges Greater than \$10 million

**Complete?** Yes

**Most Recent RUC Meeting:** September 2011

**Tab** 24 **Specialty Developing Recommendation:** ASA, AAPM, APMA, ASIPP

**First Identified:** October 2009

**2012 Est Medicare Utilization:** 927,792

**2007 Work RVU:** 1.27

**2013 Work RVU:** 0.75

**2007 NF PE RVU:** 1.25

**2013 NF PE RVU:** 1.58

**2007 Fac PE RVU:** 0.49

**2013 Fac PE RVU:** 0.52

**RUC Recommendation:** 0.75

**CPT Action (if applicable):**

**Referred to CPT Asst** ☒

**Published in CPT Asst:** Jan 2013

**Result:** Decrease

**64470** Deleted from CPT

**Global:** 000

**Issue:** Injection Anesthetic Agent

**Screen:** High Volume Growth1

**Complete?** Yes

**Most Recent RUC Meeting:** April 2008

**Tab** 57 **Specialty Developing Recommendation:** ASA, NASS, AAPM

**First Identified:** April 2008

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 1.85

**2013 Work RVU:**

**2007 NF PE RVU:** 6.37

**2013 NF PE RVU:**

**2007 Fac PE RVU:** 0.71

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** February 2009

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Deleted from CPT



## Status Report: CMS Requests and Relativity Assessment Issues

**64472 Deleted from CPT** **Global:** ZZZ **Issue:** Injection Anesthetic Agent **Screen:** High Volume Growth1 **Complete?** Yes

**Most Recent** **Tab** 57 **Specialty Developing** ASA, NASS, **First** **2012 Est** **2007 Work RVU:** 1.29 **2013 Work RVU:**  
**RUC Meeting:** April 2008 **Recommendation:** AAPM **Identified:** February 2008 **Medicare** **2007 NF PE RVU:** 2.05 **2013 NF PE RVU:**  
**Utilization:** **2007 Fac PE RVU** 0.34 **2013 Fac PE RVU:**  
**RUC Recommendation:** Deleted from CPT **CPT Action (if applicable):** February 2009 **Result:** Deleted from CPT  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**64475 Deleted from CPT** **Global:** 000 **Issue:** Injection Anesthetic Agent **Screen:** High Volume Growth1 **Complete?** Yes

**Most Recent** **Tab** 57 **Specialty Developing** ASA, NASS, **First** **2012 Est** **2007 Work RVU:** 1.41 **2013 Work RVU:**  
**RUC Meeting:** April 2008 **Recommendation:** AAPM **Identified:** April 2008 **Medicare** **2007 NF PE RVU:** 6.07 **2013 NF PE RVU:**  
**Utilization:** **2007 Fac PE RVU** 0.62 **2013 Fac PE RVU:**  
**RUC Recommendation:** Deleted from CPT **CPT Action (if applicable):** February 2009 **Result:** Deleted from CPT  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**64476 Deleted from CPT** **Global:** ZZZ **Issue:** Injection Anesthetic Agent **Screen:** High Volume Growth1 **Complete?** Yes

**Most Recent** **Tab** 57 **Specialty Developing** ASA, NASS, **First** **2012 Est** **2007 Work RVU:** 0.98 **2013 Work RVU:**  
**RUC Meeting:** April 2008 **Recommendation:** AAPM **Identified:** April 2008 **Medicare** **2007 NF PE RVU:** 1.86 **2013 NF PE RVU:**  
**Utilization:** **2007 Fac PE RVU** 0.24 **2013 Fac PE RVU:**  
**RUC Recommendation:** Deleted from CPT **CPT Action (if applicable):** February 2009 **Result:** Deleted from CPT  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**64479 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with** **Global:** 000 **Issue:** Injection Anesthetic Agent **Screen:** CMS Fastest Growing **Complete?** Yes  
**imaging guidance (fluoroscopy or CT); cervical or thoracic, single level**

**Most Recent** **Tab** 05 **Specialty Developing** AAPM, ISIS, **First** **2012 Est** **2007 Work RVU:** 2.20 **2013 Work RVU:** 2.29  
**RUC Meeting:** October 2009 **Recommendation:** ASA, NASS, **Identified:** October 2008 **Medicare** **2007 NF PE RVU:** 6.55 **2013 NF PE RVU:** 4.77  
**Utilization:** 39,956 **2007 Fac PE RVU** 0.87 **2013 Fac PE RVU:** 1.46  
**RUC Recommendation:** 2.29 **CPT Action (if applicable):** June 2009 **Result:** Increase  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**64480** Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Injection Anesthetic Agent **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent RUC Meeting:** October 2009

**Tab** 05

**Specialty Developing Recommendation:**

AAPM, ISIS, ASA, NASS, AAPMR

**First Identified:** October 2008

**2012 Est Medicare Utilization:** 23,630

**2007 Work RVU:** 1.54

**2013 Work RVU:** 1.20

**2007 NF PE RVU:** 2.5

**2013 NF PE RVU:** 2.09

**2007 Fac PE RVU:** 0.45

**2013 Fac PE RVU:** 0.56

**RUC Recommendation:** 1.20

**CPT Action (if applicable):** June 2009  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Decrease

**64483** Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level **Global:** 000 **Issue:** Injection of Anesthetic Agent **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent RUC Meeting:** October 2009

**Tab** 05

**Specialty Developing Recommendation:**

AAPM, ISIS, ASA, NASS, AAPMR

**First Identified:** October 2008

**2012 Est Medicare Utilization:** 883,367

**2007 Work RVU:** 1.90

**2013 Work RVU:** 1.90

**2007 NF PE RVU:** 6.86

**2013 NF PE RVU:** 4.80

**2007 Fac PE RVU:** 0.81

**2013 Fac PE RVU:** 1.33

**RUC Recommendation:** 1.90

**CPT Action (if applicable):** June 2009  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Decrease

**64484** Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional level (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Injection of Anesthetic Agent **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent RUC Meeting:** October 2009

**Tab** 05

**Specialty Developing Recommendation:**

AAPM, ISIS, ASA, NASS, AAPMR

**First Identified:** October 2008

**2012 Est Medicare Utilization:** 436,416

**2007 Work RVU:** 1.33

**2013 Work RVU:** 1.00

**2007 NF PE RVU:** 2.86

**2013 NF PE RVU:** 1.60

**2007 Fac PE RVU:** 0.36

**2013 Fac PE RVU:** 0.47

**RUC Recommendation:** 1.00

**CPT Action (if applicable):** June 2009  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Decrease

## Status Report: CMS Requests and Relativity Assessment Issues

**64490** Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level **Global:** 000 **Issue:** Facet Joint Injections **Screen:** High Volume Growth1 **Complete?** Yes

**Most Recent RUC Meeting:** April 2009

**Tab** 18

**Specialty Developing Recommendation:**

ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS

**First Identified:**

**2012 Est Medicare Utilization:** 182,613

**2007 Work RVU:**

**2007 NF PE RVU:**

**2007 Fac PE RVU**

**2013 Work RVU:** 1.82

**2013 NF PE RVU:** 3.94

**2013 Fac PE RVU:** 1.23

**RUC Recommendation:** 1.82

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**64491** Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Facet Joint Injections **Screen:** High Volume Growth1 **Complete?** Yes

**Most Recent RUC Meeting:** April 2009

**Tab** 18

**Specialty Developing Recommendation:**

ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS

**First Identified:**

**2012 Est Medicare Utilization:** 163,916

**2007 Work RVU:**

**2007 NF PE RVU:**

**2007 Fac PE RVU**

**2013 Work RVU:** 1.16

**2013 NF PE RVU:** 1.61

**2013 Fac PE RVU:** 0.54

**RUC Recommendation:** 1.16

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**64492** Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Facet Joint Injections **Screen:** High Volume Growth1 **Complete?** Yes

**Most Recent RUC Meeting:** April 2009

**Tab** 18

**Specialty Developing Recommendation:**

ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS

**First Identified:**

**2012 Est Medicare Utilization:** 118,426

**2007 Work RVU:**

**2007 NF PE RVU:**

**2007 Fac PE RVU**

**2013 Work RVU:** 1.16

**2013 NF PE RVU:** 1.62

**2013 Fac PE RVU:** 0.56

**RUC Recommendation:** 1.16

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

## Status Report: CMS Requests and Relativity Assessment Issues

**64493** Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level **Global:** 000 **Issue:** Facet Joint Injections **Screen:** High Volume Growth1 **Complete?** Yes

**Most Recent RUC Meeting:** April 2009

**Tab** 18

**Specialty Developing Recommendation:**

ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS

**First Identified:**

**2012 Est Medicare Utilization:** 647,151

**2007 Work RVU:**

**2007 NF PE RVU:**

**2007 Fac PE RVU**

**2013 Work RVU:** 1.52

**2013 NF PE RVU:** 3.73

**2013 Fac PE RVU:** 1.09

**RUC Recommendation:** 1.52

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**64494** Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Facet Joint Injections **Screen:** High Volume Growth1 **Complete?** Yes

**Most Recent RUC Meeting:** April 2009

**Tab** 18

**Specialty Developing Recommendation:**

ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS

**First Identified:**

**2012 Est Medicare Utilization:** 574,778

**2007 Work RVU:**

**2007 NF PE RVU:**

**2007 Fac PE RVU**

**2013 Work RVU:** 1.00

**2013 NF PE RVU:** 1.56

**2013 Fac PE RVU:** 0.46

**RUC Recommendation:** 1.00

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**64495** Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Facet Joint Injections **Screen:** High Volume Growth1 **Complete?** Yes

**Most Recent RUC Meeting:** April 2009

**Tab** 18

**Specialty Developing Recommendation:**

ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS

**First Identified:**

**2012 Est Medicare Utilization:** 365,232

**2007 Work RVU:**

**2007 NF PE RVU:**

**2007 Fac PE RVU**

**2013 Work RVU:** 1.00

**2013 NF PE RVU:** 1.57

**2013 Fac PE RVU:** 0.48

**RUC Recommendation:** 1.00

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

## Status Report: CMS Requests and Relativity Assessment Issues

<b>64510</b>	<b>Injection, anesthetic agent; stellate ganglion (cervical sympathetic)</b>	<b>Global:</b> 000	<b>Issue:</b> Fluroscopy	<b>Screen:</b> CMS Request - Practice Expense Review	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2009	<b>Tab</b> 27	<b>Specialty Developing Recommendation:</b> ASA, ISIS, AAPM, APM&R	<b>First Identified:</b> April 2009	<b>2012 Est Medicare Utilization:</b> 8,132	<b>2007 Work RVU:</b> 1.22 <b>2007 NF PE RVU:</b> 3.06 <b>2007 Fac PE RVU:</b> 0.49 <b>Result:</b> PE Only
<b>RUC Recommendation:</b> New PE inputs			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 1.22 <b>2013 NF PE RVU:</b> 2.59 <b>2013 Fac PE RVU:</b> 0.89
<hr/>					
<b>64520</b>	<b>Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)</b>	<b>Global:</b> 000	<b>Issue:</b> Fluroscopy	<b>Screen:</b> CMS Request - Practice Expense Review	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2009	<b>Tab</b> 27	<b>Specialty Developing Recommendation:</b> ASA, ISIS, AAPM, APM&R	<b>First Identified:</b> April 2009	<b>2012 Est Medicare Utilization:</b> 22,816	<b>2007 Work RVU:</b> 1.35 <b>2007 NF PE RVU:</b> 4.5 <b>2007 Fac PE RVU:</b> 0.54 <b>Result:</b> PE Only
<b>RUC Recommendation:</b> PE Review - no change			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 1.35 <b>2013 NF PE RVU:</b> 4.27 <b>2013 Fac PE RVU:</b> 0.94
<hr/>					
<b>64555</b>	<b>Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)</b>	<b>Global:</b> 010	<b>Issue:</b> Neurostimulators	<b>Screen:</b> High Volume Growth1 / CMS Fastest Growing	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> September 2011	<b>Tab</b> 51	<b>Specialty Developing Recommendation:</b> ASA, AAPM, ASIPP	<b>First Identified:</b> February 2008	<b>2012 Est Medicare Utilization:</b> 7,499	<b>2007 Work RVU:</b> 2.29 <b>2007 NF PE RVU:</b> 2.96 <b>2007 Fac PE RVU:</b> 1.23 <b>Result:</b>
<b>RUC Recommendation:</b> Review September 2014. CPT Assistant article published.			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input checked="" type="checkbox"/>	<b>Published in CPT Asst:</b> Aug 2009	<b>2013 Work RVU:</b> 2.32 <b>2013 NF PE RVU:</b> 3.41 <b>2013 Fac PE RVU:</b> 1.83

## Status Report: CMS Requests and Relativity Assessment Issues

<b>64561</b>	<b>Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed</b>	<b>Global:</b> 010	<b>Issue:</b> Neurostimulators	<b>Screen:</b> CMS Fastest Growing / High Volume Growth2	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> October 2008	<b>Tab</b> 26 <b>Specialty Developing Recommendation:</b> ISIS, AUA	<b>First Identified:</b> October 2008	<b>2012 Est Medicare Utilization:</b> 17,771	<b>2007 Work RVU:</b> 7.07 <b>2007 NF PE RVU:</b> 27.51 <b>2007 Fac PE RVU:</b> 3.05	<b>2013 Work RVU:</b> 7.15 <b>2013 NF PE RVU:</b> 15.98 <b>2013 Fac PE RVU:</b> 3.70
<b>RUC Recommendation:</b> Review action plan. Remove from cMS Fastest Growing screen.	<b>CPT Action (if applicable):</b>		<b>Result:</b> Remove from Screen		
		<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		
<b>64568</b>	<b>Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator</b>	<b>Global:</b> 090	<b>Issue:</b> Vagus Nerve Stimulator	<b>Screen:</b> Site of Service Anomaly	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2010	<b>Tab</b> 14 <b>Specialty Developing Recommendation:</b> AANS/CNS	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 669	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU:</b>	<b>2013 Work RVU:</b> 9.00 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 8.01
<b>RUC Recommendation:</b> 11.19	<b>CPT Action (if applicable):</b>		October 2009	<b>Result:</b> Decrease	
		<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		
<b>64573</b>	<b>Deleted from CPT</b>	<b>Global:</b> 090	<b>Issue:</b> Neurosurgical Procedures	<b>Screen:</b> Site of Service Anomaly	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2009	<b>Tab</b> 28 <b>Specialty Developing Recommendation:</b> AANS/CNS	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> 8.15 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 5.31	<b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>
<b>RUC Recommendation:</b> Deleted from CPT	<b>CPT Action (if applicable):</b>		October 2009	<b>Result:</b> Deleted from CPT	
		<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		
<b>64581</b>	<b>Incision for implantation of neurostimulator electrode array; sacral nerve (transforaminal placement)</b>	<b>Global:</b> 090	<b>Issue:</b> Urological Procedures	<b>Screen:</b> Site of Service Anomaly	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2009	<b>Tab</b> 17 <b>Specialty Developing Recommendation:</b> AUA	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 10,401	<b>2007 Work RVU:</b> 14.15 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 5.73	<b>2013 Work RVU:</b> 12.20 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 5.69
<b>RUC Recommendation:</b> 12.20	<b>CPT Action (if applicable):</b>			<b>Result:</b> Decrease	
		<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

## Status Report: CMS Requests and Relativity Assessment Issues

<b>64590</b>	Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling	<b>Global:</b> 010	<b>Issue:</b> RAW	<b>Screen:</b> Harvard-Valued Annual Allowed Charges Greater than \$10 million	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab 27</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> October 2012	<b>2012 Est Medicare Utilization:</b> 10,200	<b>2007 Work RVU:</b> 2.42 <b>2007 NF PE RVU:</b> 6.95 <b>2007 Fac PE RVU:</b> 2.33 <b>2013 Work RVU:</b> 2.45 <b>2013 NF PE RVU:</b> 5.12 <b>2013 Fac PE RVU:</b> 1.98
<b>RUC Recommendation:</b> Remove from screen			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b> Remove from Screen
<b>64622</b>	Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, single level	<b>Global:</b> 010	<b>Issue:</b> Fluroscopy	<b>Screen:</b> CMS Request - Practice Expense Review, High Volume Growth1 / CMS Fastest Growing, Harvard Valued - Utilization over 100,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2009	<b>Tab 27</b>	<b>Specialty Developing Recommendation:</b> ASA, ISIS, AAPM, APM&R	<b>First Identified:</b> April 2008	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> 3.02 <b>2007 NF PE RVU:</b> 6.82 <b>2007 Fac PE RVU:</b> 1.34 <b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>
<b>RUC Recommendation:</b> PE Review - no change			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	June 2008 and Feb 2011 <b>Published in CPT Asst:</b>	<b>Result:</b> PE Only
<b>64623</b>	Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, each additional level (List separately in addition to code for primary procedure)	<b>Global:</b> ZZZ	<b>Issue:</b> Destruction by Neurolytic Agent	<b>Screen:</b> High Volume Growth1, Harvard Valued - Utilization over 100,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2008	<b>Tab 57</b>	<b>Specialty Developing Recommendation:</b> ASA, NASS, AAPM	<b>First Identified:</b> February 2008	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> 0.99 <b>2007 NF PE RVU:</b> 2.62 <b>2007 Fac PE RVU:</b> 0.22 <b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>
<b>RUC Recommendation:</b> 0.99			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	June 2008 and Feb 2011 <b>Published in CPT Asst:</b>	<b>Result:</b> Maintain

## Status Report: CMS Requests and Relativity Assessment Issues

<b>64626</b>	<b>Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, single level</b>	<b>Global:</b> 010	<b>Issue:</b> Fluroscopy	<b>Screen:</b> CMS Request - Practice Expense Review, High Volume Growth1 / CMS Fastest Growing	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2009	<b>Tab</b> 27	<b>Specialty Developing Recommendation:</b> ASA, ISIS, AAPM, APM&R	<b>First Identified:</b> April 2008	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> 3.82 <b>2007 NF PE RVU:</b> 6.99 <b>2007 Fac PE RVU</b> 1.93 <b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>
<b>RUC Recommendation:</b> PE Review - no change			<b>CPT Action (if applicable):</b> June 2008 and Feb 2011	<b>Published in CPT Asst:</b>	<b>Result:</b> PE Only
			<b>Referred to CPT Asst</b> <input type="checkbox"/>		
<b>64627</b>	<b>Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure)</b>	<b>Global:</b> ZZZ	<b>Issue:</b> Destruction by Neurolytic Agent	<b>Screen:</b> High Volume Growth1/ CMS Fastest Growing	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2008	<b>Tab</b> 57	<b>Specialty Developing Recommendation:</b> ASA, NASS, AAPM	<b>First Identified:</b> April 2008	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> 1.16 <b>2007 NF PE RVU:</b> 3.98 <b>2007 Fac PE RVU</b> 0.26 <b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>
<b>RUC Recommendation:</b> Deleted from CPT			<b>CPT Action (if applicable):</b> June 2008 and Feb 2011	<b>Published in CPT Asst:</b>	<b>Result:</b> Deleted from CPT
			<b>Referred to CPT Asst</b> <input type="checkbox"/>		
<b>64640</b>	<b>Destruction by neurolytic agent; other peripheral nerve or branch</b>	<b>Global:</b> 010	<b>Issue:</b> Injection Treatment of Nerve	<b>Screen:</b> Site of Service Anomaly (99238-Only) / Harvard Valued - Utilization over 30,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> September 2011	<b>Tab</b> 25	<b>Specialty Developing Recommendation:</b> ASAM, AAPM, APMA, ASIPP	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 72,114	<b>2007 Work RVU:</b> 2.78 <b>2007 NF PE RVU:</b> 3.75 <b>2007 Fac PE RVU</b> 1.75 <b>2013 Work RVU:</b> 1.23 <b>2013 NF PE RVU:</b> 2.73 <b>2013 Fac PE RVU:</b> 1.48
<b>RUC Recommendation:</b> 1.23. Remove 99238.			<b>CPT Action (if applicable):</b>	<b>Published in CPT Asst:</b>	<b>Result:</b> Decrease
			<b>Referred to CPT Asst</b> <input type="checkbox"/>		



# Status Report: CMS Requests and Relativity Assessment Issues

**64708** Neuroplasty, major peripheral nerve, arm or leg, open; other than specified **Global:** 090 **Issue:** Neuroplasty – Leg or Arm **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** October 2010 **Tab** 69 **Specialty Developing Recommendation:** AOFAS, ASSH, AAOS, ASPS **First Identified:** September 2007 **2012 Est Medicare Utilization:** 3,272 **2007 Work RVU:** 6.22 **2013 Work RVU:** 6.36 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 4.73 **2013 Fac PE RVU:** 7.35 **Result:** Maintain

**RUC Recommendation:** 6.36 **CPT Action (if applicable):** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

**64712** Neuroplasty, major peripheral nerve, arm or leg, open; sciatic nerve **Global:** 090 **Issue:** Neuroplasty – Leg or Arm **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** October 2009 **Tab** 40 **Specialty Developing Recommendation:** AOFAS, ASSH, AAOS, ASPS **First Identified:** September 2007 **2012 Est Medicare Utilization:** 858 **2007 Work RVU:** 7.98 **2013 Work RVU:** 8.07 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 4.86 **2013 Fac PE RVU:** 7.48 **Result:** Remove from Screen

**RUC Recommendation:** Remove from screen **CPT Action (if applicable):** February 2010 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

**64831** Suture of digital nerve, hand or foot; 1 nerve **Global:** 090 **Issue:** Neurorrhaphy – Finger **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** October 2010 **Tab** 70 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** September 2007 **2012 Est Medicare Utilization:** 1,057 **2007 Work RVU:** 10.23 **2013 Work RVU:** 9.16 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 7 **2013 Fac PE RVU:** 9.58 **Result:** Decrease

**RUC Recommendation:** 9.16 **CPT Action (if applicable):** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

**65105** Enucleation of eye; with implant, muscles attached to implant **Global:** 090 **Issue:** Ophthalmologic Procedures **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

**Most Recent RUC Meeting:** September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2012 Est Medicare Utilization:** 918 **2007 Work RVU:** 9.70 **2013 Work RVU:** 9.93 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU:** 10.13 **2013 Fac PE RVU:** 14.55 **Result:** PE Only

**RUC Recommendation:** Reduce 99238 to 0.5 **CPT Action (if applicable):** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

# Status Report: CMS Requests and Relativity Assessment Issues

<b>65222</b>	<b>Removal of foreign body, external eye; corneal, with slit lamp</b>	<b>Global:</b> 000	<b>Issue:</b> Removal of Foreign Body	<b>Screen:</b> Harvard Valued - Utilization over 30,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> September 2011	<b>Tab</b> 26	<b>Specialty Developing Recommendation:</b> AAO, AOA (optometric)	<b>First Identified:</b> April 2011	<b>2012 Est Medicare Utilization:</b> 31,989	<b>2007 Work RVU:</b> 0.93 <b>2007 NF PE RVU:</b> 0.87 <b>2007 Fac PE RVU:</b> 0.40 <b>Result:</b> Maintain
<b>RUC Recommendation:</b> 0.93			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 0.84 <b>2013 NF PE RVU:</b> 1.09 <b>2013 Fac PE RVU:</b> 0.64
<hr/>					
<b>65285</b>	<b>Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue</b>	<b>Global:</b> 090	<b>Issue:</b> Repair of Eye Wound	<b>Screen:</b> Site of Service Anomaly	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2011	<b>Tab</b> 8	<b>Specialty Developing Recommendation:</b> AAO	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 932	<b>2007 Work RVU:</b> 14.43 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 9.12 <b>Result:</b> Decrease
<b>RUC Recommendation:</b> 16.00			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 15.36 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 16.19
<hr/>					
<b>65780</b>	<b>Ocular surface reconstruction; amniotic membrane transplantation, multiple layers</b>	<b>Global:</b> 090	<b>Issue:</b> Ophthalmological Procedures	<b>Screen:</b> CMS Fastest Growing	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> September 2011	<b>Tab</b> 51	<b>Specialty Developing Recommendation:</b> AAO	<b>First Identified:</b> October 2008	<b>2012 Est Medicare Utilization:</b> 2,379	<b>2007 Work RVU:</b> 10.43 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 10.04 <b>Result:</b>
<b>RUC Recommendation:</b> Add to new technology list and review in 3 years (Sept 2014). CPT Assistant article published.			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input checked="" type="checkbox"/>	<b>Published in CPT Asst:</b> Jun 2009	<b>2013 Work RVU:</b> 10.73 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 14.88
<hr/>					
<b>65800</b>	<b>Paracentesis of anterior chamber of eye (separate procedure); with removal of aqueous</b>	<b>Global:</b> 000	<b>Issue:</b> Paracentesis of the Eye	<b>Screen:</b> Harvard Valued - Utilization over 30,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2012	<b>Tab</b> 21	<b>Specialty Developing Recommendation:</b> AAO	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 3,653	<b>2007 Work RVU:</b> 1.91 <b>2007 NF PE RVU:</b> 1.71 <b>2007 Fac PE RVU:</b> 1.16 <b>Result:</b> Decrease
<b>RUC Recommendation:</b> 1.53			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b> October 2011	<b>2013 Work RVU:</b> 1.53 <b>2013 NF PE RVU:</b> 1.88 <b>2013 Fac PE RVU:</b> 1.03

## Status Report: CMS Requests and Relativity Assessment Issues

**65805** Paracentesis of anterior chamber of eye (separate procedure); with therapeutic release of aqueous      **Global:** 000      **Issue:** Paracentesis of the Eye      **Screen:** Harvard Valued - Utilization over 30,000      **Complete?** Yes

**Most Recent**      **Tab** 21      **Specialty Developing**      AAO  
**RUC Meeting:** April 2012      **Recommendation:**

**First**  
**Identified:** April 2011

**2012 Est**  
**Medicare**  
**Utilization:** 43,870

**2007 Work RVU:** 1.91  
**2007 NF PE RVU:** 2.07  
**2007 Fac PE RVU** 1.16

**2013 Work RVU:**  
**2013 NF PE RVU:**  
**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2011  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

**Result:** Deleted from CPT

**66180** Aqueous shunt to extraocular reservoir (eg, Molteno, Schocket, Denver-Krupin)      **Global:** 090      **Issue:** Aqueous Shunt      **Screen:** Harvard-Valued Annual Allowed Charges Greater than \$10 million      **Complete?** No

**Most Recent**      **Tab** 23      **Specialty Developing**      AAO  
**RUC Meeting:** April 2013      **Recommendation:**

**First**  
**Identified:** October 2012

**2012 Est**  
**Medicare**  
**Utilization:** 12,139

**2007 Work RVU:** 16.02      **2013 Work RVU:** 16.30  
**2007 NF PE RVU:** NA      **2013 NF PE RVU:** NA  
**2007 Fac PE RVU** 10.62      **2013 Fac PE RVU:** 16.84  
**Result:**

**RUC Recommendation:** Refer to CPT

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

**66185** Revision of aqueous shunt to extraocular reservoir      **Global:** 090      **Issue:** Aqueous Shunt      **Screen:** Harvard-Valued Annual Allowed Charges Greater than \$10 million      **Complete?** No

**Most Recent**      **Tab** 23      **Specialty Developing**      AAO  
**RUC Meeting:** April 2013      **Recommendation:**

**First**  
**Identified:** October 2012

**2012 Est**  
**Medicare**  
**Utilization:** 1,879

**2007 Work RVU:** 9.35      **2013 Work RVU:** 9.58  
**2007 NF PE RVU:** NA      **2013 NF PE RVU:** NA  
**2007 Fac PE RVU** 7.37      **2013 Fac PE RVU:** 11.93  
**Result:**

**RUC Recommendation:** Refer to CPT

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

<b>66761</b>	<b>Iridotomy/iridectomy by laser surgery (eg, for glaucoma) (per session)</b>	<b>Global:</b> 010	<b>Issue:</b> Iridotomy	<b>Screen:</b> High IWPUT	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab</b> 14 <b>Specialty Developing Recommendation:</b> AAO	<b>First Identified:</b> February 2008	<b>2012 Est Medicare Utilization:</b> 81,536	<b>2007 Work RVU:</b> 4.87 <b>2007 NF PE RVU:</b> 5.49 <b>2007 Fac PE RVU:</b> 4.32 <b>Result:</b> Decrease	<b>2013 Work RVU:</b> 3.00 <b>2013 NF PE RVU:</b> 5.64 <b>2013 Fac PE RVU:</b> 3.77
<b>RUC Recommendation:</b> 3.00		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	February 2010 <b>Published in CPT Asst:</b>		
<hr/>					
<b>66821</b>	<b>Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (eg, YAG laser) (1 or more stages)</b>	<b>Global:</b> 090	<b>Issue:</b>	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2011	<b>Tab</b> 41 <b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> October 2010	<b>2012 Est Medicare Utilization:</b> 600,569	<b>2007 Work RVU:</b> 3.32 <b>2007 NF PE RVU:</b> 4.05 <b>2007 Fac PE RVU:</b> 3.6 <b>Result:</b> Maintain	<b>2013 Work RVU:</b> 3.42 <b>2013 NF PE RVU:</b> 6.19 <b>2013 Fac PE RVU:</b> 5.61
<b>RUC Recommendation:</b> Reaffirmed RUC recommendation		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		
<hr/>					
<b>66982</b>	<b>Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage</b>	<b>Global:</b> 090	<b>Issue:</b> Cataract Surgery	<b>Screen:</b> High IWPUT / CMS Fastest Growing, Site of Service Anomaly (99238-Only) / CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2012	<b>Tab</b> 17 <b>Specialty Developing Recommendation:</b> AAO	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 165,148	<b>2007 Work RVU:</b> 14.83 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 9.75 <b>Result:</b> Decrease	<b>2013 Work RVU:</b> 11.08 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 11.55
<b>RUC Recommendation:</b> 11.08. CPT Assistant article published; Reduce to 2x99213 & 3x99212		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input checked="" type="checkbox"/>	<b>Published in CPT Asst:</b> Sep 2009		

## Status Report: CMS Requests and Relativity Assessment Issues

**66984** Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification) **Global:** 090 **Issue:** Cataract Surgery **Screen:** High IWP/PUT / MPC List **Complete?** Yes

**Most Recent**  
**RUC Meeting:** January 2012 **Tab** 17 **Specialty Developing Recommendation:** AAO

**First Identified:** February 2008

**2012 Est Medicare Utilization:** 1,661,835

**2007 Work RVU:** 10.36 **2013 Work RVU:** 8.52  
**2007 NF PE RVU:** NA **2013 NF PE RVU:** NA  
**2007 Fac PE RVU:** 7.24 **2013 Fac PE RVU:** 9.77  
**Result:** Decrease

**RUC Recommendation:** 8.52

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**67028** Intravitreal injection of a pharmacologic agent (separate procedure)

**Global:** 000 **Issue:** Treatment of Retinal Lesion **Screen:** High Volume Growth1 / CMS Fastest Growing, Harvard Valued - Utilization over 100,000 / CMS High Expenditure Procedural Codes **Complete?** Yes

**Most Recent**  
**RUC Meeting:** Jan11, Oct09 **Tab** 30 **Specialty Developing Recommendation:** AAO

**First Identified:** February 2008

**2012 Est Medicare Utilization:** 2,375,397

**2007 Work RVU:** 2.52 **2013 Work RVU:** 1.44  
**2007 NF PE RVU:** 2.59 **2013 NF PE RVU:** 1.45  
**2007 Fac PE RVU:** 1.42 **2013 Fac PE RVU:** 1.40  
**Result:** Decrease

**RUC Recommendation:** 1.44

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**67036** Vitrectomy, mechanical, pars plana approach;

**Global:** 090 **Issue:** RAW **Screen:** Harvard-Valued Annual Allowed Charges Greater than \$10 million **Complete?** No

**Most Recent**  
**RUC Meeting:** October 2012 **Tab** 27 **Specialty Developing Recommendation:**

**First Identified:** October 2012

**2012 Est Medicare Utilization:** 14,561

**2007 Work RVU:** 13.09 **2013 Work RVU:** 13.32  
**2007 NF PE RVU:** NA **2013 NF PE RVU:** NA  
**2007 Fac PE RVU:** 8.96 **2013 Fac PE RVU:** 13.97  
**Result:**

**RUC Recommendation:** Survey for October 2013.

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**67038 Deleted from CPT**

**Global:** 090

**Issue:** Ophthalmological Procedures

**Screen:** Site of Service Anomaly

**Complete?** Yes

**Most Recent RUC Meeting:** September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAO

**First Identified:** September 2007

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 23.30

**2013 Work RVU:**

**2007 NF PE RVU:** NA

**2013 NF PE RVU:**

**2007 Fac PE RVU** 15.16

**2013 Fac PE RVU:**

**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** February 2007

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**67039 Vitrectomy, mechanical, pars plana approach; with focal endolaser photocoagulation**

**Global:** 090

**Issue:** Vitrectomy

**Screen:** Site of Service Anomaly (99238-Only) / Harvard-Valued Annual Allowed Charges Greater than \$10 million

**Complete?** No

**Most Recent RUC Meeting:** September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAO

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 2,248

**2007 Work RVU:** 16.39

**2013 Work RVU:** 16.74

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 11.94

**2013 Fac PE RVU:** 18.44

**Result:** PE Only

**RUC Recommendation:** Survey for October 2013. Reduce 99238 to 0.5

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**67040 Vitrectomy, mechanical, pars plana approach; with endolaser panretinal photocoagulation**

**Global:** 090

**Issue:** Vitrectomy

**Screen:** Site of Service Anomaly (99238-Only) / Harvard-Valued Annual Allowed Charges Greater than \$10 million

**Complete?** No

**Most Recent RUC Meeting:** September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAO

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 11,332

**2007 Work RVU:** 19.23

**2013 Work RVU:** 19.61

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 13.41

**2013 Fac PE RVU:** 20.79

**Result:** PE Only

**RUC Recommendation:** Survey for October 2013. Reduce 99238 to 0.5

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

67041	Vitrectomy, mechanical, pars plana approach; with removal of preretinal cellular membrane (eg, macular pucker)	Global: 090	Issue: RAW	Screen: Harvard-Valued Annual Allowed Charges Greater than \$10 million	Complete?	No				
Most Recent RUC Meeting:	October 2012	Tab 27	Specialty Developing Recommendation:	First Identified:	October 2012	2012 Est Medicare Utilization:	16,423	2007 Work RVU:	2013 Work RVU:	19.25
						2007 NF PE RVU:		2013 NF PE RVU:		NA
						2007 Fac PE RVU Result:		2013 Fac PE RVU:		18.27
RUC Recommendation:	Survey for October 2013.			CPT Action (if applicable):	Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:			
67042	Vitrectomy, mechanical, pars plana approach; with removal of internal limiting membrane of retina (eg, for repair of macular hole, diabetic macular edema), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil)	Global: 090	Issue: RAW	Screen: Harvard-Valued Annual Allowed Charges Greater than \$10 million	Complete?	No				
Most Recent RUC Meeting:	October 2012	Tab 27	Specialty Developing Recommendation:	First Identified:	October 2012	2012 Est Medicare Utilization:	24,562	2007 Work RVU:	2013 Work RVU:	22.38
						2007 NF PE RVU:		2013 NF PE RVU:		NA
						2007 Fac PE RVU Result:		2013 Fac PE RVU:		20.38
RUC Recommendation:	Survey for October 2013.			CPT Action (if applicable):	Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:			
67043	Vitrectomy, mechanical, pars plana approach; with removal of subretinal membrane (eg, choroidal neovascularization), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil) and laser photocoagulation	Global: 090	Issue: RAW	Screen: Harvard-Valued Annual Allowed Charges Greater than \$10 million	Complete?	No				
Most Recent RUC Meeting:	October 2012	Tab 27	Specialty Developing Recommendation:	First Identified:	October 2012	2012 Est Medicare Utilization:	1,211	2007 Work RVU:	2013 Work RVU:	23.24
						2007 NF PE RVU:		2013 NF PE RVU:		NA
						2007 Fac PE RVU Result:		2013 Fac PE RVU:		21.81
RUC Recommendation:	Survey for October 2013.			CPT Action (if applicable):	Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:			

## Status Report: CMS Requests and Relativity Assessment Issues

---

<b>67107</b>	<b>Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), with or without implant, with or without cryotherapy, photocoagulation, and drainage of subretinal fluid</b>	<b>Global:</b> 090	<b>Issue:</b> Retinal Detachment	<b>Screen:</b> Site of Service Anomaly (99238-Only)	<b>Complete?</b> Yes
--------------	--	--------------------	----------------------------------	---	----------------------

<b>Most Recent RUC Meeting:</b> September 2007	<b>Tab</b> 16	<b>Specialty Developing Recommendation:</b> AAO
--	---------------	---

<b>First Identified:</b> September 2007
---

<b>2012 Est Medicare Utilization:</b> 1,286
---

<b>2007 Work RVU:</b> 16.35	<b>2013 Work RVU:</b> 16.71
<b>2007 NF PE RVU:</b> NA	<b>2013 NF PE RVU:</b> NA
<b>2007 Fac PE RVU</b> 11.19	<b>2013 Fac PE RVU:</b> 17.90
<b>Result:</b> PE Only	

**RUC Recommendation:** Reduce 99238 to 0.5

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

---

<b>67108</b>	<b>Repair of retinal detachment; with vitrectomy, any method, with or without air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique</b>
--------------	---

<b>Global:</b> 090	<b>Issue:</b> Retinal Detachment
--------------------	----------------------------------

<b>Screen:</b> Site of Service Anomaly (99238-Only)	<b>Complete?</b> Yes
---	----------------------

<b>Most Recent RUC Meeting:</b> September 2007	<b>Tab</b> 16	<b>Specialty Developing Recommendation:</b> AAO
--	---------------	---

<b>First Identified:</b> September 2007
---

<b>2012 Est Medicare Utilization:</b> 13,353
--

<b>2007 Work RVU:</b> 22.49	<b>2013 Work RVU:</b> 22.89
<b>2007 NF PE RVU:</b> NA	<b>2013 NF PE RVU:</b> NA
<b>2007 Fac PE RVU</b> 14.22	<b>2013 Fac PE RVU:</b> 22.66
<b>Result:</b> PE Only	

**RUC Recommendation:** Reduce 99238 to 0.5

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

---

<b>67110</b>	<b>Repair of retinal detachment; by injection of air or other gas (eg, pneumatic retinopexy)</b>
--------------	--

<b>Global:</b> 090	<b>Issue:</b> Retinal Detachment
--------------------	----------------------------------

<b>Screen:</b> Site of Service Anomaly (99238-Only)	<b>Complete?</b> Yes
---	----------------------

<b>Most Recent RUC Meeting:</b> September 2007	<b>Tab</b> 16	<b>Specialty Developing Recommendation:</b> AAO
--	---------------	---

<b>First Identified:</b> September 2007
---

<b>2012 Est Medicare Utilization:</b> 2,910
---

<b>2007 Work RVU:</b> 10.02	<b>2013 Work RVU:</b> 10.25
<b>2007 NF PE RVU:</b> 9.99	<b>2013 NF PE RVU:</b> 14.81
<b>2007 Fac PE RVU</b> 7.37	<b>2013 Fac PE RVU:</b> 11.90
<b>Result:</b> PE Only	

**RUC Recommendation:** Remove 99238

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**



## Status Report: CMS Requests and Relativity Assessment Issues

**67210** Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; photocoagulation **Global:** 090 **Issue:** Treatment of Retinal Lesion or Choroid **Screen:** High IWPUT **Complete?** Yes

**Most Recent** **Tab** 13 **Specialty Developing** AAO  
**RUC Meeting:** October 2010 **Recommendation:**

**First**  
**Identified:** February 2008

**2012 Est**  
**Medicare**  
**Utilization:** 97,307

**2007 Work RVU:** 9.35  
**2007 NF PE RVU:** 6.48  
**2007 Fac PE RVU** 5.84  
**Result:** Decrease

**2013 Work RVU:** 6.36  
**2013 NF PE RVU:** 8.54  
**2013 Fac PE RVU:** 8.00

**RUC Recommendation:** 6.36

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**67220** Destruction of localized lesion of choroid (eg, choroidal neovascularization); photocoagulation (eg, laser), 1 or more sessions **Global:** 090 **Issue:** Treatment of Retinal Lesion or Choroid **Screen:** High IWPUT **Complete?** Yes

**Most Recent** **Tab** 13 **Specialty Developing** AAO  
**RUC Meeting:** October 2010 **Recommendation:**

**First**  
**Identified:** February 2008

**2012 Est**  
**Medicare**  
**Utilization:** 8,486

**2007 Work RVU:** 14.19  
**2007 NF PE RVU:** 10.23  
**2007 Fac PE RVU** 8.9  
**Result:** Decrease

**2013 Work RVU:** 6.36  
**2013 NF PE RVU:** 9.04  
**2013 Fac PE RVU:** 8.00

**RUC Recommendation:** 6.36

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**67225** Destruction of localized lesion of choroid (eg, choroidal neovascularization); photodynamic therapy, second eye, at single session (List separately in addition to code for primary eye treatment) **Global:** ZZZ **Issue:** Photodynamic Therapy of the Eye **Screen:** New Technology **Complete?** Yes

**Most Recent** **Tab** P **Specialty Developing** AAO  
**RUC Meeting:** February 2008 **Recommendation:**

**First**  
**Identified:** September 2007

**2012 Est**  
**Medicare**  
**Utilization:** 329

**2007 Work RVU:** 0.47  
**2007 NF PE RVU:** 0.25  
**2007 Fac PE RVU** 0.20  
**Result:** Maintain

**2013 Work RVU:** 0.47  
**2013 NF PE RVU:** 0.37  
**2013 Fac PE RVU:** 0.32

**RUC Recommendation:** 0.47

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**67228** Treatment of extensive or progressive retinopathy, 1 or more sessions; (eg, diabetic retinopathy), photocoagulation **Global:** 090 **Issue:** Treatment of Retinal Lesion or Choroid **Screen:** High IWPUT **Complete?** Yes

**Most Recent** **Tab** 40 **Specialty Developing** AAO  
**RUC Meeting:** October 2009 **Recommendation:**

**First**  
**Identified:** February 2008

**2012 Est**  
**Medicare**  
**Utilization:** 83,585

**2007 Work RVU:** 13.67  
**2007 NF PE RVU:** 11.2  
**2007 Fac PE RVU** 8.43  
**Result:** Remove from Screen

**2013 Work RVU:** 13.82  
**2013 NF PE RVU:** 14.63  
**2013 Fac PE RVU:** 13.01

**RUC Recommendation:** Remove from screen

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**67914** Repair of ectropion; suture

**Global:** 090

**Issue:** Repair of Eyelid

**Screen:** Harvard-Valued Annual  
Allowed Charges  
Greater than \$10 million

**Complete?** Yes

**Most Recent  
RUC Meeting:** April 2013

**Tab** 24

**Specialty Developing  
Recommendation:**

**First  
Identified:** October 2012

**2012 Est  
Medicare  
Utilization:** 2,035

**2007 Work RVU:** 3.70

**2013 Work RVU:** 3.75

**2007 NF PE RVU:** 5.98

**2013 NF PE RVU:** 7.56

**2007 Fac PE RVU** 2.99

**2013 Fac PE RVU:** 4.49

**Result:** Maintain

**RUC Recommendation:** 3.75

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**67915** Repair of ectropion; thermocauterization

**Global:** 090

**Issue:** Repair of Eyelid

**Screen:** Harvard-Valued Annual  
Allowed Charges  
Greater than \$10 million

**Complete?** Yes

**Most Recent  
RUC Meeting:** April 2013

**Tab** 24

**Specialty Developing  
Recommendation:**

**First  
Identified:** October 2012

**2012 Est  
Medicare  
Utilization:** 455

**2007 Work RVU:** 3.21

**2013 Work RVU:** 3.26

**2007 NF PE RVU:** 5.62

**2013 NF PE RVU:** 7.03

**2007 Fac PE RVU** 2.75

**2013 Fac PE RVU:** 4.16

**Result:** Decrease

**RUC Recommendation:** 2.03

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**67916** Repair of ectropion; excision tarsal wedge

**Global:** 090

**Issue:** Repair of Eyelid

**Screen:** Harvard-Valued Annual  
Allowed Charges  
Greater than \$10 million

**Complete?** Yes

**Most Recent  
RUC Meeting:** April 2013

**Tab** 24

**Specialty Developing  
Recommendation:**

**First  
Identified:** October 2012

**2012 Est  
Medicare  
Utilization:** 3,015

**2007 Work RVU:** 5.37

**2013 Work RVU:** 5.48

**2007 NF PE RVU:** 7.68

**2013 NF PE RVU:** 10.17

**2007 Fac PE RVU** 4.65

**2013 Fac PE RVU:** 6.90

**Result:** Maintain

**RUC Recommendation:** 5.48

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**67917** Repair of ectropion; extensive (eg, tarsal strip operations)

**Global:** 090

**Issue:** Repair of Eyelid

**Screen:** Harvard-Valued Annual  
Allowed Charges  
Greater than \$10 million

**Complete?** Yes

**Most Recent  
RUC Meeting:** April 2013

**Tab** 24

**Specialty Developing  
Recommendation:**

**First  
Identified:** October 2012

**2012 Est  
Medicare  
Utilization:** 27,845

**2007 Work RVU:** 6.08

**2013 Work RVU:** 6.19

**2007 NF PE RVU:** 8.08

**2013 NF PE RVU:** 10.79

**2007 Fac PE RVU** 4.95

**2013 Fac PE RVU:** 7.38

**Result:** Decrease

**RUC Recommendation:** 5.93

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**67921** Repair of entropion; suture

**Global:** 090

**Issue:** Repair of Eyelid

**Screen:** Harvard-Valued Annual  
Allowed Charges  
Greater than \$10 million

**Complete?** Yes

**Most Recent  
RUC Meeting:** April 2013

**Tab** 24

**Specialty Developing  
Recommendation:**

**First  
Identified:** October 2012

**2012 Est  
Medicare  
Utilization:** 4,893

**2007 Work RVU:** 3.42

**2013 Work RVU:** 3.47

**2007 NF PE RVU:** 5.83

**2013 NF PE RVU:** 7.38

**2007 Fac PE RVU** 2.84

**2013 Fac PE RVU:** 4.31

**Result:** Maintain

**RUC Recommendation:** 3.47

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**67922** Repair of entropion; thermocauterization

**Global:** 090

**Issue:** Repair of Eyelid

**Screen:** Harvard-Valued Annual  
Allowed Charges  
Greater than \$10 million

**Complete?** Yes

**Most Recent  
RUC Meeting:** April 2013

**Tab** 24

**Specialty Developing  
Recommendation:**

**First  
Identified:** October 2012

**2012 Est  
Medicare  
Utilization:** 193

**2007 Work RVU:** 3.09

**2013 Work RVU:** 3.14

**2007 NF PE RVU:** 5.55

**2013 NF PE RVU:** 6.91

**2007 Fac PE RVU** 2.7

**2013 Fac PE RVU:** 4.09

**Result:** Decrease

**RUC Recommendation:** 2.03

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

<b>67923</b>	Repair of entropion; excision tarsal wedge		<b>Global:</b> 090	<b>Issue:</b> Repair of Eyelid	<b>Screen:</b> Harvard-Valued Annual Allowed Charges Greater than \$10 million	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 24	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> October 2012	<b>2012 Est Medicare Utilization:</b> 2,369	<b>2007 Work RVU:</b> 5.94 <b>2007 NF PE RVU:</b> 7.76 <b>2007 Fac PE RVU:</b> 4.86 <b>Result:</b> Decrease	<b>2013 Work RVU:</b> 6.05 <b>2013 NF PE RVU:</b> 10.42 <b>2013 Fac PE RVU:</b> 7.29
<b>RUC Recommendation:</b> 5.48			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		
<b>67924</b>	Repair of entropion; extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)		<b>Global:</b> 090	<b>Issue:</b> Repair of Eyelid	<b>Screen:</b> Harvard-Valued Annual Allowed Charges Greater than \$10 million	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 24	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> October 2012	<b>2012 Est Medicare Utilization:</b> 12,754	<b>2007 Work RVU:</b> 5.84 <b>2007 NF PE RVU:</b> 8.48 <b>2007 Fac PE RVU:</b> 4.57 <b>Result:</b> Maintain	<b>2013 Work RVU:</b> 5.93 <b>2013 NF PE RVU:</b> 11.12 <b>2013 Fac PE RVU:</b> 6.89
<b>RUC Recommendation:</b> 5.93			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		
<b>68040</b>	Expression of conjunctival follicles (eg, for trachoma)		<b>Global:</b> 000	<b>Issue:</b> Treatment of Eyelid Lesions	<b>Screen:</b> High Volume Growth1	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> September 2011	<b>Tab</b> 51	<b>Specialty Developing Recommendation:</b> AAO	<b>First Identified:</b> February 2008	<b>2012 Est Medicare Utilization:</b> 6,026	<b>2007 Work RVU:</b> 0.85 <b>2007 NF PE RVU:</b> 0.69 <b>2007 Fac PE RVU:</b> 0.42 <b>Result:</b>	<b>2013 Work RVU:</b> 0.85 <b>2013 NF PE RVU:</b> 0.99 <b>2013 Fac PE RVU:</b> 0.63
<b>RUC Recommendation:</b> Refer to CPT			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

# Status Report: CMS Requests and Relativity Assessment Issues

68200	Subconjunctival injection			Global: 000	Issue: Subconjunctival Injection	Screen: Harvard Valued - Utilization over 30,000	Complete? No
Most Recent RUC Meeting:	September 2011	Tab 28	Specialty Developing Recommendation:	AAO	First Identified: April 2011	2012 Est Medicare Utilization: 28,820	2007 Work RVU: 0.49 2007 NF PE RVU: 0.52 2007 Fac PE RVU 0.32 2013 Work RVU: 0.49 2013 NF PE RVU: 0.69 2013 Fac PE RVU: 0.50
RUC Recommendation: 0.49 and Review October 2013.					CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Maintain
68810	Probing of nasolacrimal duct, with or without irrigation;			Global: 010	Issue: Ophthalmological Procedures	Screen: Site of Service Anomaly	Complete? Yes
Most Recent RUC Meeting:	February 2008	Tab L	Specialty Developing Recommendation:	AAO	First Identified: September 2007	2012 Est Medicare Utilization: 33,538	2007 Work RVU: 2.63 2007 NF PE RVU: 3.62 2007 Fac PE RVU 2.7 2013 Work RVU: 2.15 2013 NF PE RVU: 4.96 2013 Fac PE RVU: 3.28
RUC Recommendation: 2.09					CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Decrease
69100	Biopsy external ear			Global: 000	Issue: Biopsy of Ear	Screen: CMS Fastest Growing	Complete? Yes
Most Recent RUC Meeting:	April 2009	Tab 28	Specialty Developing Recommendation:	AAD	First Identified: October 2008	2012 Est Medicare Utilization: 114,102	2007 Work RVU: 0.81 2007 NF PE RVU: 1.75 2007 Fac PE RVU 0.40 2013 Work RVU: 0.81 2013 NF PE RVU: 2.13 2013 Fac PE RVU: 0.53
RUC Recommendation: 0.81					CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Maintain
69200	Removal foreign body from external auditory canal; without general anesthesia			Global: 000	Issue: Removal of Foreign Body	Screen: Harvard Valued - Utilization over 30,000	Complete? Yes
Most Recent RUC Meeting:	September 2011	Tab 29	Specialty Developing Recommendation:	AAO-HNS	First Identified: April 2011	2012 Est Medicare Utilization: 41,265	2007 Work RVU: 0.77 2007 NF PE RVU: 2.29 2007 Fac PE RVU 0.56 2013 Work RVU: 0.77 2013 NF PE RVU: 2.94 2013 Fac PE RVU: 0.88
RUC Recommendation: 0.77					CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Maintain

# Status Report: CMS Requests and Relativity Assessment Issues

**69210** Removal impacted cerumen (separate procedure), 1 or both ears      **Global:** 000      **Issue:** Removal of Cerumen      **Screen:** CMS High Expenditure Procedural Codes      **Complete?** No

**Most Recent RUC Meeting:** January 2013      **Tab** 13      **Specialty Developing Recommendation:** AAFP, AAO-HNS      **First Identified:** September 2011      **2012 Est Medicare Utilization:** 1,541,962      **2007 Work RVU:** 0.61      **2013 Work RVU:** 0.61  
**2007 NF PE RVU:** 0.61      **2013 NF PE RVU:** 0.88  
**2007 Fac PE RVU:** 0.21      **2013 Fac PE RVU:** 0.28  
**RUC Recommendation:** 0.58. Re-review bilateral data January 2015.      **CPT Action (if applicable):** October 2012  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

**69401** Eustachian tube inflation, transnasal; without catheterization      **Global:** 000      **Issue:** RAW      **Screen:** High Volume Growth2      **Complete?** No

**Most Recent RUC Meeting:**      **Tab**      **Specialty Developing Recommendation:**      **First Identified:** April 2013      **2012 Est Medicare Utilization:** 9,926      **2007 Work RVU:** 0.63      **2013 Work RVU:** 0.63  
**2007 NF PE RVU:** 1.3      **2013 NF PE RVU:** 2.04  
**2007 Fac PE RVU:** 0.63      **2013 Fac PE RVU:** 0.81  
**RUC Recommendation:** Review Action Plan      **CPT Action (if applicable):**  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

**69433** Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia      **Global:** 010      **Issue:** Tympanostomy      **Screen:** Harvard Valued - Utilization over 30,000      **Complete?** Yes

**Most Recent RUC Meeting:** September 2011      **Tab** 30      **Specialty Developing Recommendation:** AAO-HNS      **First Identified:** April 2011      **2012 Est Medicare Utilization:** 44,842      **2007 Work RVU:** 1.54      **2013 Work RVU:** 1.57  
**2007 NF PE RVU:** 3.09      **2013 NF PE RVU:** 4.50  
**2007 Fac PE RVU:** 1.60      **2013 Fac PE RVU:** 2.26  
**RUC Recommendation:** 1.57      **CPT Action (if applicable):**  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

**69801** Labyrinthotomy, with perfusion of vestibuloactive drug(s); transcanal      **Global:** 000      **Issue:** Labyrinthotomy      **Screen:** CMS Fastest Growing, Site of Service Anomaly (99238-Only)      **Complete?** Yes

**Most Recent RUC Meeting:** April 2010      **Tab** 16      **Specialty Developing Recommendation:** AAO-HNS      **First Identified:** September 2007      **2012 Est Medicare Utilization:** 14,442      **2007 Work RVU:** 8.61      **2013 Work RVU:** 2.06  
**2007 NF PE RVU:** NA      **2013 NF PE RVU:** 3.66  
**2007 Fac PE RVU:** 9.31      **2013 Fac PE RVU:** 1.43  
**RUC Recommendation:** 2.06      **CPT Action (if applicable):** Feb 2010  
**Referred to CPT Asst** ☒      **Published in CPT Asst:** May 2011

# Status Report: CMS Requests and Relativity Assessment Issues

**69802** Labyrinthotomy, with perfusion of vestibuloactive drug(s); with mastoidectomy **Global:** 090 **Issue:** Labryinthotomy **Screen:** CMS Fastest Growing, Site of Service Anomaly (99238-Only) **Complete?** Yes

**Most Recent RUC Meeting:** April 2010 **Tab** 16 **Specialty Developing Recommendation:** AAO-HNS

**First Identified:** **2012 Est Medicare Utilization:** **CPT Action (if applicable):** February 2011 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

**2007 Work RVU:** 13.39 **2013 Work RVU:** **2007 NF PE RVU:** NA **2013 NF PE RVU:** **2007 Fac PE RVU** 11.91 **2013 Fac PE RVU:** **Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**69930** Cochlear device implantation, with or without mastoidectomy **Global:** 090 **Issue:** Cochlear Device Implantation **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** February 2008 **Tab** M **Specialty Developing Recommendation:** AAO-HNS

**First Identified:** September 2007 **2012 Est Medicare Utilization:** 2,712 **CPT Action (if applicable):** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

**2007 Work RVU:** 17.60 **2013 Work RVU:** 17.73 **2007 NF PE RVU:** NA **2013 NF PE RVU:** NA **2007 Fac PE RVU** 14.06 **2013 Fac PE RVU:** 16.88 **Result:** Maintain

**RUC Recommendation:** 17.60

**70100** Radiologic examination, mandible; partial, less than 4 views **Global:** XXX **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** No

**Most Recent RUC Meeting:** **Tab** **Specialty Developing Recommendation:**

**First Identified:** April 2013 **2012 Est Medicare Utilization:** 21,797 **CPT Action (if applicable):** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

**2007 Work RVU:** 0.18 **2013 Work RVU:** 0.18 **2007 NF PE RVU:** 0.59 **2013 NF PE RVU:** 0.85 **2007 Fac PE RVU** NA **2013 Fac PE RVU:** NA **Result:**

**RUC Recommendation:** Review Action Plan

**70310** Radiologic examination, teeth; partial examination, less than full mouth **Global:** XXX **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** No

**Most Recent RUC Meeting:** **Tab** **Specialty Developing Recommendation:**

**First Identified:** April 2013 **2012 Est Medicare Utilization:** 14,896 **CPT Action (if applicable):** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

**2007 Work RVU:** 0.16 **2013 Work RVU:** 0.16 **2007 NF PE RVU:** 0.58 **2013 NF PE RVU:** 0.99 **2007 Fac PE RVU** NA **2013 Fac PE RVU:** NA **Result:**

**RUC Recommendation:** Review Action Plan

# Status Report: CMS Requests and Relativity Assessment Issues

70371	Complex dynamic pharyngeal and speech evaluation by cine or video recording			Global: XXX	Issue: Laryngography	Screen: Codes Reported Together 75% or More-Part2	Complete?	No																	
Most Recent RUC Meeting:	October 2012	Tab	Specialty Developing Recommendation:	ACR, AAFP	First Identified:	October 2012	2012 Est Medicare Utilization:	12,899	2007 Work RVU:	0.84	2013 Work RVU:	0.84	2007 NF PE RVU:	2.14	2013 NF PE RVU:	1.87	2007 Fac PE RVU	NA	2013 Fac PE RVU:	NA					
RUC Recommendation:					Develop CPT Assistant article.					CPT Action (if applicable):					Referred to CPT Asst					<input checked="" type="checkbox"/>	Published in CPT Asst:				
<hr/>																									
70373	Laryngography, contrast, radiological supervision and interpretation			Global: XXX	Issue: Laryngography	Screen: Codes Reported Together 75% or More-Part2	Complete?	No																	
Most Recent RUC Meeting:		Tab	Specialty Developing Recommendation:	ACR, AAFP	First Identified:	October 2012	2012 Est Medicare Utilization:	4,561	2007 Work RVU:	0.44	2013 Work RVU:	0.44	2007 NF PE RVU:	1.83	2013 NF PE RVU:	1.94	2007 Fac PE RVU	NA	2013 Fac PE RVU:	NA					
RUC Recommendation:					Develop CPT Assistant article.					CPT Action (if applicable):					Referred to CPT Asst					<input checked="" type="checkbox"/>	Published in CPT Asst:				
<hr/>																									
70450	Computed tomography, head or brain; without contrast material			Global: XXX	Issue: CT Head/Brain	Screen: CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes	Complete?	Yes																	
Most Recent RUC Meeting:	October 2012	Tab	19	Specialty Developing Recommendation:	ACR, ASNR	First Identified:	April 2011	2012 Est Medicare Utilization:	5,295,868	2007 Work RVU:	0.85	2013 Work RVU:	0.85	2007 NF PE RVU:	4.91	2013 NF PE RVU:	4.02	2007 Fac PE RVU	NA	2013 Fac PE RVU:	NA				
RUC Recommendation:					0.85					CPT Action (if applicable):					Referred to CPT Asst					<input type="checkbox"/>	Published in CPT Asst:				
<hr/>																									



## Status Report: CMS Requests and Relativity Assessment Issues

---

**70460** Computed tomography, head or brain; with contrast material(s)      **Global:** XXX    **Issue:** CT Head/Brain      **Screen:** CMS High Expenditure Procedural Codes      **Complete?** Yes

**Most Recent RUC Meeting:** October 2012      **Tab** 19      **Specialty Developing Recommendation:** ACR, ASNR      **First Identified:**      **2012 Est Medicare Utilization:** 37,587      **2007 Work RVU:** 1.13      **2013 Work RVU:** 1.13  
**2007 NF PE RVU:** 6.06      **2013 NF PE RVU:** 5.26  
**2007 Fac PE RVU:** NA      **2013 Fac PE RVU:** NA  
**Result:** Maintain

**RUC Recommendation:** 1.13      **CPT Action (if applicable):**  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

---

**70470** Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections      **Global:** XXX    **Issue:** CT Head/Brain      **Screen:** Harvard Valued - Utilization over 100,000      **Complete?** Yes

**Most Recent RUC Meeting:** October 2012      **Tab** 19      **Specialty Developing Recommendation:** ACR, ASNR      **First Identified:** October 2009      **2012 Est Medicare Utilization:** 174,800      **2007 Work RVU:** 1.27      **2013 Work RVU:** 1.27  
**2007 NF PE RVU:** 7.49      **2013 NF PE RVU:** 5.17  
**2007 Fac PE RVU:** NA      **2013 Fac PE RVU:** NA  
**Result:** Maintain

**RUC Recommendation:** 1.27. Survey for work and PE for April 2013 RUC meeting (Identified as part of 70450 family).      **CPT Action (if applicable):**  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

---

**70486** Computed tomography, maxillofacial area; without contrast material      **Global:** XXX    **Issue:** RAW      **Screen:** CMS-Other - Utilization over 250,000      **Complete?** No

**Most Recent RUC Meeting:**      **Tab**      **Specialty Developing Recommendation:**      **First Identified:** April 2013      **2012 Est Medicare Utilization:** 451,573      **2007 Work RVU:** 1.14      **2013 Work RVU:** 1.14  
**2007 NF PE RVU:** 5.42      **2013 NF PE RVU:** 5.60  
**2007 Fac PE RVU:** NA      **2013 Fac PE RVU:** NA  
**Result:**

**RUC Recommendation:** Review Action Plan      **CPT Action (if applicable):**  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

---

## Status Report: CMS Requests and Relativity Assessment Issues

<b>70496</b>	Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing	<b>Global:</b> XXX	<b>Issue:</b> CT Angiography	<b>Screen:</b> High Volume Growth1 / CMS Fastest Growing / High Volume Growth2	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> April 2008	<b>Tab</b> 57 <b>Specialty Developing Recommendation:</b> ACR, ASNR	<b>First Identified:</b> February 2008	<b>2012 Est Medicare Utilization:</b> 159,828	<b>2007 Work RVU:</b> 1.75 <b>2007 NF PE RVU:</b> 12.43 <b>2007 Fac PE RVU:</b> NA <b>Result:</b> Remove from Screen	<b>2013 Work RVU:</b> 1.75 <b>2013 NF PE RVU:</b> 13.08 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Review action plan. April 2009 rec=remove from screen.		<b>CPT Action (if applicable):</b>			
		<b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	
<b>70498</b>	Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing	<b>Global:</b> XXX	<b>Issue:</b> CT Angiography	<b>Screen:</b> High Volume Growth1 / CMS Fastest Growing	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2008	<b>Tab</b> 57 <b>Specialty Developing Recommendation:</b> ACR, ASNR	<b>First Identified:</b> February 2008	<b>2012 Est Medicare Utilization:</b> 187,775	<b>2007 Work RVU:</b> 1.75 <b>2007 NF PE RVU:</b> 12.45 <b>2007 Fac PE RVU:</b> NA <b>Result:</b> Remove from Screen	<b>2013 Work RVU:</b> 1.75 <b>2013 NF PE RVU:</b> 13.59 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Remove from Screen		<b>CPT Action (if applicable):</b>			
		<b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	
<b>70551</b>	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material	<b>Global:</b> XXX	<b>Issue:</b> MRI-Brain	<b>Screen:</b> CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2013	<b>Tab</b> 26 <b>Specialty Developing Recommendation:</b> ACR, ASNR	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 885,299	<b>2007 Work RVU:</b> 1.48 <b>2007 NF PE RVU:</b> 12.2 <b>2007 Fac PE RVU:</b> NA <b>Result:</b> Maintain	<b>2013 Work RVU:</b> 1.48 <b>2013 NF PE RVU:</b> 11.28 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 1.48		<b>CPT Action (if applicable):</b>			
		<b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	

# Status Report: CMS Requests and Relativity Assessment Issues

<b>70552</b>	<b>Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s)</b>		<b>Global:</b> XXX	<b>Issue:</b> MRI-Brain		<b>Screen:</b> CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2013	<b>Tab</b> 26	<b>Specialty Developing Recommendation:</b>	ACR, ASNR	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 26,567	<b>2007 Work RVU:</b> 1.78 <b>2007 NF PE RVU:</b> 14.22 <b>2007 Fac PE RVU:</b> NA <b>Result:</b> Maintain	<b>2013 Work RVU:</b> 1.78 <b>2013 NF PE RVU:</b> 12.45 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 1.78				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

<b>70553</b>	<b>Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences</b>		<b>Global:</b> XXX	<b>Issue:</b> MRI-Brain		<b>Screen:</b> CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2013	<b>Tab</b> 26	<b>Specialty Developing Recommendation:</b>	ACR, ASNR	<b>First Identified:</b> April 2011	<b>2012 Est Medicare Utilization:</b> 966,255	<b>2007 Work RVU:</b> 2.36 <b>2007 NF PE RVU:</b> 23.53 <b>2007 Fac PE RVU:</b> NA <b>Result:</b> Maintain	<b>2013 Work RVU:</b> 2.36 <b>2013 NF PE RVU:</b> 14.30 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 2.36				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

<b>71010</b>	<b>Radiologic examination, chest; single view, frontal</b>		<b>Global:</b> XXX	<b>Issue:</b>		<b>Screen:</b> Low Value-High Volume	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2011	<b>Tab</b> 41	<b>Specialty Developing Recommendation:</b>		<b>First Identified:</b> October 2010	<b>2012 Est Medicare Utilization:</b> 18,551,373	<b>2007 Work RVU:</b> 0.18 <b>2007 NF PE RVU:</b> 0.5 <b>2007 Fac PE RVU:</b> NA <b>Result:</b> Maintain	<b>2013 Work RVU:</b> 0.18 <b>2013 NF PE RVU:</b> 0.50 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 0.18				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

<b>71020</b>	<b>Radiologic examination, chest, 2 views, frontal and lateral;</b>		<b>Global:</b> XXX	<b>Issue:</b>		<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2011	<b>Tab</b> 41	<b>Specialty Developing Recommendation:</b>		<b>First Identified:</b> October 2010	<b>2012 Est Medicare Utilization:</b> 12,805,513	<b>2007 Work RVU:</b> 0.22 <b>2007 NF PE RVU:</b> 0.66 <b>2007 Fac PE RVU:</b> NA <b>Result:</b> Maintain	<b>2013 Work RVU:</b> 0.22 <b>2013 NF PE RVU:</b> 0.67 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Reaffirmed RUC recommendation				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

## Status Report: CMS Requests and Relativity Assessment Issues

**71090** Insertion pacemaker, fluoroscopy and radiography, radiological supervision and interpretation **Global:** XXX **Issue:** Insertion/Removal of Pacemaker or Pacing Cardioverter-Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

**Most Recent RUC Meeting:** April 2011 **Tab** 10 **Specialty Developing Recommendation:** ACC

**First Identified:** February 2010

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 0.00

**2013 Work RVU:**

**2007 NF PE RVU:** NA

**2013 NF PE RVU:**

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:**

**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** February 2011  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**71100** Radiologic examination, ribs, unilateral; 2 views

**Global:** XXX **Issue:** RAW

**Screen:** CMS-Other - Utilization over 250,000

**Complete?** No

**Most Recent RUC Meeting:** **Tab** **Specialty Developing Recommendation:**

**First Identified:** April 2013

**2012 Est Medicare Utilization:** 255,357

**2007 Work RVU:** 0.22

**2013 Work RVU:** 0.22

**2007 NF PE RVU:** 0.63

**2013 NF PE RVU:** 0.74

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:**

**RUC Recommendation:** Review Action Plan

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**71250** Computed tomography, thorax; without contrast material

**Global:** XXX **Issue:** CT Thorax

**Screen:** CMS Fastest Growing

**Complete?** Yes

**Most Recent RUC Meeting:** October 2009 **Tab** 21 **Specialty Developing Recommendation:** ACR

**First Identified:** October 2008

**2012 Est Medicare Utilization:** 1,469,692

**2007 Work RVU:** 1.16

**2013 Work RVU:** 1.02

**2007 NF PE RVU:** 6.24

**2013 NF PE RVU:** 5.18

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** 1.16

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

# Status Report: CMS Requests and Relativity Assessment Issues

<b>71275</b>	Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing	<b>Global:</b> XXX	<b>Issue:</b> CT Angiography	<b>Screen:</b> CMS Fastest Growing / MPC List	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> September 2011	<b>Tab</b> 51 <b>Specialty Developing Recommendation:</b> ACR	<b>First Identified:</b> October 2008	<b>2012 Est Medicare Utilization:</b> 737,840	<b>2007 Work RVU:</b> 1.92 <b>2007 NF PE RVU:</b> 12.53 <b>2007 Fac PE RVU Result:</b> NA	<b>2013 Work RVU:</b> 1.92 <b>2013 NF PE RVU:</b> 10.00 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Review September 2013. CPT Assistant article published.		<b>CPT Action (if applicable):</b>			
		<b>Referred to CPT Asst</b> <input checked="" type="checkbox"/>	<b>Published in CPT Asst:</b> Jun 2009		
<b>72040</b>	Radiologic examination, spine, cervical; 3 views or less	<b>Global:</b> XXX	<b>Issue:</b> X-ray of Cervical Spine	<b>Screen:</b> Low Value-High Volume	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2012	<b>Tab</b> 09 <b>Specialty Developing Recommendation:</b> ACR, ASNR	<b>First Identified:</b> October 2010	<b>2012 Est Medicare Utilization:</b> 593,017	<b>2007 Work RVU:</b> 0.22 <b>2007 NF PE RVU:</b> 0.69 <b>2007 Fac PE RVU Result:</b> NA	<b>2013 Work RVU:</b> 0.22 <b>2013 NF PE RVU:</b> 0.82 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 0.22		<b>CPT Action (if applicable):</b> October 2011			
		<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		
<b>72050</b>	Radiologic examination, spine, cervical; 4 or 5 views	<b>Global:</b> XXX	<b>Issue:</b>	<b>Screen:</b> Low Value-High Volume	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2012	<b>Tab</b> 09 <b>Specialty Developing Recommendation:</b> ACR, ASNR	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 454,829	<b>2007 Work RVU:</b> 0.31 <b>2007 NF PE RVU:</b> 1 <b>2007 Fac PE RVU Result:</b> NA	<b>2013 Work RVU:</b> 0.31 <b>2013 NF PE RVU:</b> 1.11 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 0.31		<b>CPT Action (if applicable):</b> October 2011			
		<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		
<b>72052</b>	Radiologic examination, spine, cervical; 6 or more views	<b>Global:</b> XXX	<b>Issue:</b>	<b>Screen:</b> Low Value-High Volume	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2012	<b>Tab</b> 09 <b>Specialty Developing Recommendation:</b> ACR, ASNR	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 88,911	<b>2007 Work RVU:</b> 0.36 <b>2007 NF PE RVU:</b> 1.27 <b>2007 Fac PE RVU Result:</b> NA	<b>2013 Work RVU:</b> 0.36 <b>2013 NF PE RVU:</b> 1.48 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 0.36		<b>CPT Action (if applicable):</b> October 2011			
		<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

# Status Report: CMS Requests and Relativity Assessment Issues

<b>72070</b>	Radiologic examination, spine; thoracic, 2 views			<b>Global:</b> XXX	<b>Issue:</b> RAW	<b>Screen:</b> CMS-Other - Utilization over 250,000	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>		<b>First Identified:</b> April 2013	<b>2012 Est Medicare Utilization:</b> 328,980	<b>2007 Work RVU:</b> 0.22 <b>2007 NF PE RVU:</b> 0.69 <b>2007 Fac PE RVU:</b> NA	<b>2013 Work RVU:</b> 0.22 <b>2013 NF PE RVU:</b> 0.78 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Review Action Plan				<b>CPT Action (if applicable):</b>		<b>Result:</b>	
				<b>Referred to CPT Asst</b>	<input type="checkbox"/>	<b>Published in CPT Asst:</b>	

<b>72100</b>	Radiologic examination, spine, lumbosacral; 2 or 3 views			<b>Global:</b> XXX	<b>Issue:</b> Radiologic Examination - Spine	<b>Screen:</b> Harvard Valued - Utilization over 100,000 / Low Value-High Volume	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2011	<b>Tab</b> 09	<b>Specialty Developing Recommendation:</b>	ACR, ASNR, AUR, NASS, AAFP, AAMP&R, ACRh, AAOS	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 1,862,830	<b>2007 Work RVU:</b> 0.22 <b>2007 NF PE RVU:</b> 0.75 <b>2007 Fac PE RVU:</b> NA	<b>2013 Work RVU:</b> 0.22 <b>2013 NF PE RVU:</b> 0.83 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 0.22				<b>CPT Action (if applicable):</b>		<b>Result:</b> Maintain	
				<b>Referred to CPT Asst</b>	<input type="checkbox"/>	<b>Published in CPT Asst:</b>	

<b>72110</b>	Radiologic examination, spine, lumbosacral; minimum of 4 views			<b>Global:</b> XXX	<b>Issue:</b> Radiologic Examination – Spine	<b>Screen:</b> Harvard Valued - Utilization over 100,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2011	<b>Tab</b> 09	<b>Specialty Developing Recommendation:</b>	ACR, ASNR, AUR, NASS, AAFP, AAMP&R, ACRh, AAOS	<b>First Identified:</b> October 2009	<b>2012 Est Medicare Utilization:</b> 913,019	<b>2007 Work RVU:</b> 0.31 <b>2007 NF PE RVU:</b> 1.03 <b>2007 Fac PE RVU:</b> NA	<b>2013 Work RVU:</b> 0.31 <b>2013 NF PE RVU:</b> 1.13 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 0.31				<b>CPT Action (if applicable):</b>		<b>Result:</b> Maintain	
				<b>Referred to CPT Asst</b>	<input type="checkbox"/>	<b>Published in CPT Asst:</b>	

## Status Report: CMS Requests and Relativity Assessment Issues

**72114** Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views **Global:** XXX **Issue:** Radiologic Examination – Spine **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** February 2011

**Tab** 09

**Specialty Developing Recommendation:**

ACR, ASNR, AUR, NASS, AAFP, AAMP&R, ACRh, AAOS

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 91,934

**2007 Work RVU:** 0.36

**2013 Work RVU:** 0.32

**2007 NF PE RVU:** 1.36

**2013 NF PE RVU:** 1.57

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** 0.32

**CPT Action (if applicable):** October 2010  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Decrease

**72120** Radiologic examination, spine, lumbosacral; bending views only, 2 or 3 views **Global:** XXX **Issue:** Radiologic Examination – Spine **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** February 2011

**Tab** 09

**Specialty Developing Recommendation:**

ACR, ASNR, AUR, NASS, AAFP, AAMP&R, ACRh, AAOS

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 30,895

**2007 Work RVU:** 0.22

**2013 Work RVU:** 0.22

**2007 NF PE RVU:** 0.98

**2013 NF PE RVU:** 1.03

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** 0.22

**CPT Action (if applicable):** October 2010  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Maintain

**72125** Computed tomography, cervical spine; without contrast material **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent RUC Meeting:** October 2009

**Tab** 22

**Specialty Developing Recommendation:**

ACR, ASNR

**First Identified:** October 2008

**2012 Est Medicare Utilization:** 800,197

**2007 Work RVU:** 1.16

**2013 Work RVU:** 1.07

**2007 NF PE RVU:** 6.24

**2013 NF PE RVU:** 5.27

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** 1.16

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Maintain

## *Status Report: CMS Requests and Relativity Assessment Issues*

72126 Computed tomography, cervical spine; with contrast material				Global: XXX	Issue: CT Spine	Screen: CMS Fastest Growing	Complete? Yes
Most Recent RUC Meeting:	Tab 40	Specialty Developing Recommendation:	ACR	First Identified:	2012 Est Medicare Utilization:	2007 Work RVU:	2013 Work RVU:
October 2009				February 2009	20,112	1.22	1.22
						2007 NF PE RVU:	2013 NF PE RVU:
						7.49	6.52
						2007 Fac PE RVU	2013 Fac PE RVU:
						NA	NA
RUC Recommendation:	Remove from screen			CPT Action (if applicable):		Result:	Remove from Screen
				Referred to CPT Asst	Published in CPT Asst:		

72127	Computed tomography, cervical spine; without contrast material, followed by contrast material(s) and further sections			Global: XXX	Issue: CT Spine	Screen: CMS Fastest Growing	Complete? Yes
Most Recent	Tab 40	Specialty Developing	ACR	First Identified: February 2009	2012 Est Medicare Utilization: 1,870	2007 Work RVU: 1.27	2013 Work RVU: 1.27
RUC Meeting: October 2009		Recommendation:				2007 NF PE RVU: 9.3	2013 NF PE RVU: 8.01
						2007 Fac PE RVU NA	2013 Fac PE RVU: NA
RUC Recommendation: Remove from screen				CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Remove from Screen	

72128 Computed tomography, thoracic spine; without contrast material				Global: XXX	Issue: CT Spine	Screen: CMS Fastest Growing	Complete? Yes
Most Recent RUC Meeting: October 2009	Tab 22	Specialty Developing Recommendation: ACR, ASNR	First Identified: October 2008	2012 Est Medicare Utilization: 110,749	2007 Work RVU: 1.16	2013 Work RVU: 1.00	
					2007 NF PE RVU: 6.24	2013 NF PE RVU: 5.21	
					2007 Fac PE RVU NA	2013 Fac PE RVU: NA	
RUC Recommendation: 1.16			CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Maintain		

<b>72129</b>	Computed tomography, thoracic spine; with contrast material	<b>Global:</b> XXX	<b>Issue:</b> CT Spine	<b>Screen:</b> CMS Fastest Growing	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2009	<b>Tab</b> 40 <b>Specialty Developing Recommendation:</b> ACR	<b>First Identified:</b> February 2009	<b>2012 Est Medicare Utilization:</b> 13,284	<b>2007 Work RVU:</b> 1.22 <b>2007 NF PE RVU:</b> 7.49 <b>2007 Fac PE RVU:</b> NA	<b>2013 Work RVU:</b> 1.22 <b>2013 NF PE RVU:</b> 6.55 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Remove from screen		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b> Remove from Screen	



## Status Report: CMS Requests and Relativity Assessment Issues

---

<b>72130</b>	Computed tomography, thoracic spine; without contrast material, followed by contrast material(s) and further sections	<b>Global:</b> XXX	<b>Issue:</b> CT Spine	<b>Screen:</b> CMS Fastest Growing	<b>Complete?</b> Yes
--------------	---	--------------------	------------------------	------------------------------------	----------------------

<b>Most Recent RUC Meeting:</b> October 2009	<b>Tab</b> 40	<b>Specialty Developing Recommendation:</b>	ACR
--	---------------	---	-----

<b>First Identified:</b> February 2009
--

<b>2012 Est Medicare Utilization:</b> 1,078
---

<b>2007 Work RVU:</b> 1.27	<b>2013 Work RVU:</b> 1.27
<b>2007 NF PE RVU:</b> 9.29	<b>2013 NF PE RVU:</b> 8.06
<b>2007 Fac PE RVU</b> NA	<b>2013 Fac PE RVU:</b> NA
<b>Result:</b> Remove from Screen	

**RUC Recommendation:** Remove from screen

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

---

<b>72131</b>	Computed tomography, lumbar spine; without contrast material
--------------	--

**Global:** XXX

**Issue:** CT Spine

**Screen:** CMS Fastest Growing

**Complete?** Yes

<b>Most Recent RUC Meeting:</b> October 2009	<b>Tab</b> 22	<b>Specialty Developing Recommendation:</b>	ACR, ASNR
--	---------------	---	-----------

<b>First Identified:</b> February 2009
--

<b>2012 Est Medicare Utilization:</b> 358,385
---

<b>2007 Work RVU:</b> 1.16	<b>2013 Work RVU:</b> 1.00
<b>2007 NF PE RVU:</b> 6.24	<b>2013 NF PE RVU:</b> 5.19
<b>2007 Fac PE RVU</b> NA	<b>2013 Fac PE RVU:</b> NA
<b>Result:</b> Maintain	

**RUC Recommendation:** 1.16

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

---

<b>72132</b>	Computed tomography, lumbar spine; with contrast material
--------------	---

**Global:** XXX

**Issue:** CT Spine

**Screen:** CMS Fastest Growing

**Complete?** Yes

<b>Most Recent RUC Meeting:</b> October 2009	<b>Tab</b> 40	<b>Specialty Developing Recommendation:</b>	ACR
--	---------------	---	-----

<b>First Identified:</b> February 2009
--

<b>2012 Est Medicare Utilization:</b> 55,648
--

<b>2007 Work RVU:</b> 1.22	<b>2013 Work RVU:</b> 1.22
<b>2007 NF PE RVU:</b> 7.49	<b>2013 NF PE RVU:</b> 6.53
<b>2007 Fac PE RVU</b> NA	<b>2013 Fac PE RVU:</b> NA
<b>Result:</b> Remove from Screen	

**RUC Recommendation:** Remove from screen

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

---

<b>72133</b>	Computed tomography, lumbar spine; without contrast material, followed by contrast material(s) and further sections
--------------	---

**Global:** XXX

**Issue:** CT Spine

**Screen:** CMS Fastest Growing

**Complete?** Yes

<b>Most Recent RUC Meeting:</b> October 2009	<b>Tab</b> 40	<b>Specialty Developing Recommendation:</b>	ACR
--	---------------	---	-----

<b>First Identified:</b> February 2009
--

<b>2012 Est Medicare Utilization:</b> 4,082
---

<b>2007 Work RVU:</b> 1.27	<b>2013 Work RVU:</b> 1.27
<b>2007 NF PE RVU:</b> 9.34	<b>2013 NF PE RVU:</b> 8.01
<b>2007 Fac PE RVU</b> NA	<b>2013 Fac PE RVU:</b> NA
<b>Result:</b> Remove from Screen	

**RUC Recommendation:** Remove from screen

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

# Status Report: CMS Requests and Relativity Assessment Issues

**72141** Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material **Global:** XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

**Most Recent RUC Meeting:** April 2013

**Tab** 25

**Specialty Developing Recommendation:**

**First Identified:** September 2011

**2012 Est Medicare Utilization:** 523,585

**2007 Work RVU:** 1.60

**2013 Work RVU:** 1.60

**2007 NF PE RVU:** 11.76

**2013 NF PE RVU:** 9.67

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Decrease

**RUC Recommendation:** 1.48

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**72142** Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; with contrast material(s) **Global:** XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

**Most Recent RUC Meeting:** April 2013

**Tab** 25

**Specialty Developing Recommendation:**

**First Identified:** April 2013

**2012 Est Medicare Utilization:** 4,407

**2007 Work RVU:** 1.92

**2013 Work RVU:** 1.92

**2007 NF PE RVU:** 14.26

**2013 NF PE RVU:** 12.60

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Decrease

**RUC Recommendation:** 1.78

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**72146** Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material **Global:** XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

**Most Recent RUC Meeting:** April 2013

**Tab** 25

**Specialty Developing Recommendation:**

**First Identified:** April 2013

**2012 Est Medicare Utilization:** 187,026

**2007 Work RVU:** 1.60

**2013 Work RVU:** 1.60

**2007 NF PE RVU:** 12.69

**2013 NF PE RVU:** 9.69

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Decrease

**RUC Recommendation:** 1.48

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**72147** Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; with contrast material(s) **Global:** XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

**Most Recent RUC Meeting:** April 2013

**Tab** 25

**Specialty Developing Recommendation:**

**First Identified:** April 2013

**2012 Est Medicare Utilization:** 3,519

**2007 Work RVU:** 1.92

**2013 Work RVU:** 1.92

**2007 NF PE RVU:** 13.76

**2013 NF PE RVU:** 10.89

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Decrease

**RUC Recommendation:** 1.78

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

<b>72148</b>	<b>Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material</b>		<b>Global:</b> XXX	<b>Issue:</b> MRI Neck and Lumbar Spine	<b>Screen:</b> CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 25	<b>Specialty Developing Recommendation:</b> AAOS, AUR, ACR, NASS, ASNR	<b>First Identified:</b> April 2011	<b>2012 Est Medicare Utilization:</b> 1,191,082	<b>2007 Work RVU:</b> 1.48 <b>2007 NF PE RVU:</b> 12.66 <b>2007 Fac PE RVU Result:</b> NA	<b>2013 Work RVU:</b> 1.48 <b>2013 NF PE RVU:</b> 9.64 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 1.48			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	
<hr/>						
<b>72149</b>	<b>Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; with contrast material(s)</b>		<b>Global:</b> XXX	<b>Issue:</b> MRI Neck and Lumbar Spine	<b>Screen:</b> CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 25	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> April 2013	<b>2012 Est Medicare Utilization:</b> 7,095	<b>2007 Work RVU:</b> 1.78 <b>2007 NF PE RVU:</b> 14.23 <b>2007 Fac PE RVU Result:</b> NA	<b>2013 Work RVU:</b> 1.78 <b>2013 NF PE RVU:</b> 12.25 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 1.78			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	
<hr/>						
<b>72156</b>	<b>Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical</b>		<b>Global:</b> XXX	<b>Issue:</b> MRI Neck and Lumbar Spine	<b>Screen:</b> CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 25	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> April 2013	<b>2012 Est Medicare Utilization:</b> 102,709	<b>2007 Work RVU:</b> 2.57 <b>2007 NF PE RVU:</b> 23.52 <b>2007 Fac PE RVU Result:</b> NA	<b>2013 Work RVU:</b> 2.57 <b>2013 NF PE RVU:</b> 14.08 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 2.29			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	

## Status Report: CMS Requests and Relativity Assessment Issues

<b>72157</b>	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic	<b>Global:</b> XXX	<b>Issue:</b> MRI Neck and Lumbar Spine	<b>Screen:</b> CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 25 <b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> April 2013	<b>2012 Est Medicare Utilization:</b> 77,472	<b>2007 Work RVU:</b> 2.57 <b>2007 NF PE RVU:</b> 23.12 <b>2007 Fac PE RVU</b> NA <b>Result:</b> Decrease	<b>2013 Work RVU:</b> 2.57 <b>2013 NF PE RVU:</b> 12.89 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 2.29		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		
<b>72158</b>	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar	<b>Global:</b> XXX	<b>Issue:</b> MRI Neck and Lumbar Spine	<b>Screen:</b> CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 25 <b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> April 2013	<b>2012 Est Medicare Utilization:</b> 266,747	<b>2007 Work RVU:</b> 2.36 <b>2007 NF PE RVU:</b> 23.45 <b>2007 Fac PE RVU</b> NA <b>Result:</b> Decrease	<b>2013 Work RVU:</b> 2.36 <b>2013 NF PE RVU:</b> 13.93 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 2.29		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		
<b>72170</b>	Radiologic examination, pelvis; 1 or 2 views	<b>Global:</b> XXX	<b>Issue:</b> Radiologic Exam-Hip/Pelvis	<b>Screen:</b> Low Value-High Volume / Codes Reported Together 75% or More-Part2	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> April 2011	<b>Tab</b> 25 <b>Specialty Developing Recommendation:</b> ACR, AAOS	<b>First Identified:</b> October 2010	<b>2012 Est Medicare Utilization:</b> 1,787,323	<b>2007 Work RVU:</b> 0.17 <b>2007 NF PE RVU:</b> 0.56 <b>2007 Fac PE RVU</b> NA <b>Result:</b> Maintain	<b>2013 Work RVU:</b> 0.17 <b>2013 NF PE RVU:</b> 0.67 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Refer to CPT to bundle 73700 and 72170.		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b> February 2015		

## Status Report: CMS Requests and Relativity Assessment Issues

<b>72191</b>	<b>Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing</b>	<b>Global:</b> XXX	<b>Issue:</b> CT Angiography-Abdomen and Pelvis	<b>Screen:</b> High Volume Growth1 / CMS Fastest Growing / Codes Reported Together 75% or More-Part1 / CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request Final Rule for 2013	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab 26</b>	<b>Specialty Developing Recommendation:</b> ACR	<b>First Identified:</b> February 2008	<b>2012 Est Medicare Utilization:</b> 5,507	<b>2007 Work RVU:</b> 1.81 <b>2007 NF PE RVU:</b> 12.15 <b>2007 Fac PE RVU</b> NA <b>Result:</b> Maintain
<b>RUC Recommendation:</b> 1.81 Interim, Resurvey for October 2013.			<b>CPT Action (if applicable):</b> Referred to CPT Asst <input type="checkbox"/>	<b>Published in CPT Asst:</b> October 2010	<b>2013 Work RVU:</b> 1.81 <b>2013 NF PE RVU:</b> 10.02 <b>2013 Fac PE RVU:</b> NA
<hr/>					
<b>72192</b>	<b>Computed tomography, pelvis; without contrast material</b>	<b>Global:</b> XXX	<b>Issue:</b> CT Pelvis	<b>Screen:</b> Codes Reported Together 95% or More / CMS Fastest Growing / CMS Request - NPRM for 2012	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2008	<b>Tab 26</b>	<b>Specialty Developing Recommendation:</b> ACR	<b>First Identified:</b> October 2008	<b>2012 Est Medicare Utilization:</b> 133,469	<b>2007 Work RVU:</b> 1.09 <b>2007 NF PE RVU:</b> 6.12 <b>2007 Fac PE RVU</b> NA <b>Result:</b> Maintain
<b>RUC Recommendation:</b> 1.09			<b>CPT Action (if applicable):</b> Referred to CPT Asst <input type="checkbox"/>	<b>Published in CPT Asst:</b> October 2009	<b>2013 Work RVU:</b> 1.09 <b>2013 NF PE RVU:</b> 4.03 <b>2013 Fac PE RVU:</b> NA
<hr/>					
<b>72193</b>	<b>Computed tomography, pelvis; with contrast material(s)</b>	<b>Global:</b> XXX	<b>Issue:</b> CT Pelvis	<b>Screen:</b> Codes Reported Together 95% or More / CMS Fastest Growing / CMS Request - NPRM for 2012	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2008	<b>Tab 26</b>	<b>Specialty Developing Recommendation:</b> ACR	<b>First Identified:</b> October 2008	<b>2012 Est Medicare Utilization:</b> 34,892	<b>2007 Work RVU:</b> 1.16 <b>2007 NF PE RVU:</b> 7.2 <b>2007 Fac PE RVU</b> NA <b>Result:</b> Maintain
<b>RUC Recommendation:</b> 1.16			<b>CPT Action (if applicable):</b> Referred to CPT Asst <input type="checkbox"/>	<b>Published in CPT Asst:</b> October 2009	<b>2013 Work RVU:</b> 1.16 <b>2013 NF PE RVU:</b> 6.93 <b>2013 Fac PE RVU:</b> NA

## Status Report: CMS Requests and Relativity Assessment Issues

**72194** Computed tomography, pelvis; without contrast material, followed by contrast material(s) and further sections **Global:** XXX **Issue:** CT Pelvis **Screen:** Codes Reported Together 95% or More / CMS Fastest Growing / CMS Request - NPRM for 2012 **Complete?** Yes

**Most Recent RUC Meeting:** February 2008

**Tab** S

**Specialty Developing Recommendation:**

**First Identified:** February 2008

**2012 Est Medicare Utilization:** 7,150

**2007 Work RVU:** 1.22

**2013 Work RVU:** 1.22

**2007 NF PE RVU:** 9.06

**2013 NF PE RVU:** 7.86

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** 1.22

**CPT Action (if applicable):** October 2009

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**72240** Myelography, cervical, radiological supervision and interpretation

**Global:** XXX

**Issue:** Myelography with Injection

**Screen:** Codes Reported Together 75% or More-Part2

**Complete?** No

**Most Recent RUC Meeting:** October 2012

**Tab**

**Specialty Developing Recommendation:** ACR, ASNR

**First Identified:** October 2012

**2012 Est Medicare Utilization:** 8,772

**2007 Work RVU:** 0.91

**2013 Work RVU:** 0.91

**2007 NF PE RVU:** 4.37

**2013 NF PE RVU:** 2.89

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:**

**RUC Recommendation:** Refer to CPT to bundle.

**CPT Action (if applicable):** CPT 2015 cycle

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**72265** Myelography, lumbosacral, radiological supervision and interpretation

**Global:** XXX

**Issue:** Myelography with Injection

**Screen:** Codes Reported Together 75% or More-Part2

**Complete?** No

**Most Recent RUC Meeting:** October 2012

**Tab**

**Specialty Developing Recommendation:** ACR, ASNR

**First Identified:** October 2012

**2012 Est Medicare Utilization:** 38,606

**2007 Work RVU:** 0.83

**2013 Work RVU:** 0.83

**2007 NF PE RVU:** 3.83

**2013 NF PE RVU:** 2.91

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:**

**RUC Recommendation:** Refer to CPT to bundle.

**CPT Action (if applicable):** CPT 2015 cycle

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

<b>72270</b>	<b>Myelography, 2 or more regions (eg, lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical), radiological supervision and interpretation</b>	<b>Global:</b> XXX	<b>Issue:</b> Myelography with Injection	<b>Screen:</b> Codes Reported Together 75% or More-Part2	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b>	<b>Specialty Developing Recommendation:</b> ACR, ASNR	<b>First Identified:</b> October 2012	<b>2012 Est Medicare Utilization:</b> 9,636	<b>2007 Work RVU:</b> 1.33 <b>2007 NF PE RVU:</b> 5.81 <b>2007 Fac PE RVU</b> NA <b>2013 Work RVU:</b> 1.33 <b>2013 NF PE RVU:</b> 4.49 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Refer to CPT to bundle.			<b>CPT Action (if applicable):</b> CPT 2015 cycle <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b>
<hr/>					
<b>72275</b>	<b>Epidurography, radiological supervision and interpretation</b>	<b>Global:</b> XXX	<b>Issue:</b> Epidurography	<b>Screen:</b> Different Performing Specialty from Survey	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2010	<b>Tab</b> 31	<b>Specialty Developing Recommendation:</b> ASA, AAPM, AAMPR, NASS	<b>First Identified:</b> October 2009	<b>2012 Est Medicare Utilization:</b> 91,922	<b>2007 Work RVU:</b> 0.76 <b>2007 NF PE RVU:</b> 2.15 <b>2007 Fac PE RVU</b> NA <b>2013 Work RVU:</b> 0.76 <b>2013 NF PE RVU:</b> 2.81 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 0.76, CPT Assistant article published.			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input checked="" type="checkbox"/>	<b>Published in CPT Asst:</b> Oct 2009 and Q&A	<b>Result:</b> Maintain
<hr/>					
<b>72291</b>	<b>Radiological supervision and interpretation, percutaneous vertebroplasty, vertebral augmentation, or sacral augmentation (sacroplasty), including cavity creation, per vertebral body or sacrum; under fluoroscopic guidance</b>	<b>Global:</b> XXX	<b>Issue:</b> Percutaneous Vertebroplasty with Radiological S&I	<b>Screen:</b> Codes Reported Together 75% or More-Part2	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> October 2012	<b>2012 Est Medicare Utilization:</b> 62,662	<b>2007 Work RVU:</b> 0.00 <b>2007 NF PE RVU:</b> 0 <b>2007 Fac PE RVU</b> 0 <b>2013 Work RVU:</b> 0.00 <b>2013 NF PE RVU:</b> 0.00 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Refer to CPT to bundle.			<b>CPT Action (if applicable):</b> CPT 2015 cycle <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b>

# Status Report: CMS Requests and Relativity Assessment Issues

<b>72291</b>	Radiological supervision and interpretation, percutaneous vertebroplasty, vertebral augmentation, or sacral augmentation (sacroplasty), including cavity creation, per vertebral body or sacrum; under fluoroscopic guidance			<b>Global:</b> XXX	<b>Issue:</b> Percutaneous Vertebroplasty with Radiological S&I	<b>Screen:</b> Codes Reported Together 75% or More-Part2	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b>	October 2012	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> October 2012	<b>2012 Est Medicare Utilization:</b> 62,662	<b>2007 Work RVU:</b> 0.00 <b>2007 NF PE RVU:</b> 0 <b>2007 Fac PE RVU:</b> 0	<b>2013 Work RVU:</b> 0.00 <b>2013 NF PE RVU:</b> 0.00 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Refer to CPT to bundle.				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	CPT 2015 cycle <b>Published in CPT Asst:</b>	<b>Result:</b>	

---

<b>73030</b>	Radiologic examination, shoulder; complete, minimum of 2 views			<b>Global:</b> XXX	<b>Issue:</b> X-Ray Exam of Shoulder	<b>Screen:</b> Low Value-High Volume	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b>	April 2011	<b>Tab</b> 26	<b>Specialty Developing Recommendation:</b> ACR, AAOS	<b>First Identified:</b> October 2010	<b>2012 Est Medicare Utilization:</b> 2,283,400	<b>2007 Work RVU:</b> 0.18 <b>2007 NF PE RVU:</b> 0.61 <b>2007 Fac PE RVU:</b> NA	<b>2013 Work RVU:</b> 0.18 <b>2013 NF PE RVU:</b> 0.72 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 0.18				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b> Maintain	

---

<b>73060</b>	Radiologic examination; humerus, minimum of 2 views			<b>Global:</b> XXX	<b>Issue:</b> RAW	<b>Screen:</b> CMS-Other - Utilization over 250,000	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b>		<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> April 2013	<b>2012 Est Medicare Utilization:</b> 344,903	<b>2007 Work RVU:</b> 0.17 <b>2007 NF PE RVU:</b> 0.61 <b>2007 Fac PE RVU:</b> NA	<b>2013 Work RVU:</b> 0.17 <b>2013 NF PE RVU:</b> 0.69 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Review Action Plan				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b>	

---

<b>73080</b>	Radiologic examination, elbow; complete, minimum of 3 views			<b>Global:</b> XXX	<b>Issue:</b> Radiologic Examination	<b>Screen:</b> Harvard Valued - Utilization over 100,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b>	April 2010	<b>Tab</b> 39	<b>Specialty Developing Recommendation:</b> AAOS, ACR	<b>First Identified:</b> October 2009	<b>2012 Est Medicare Utilization:</b> 315,635	<b>2007 Work RVU:</b> 0.17 <b>2007 NF PE RVU:</b> 0.66 <b>2007 Fac PE RVU:</b> NA	<b>2013 Work RVU:</b> 0.17 <b>2013 NF PE RVU:</b> 0.83 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 0.17				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b> Maintain	



# Status Report: CMS Requests and Relativity Assessment Issues

## 73110 Radiologic examination, wrist; complete, minimum of 3 views

Global: XXX

Issue:

Screen: Low Value-High Volume

Complete? Yes

Most Recent  
RUC Meeting: February 2011

Tab 41

Specialty Developing  
Recommendation:

First  
Identified: October 2010

2012 Est  
Medicare  
Utilization: 918,386

2007 Work RVU: 0.17

2013 Work RVU: 0.17

2007 NF PE RVU: 0.63

2013 NF PE RVU: 0.96

2007 Fac PE RVU NA

2013 Fac PE RVU: NA

Result: Maintain

RUC Recommendation: Reaffirmed RUC recommendation

CPT Action (if applicable):

Referred to CPT Asst ☐

Published in CPT Asst:

## 73130 Radiologic examination, hand; minimum of 3 views

Global: XXX

Issue:

Screen: Low Value-High Volume

Complete? Yes

Most Recent  
RUC Meeting: February 2011

Tab 41

Specialty Developing  
Recommendation:

First  
Identified: October 2010

2012 Est  
Medicare  
Utilization: 997,728

2007 Work RVU: 0.17

2013 Work RVU: 0.17

2007 NF PE RVU: 0.6

2013 NF PE RVU: 0.80

2007 Fac PE RVU NA

2013 Fac PE RVU: NA

Result: Maintain

RUC Recommendation: Reaffirmed RUC recommendation

CPT Action (if applicable):

Referred to CPT Asst ☐

Published in CPT Asst:

## 73200 Computed tomography, upper extremity; without contrast material

Global: XXX

Issue: CT Upper Extremity

Screen: CMS Fastest Growing

Complete? Yes

Most Recent  
RUC Meeting: October 2009

Tab 23

Specialty Developing  
Recommendation: ACR

First  
Identified: October 2008

2012 Est  
Medicare  
Utilization: 75,960

2007 Work RVU: 1.09

2013 Work RVU: 1.00

2007 NF PE RVU: 5.5

2013 NF PE RVU: 5.15

2007 Fac PE RVU NA

2013 Fac PE RVU: NA

Result: Maintain

RUC Recommendation: 1.09

CPT Action (if applicable):

Referred to CPT Asst ☐

Published in CPT Asst:

## 73201 Computed tomography, upper extremity; with contrast material(s)

Global: XXX

Issue: CT Upper Extremity

Screen: CMS Fastest Growing

Complete? Yes

Most Recent  
RUC Meeting: October 2009

Tab 40

Specialty Developing  
Recommendation: ACR

First  
Identified: February 2009

2012 Est  
Medicare  
Utilization: 11,923

2007 Work RVU: 1.16

2013 Work RVU: 1.16

2007 NF PE RVU: 6.58

2013 NF PE RVU: 6.41

2007 Fac PE RVU NA

2013 Fac PE RVU: NA

Result: Remove from Screen

RUC Recommendation: Remove from screen

CPT Action (if applicable):

Referred to CPT Asst ☐

Published in CPT Asst:

# Status Report: CMS Requests and Relativity Assessment Issues

**73202** Computed tomography, upper extremity; without contrast material, followed by contrast material(s) and further sections **Global:** XXX **Issue:** CT Upper Extremity **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent** **Tab** 40 **Specialty Developing** ACR  
**RUC Meeting:** October 2009 **Recommendation:**

**First Identified:** February 2009

**2012 Est Medicare Utilization:** 1,727

**2007 Work RVU:** 1.22

**2013 Work RVU:** 1.22

**2007 NF PE RVU:** 8.38

**2013 NF PE RVU:** 8.44

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** Remove from screen

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Remove from Screen

**73218** Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without contrast material(s)

**Global:** XXX **Issue:** MRI

**Screen:** CMS Fastest Growing

**Complete?** No

**Most Recent** **Tab** 51 **Specialty Developing** ACR  
**RUC Meeting:** September 2011 **Recommendation:**

**First Identified:** October 2008

**2012 Est Medicare Utilization:** 28,577

**2007 Work RVU:** 1.35

**2013 Work RVU:** 1.35

**2007 NF PE RVU:** 12.24

**2013 NF PE RVU:** 11.06

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** Review September 2013. CPT Assistant published.

**CPT Action (if applicable):**

**Referred to CPT Asst** ☒

**Published in CPT Asst:**

**Result:**

Feb 2011

**73221** Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)

**Global:** XXX **Issue:** MRI

**Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes

**Complete?** Yes

**Most Recent** **Tab** 20 **Specialty Developing** ACR  
**RUC Meeting:** January 2012 **Recommendation:**

**First Identified:** October 2008

**2012 Est Medicare Utilization:** 414,010

**2007 Work RVU:** 1.35

**2013 Work RVU:** 1.35

**2007 NF PE RVU:** 11.98

**2013 NF PE RVU:** 6.83

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** 1.35

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Maintain

**7327X8**

**Global:** 000 **Issue:** ERCP

**Screen:** MPC List

**Complete?** Yes

**Most Recent** **Tab** 12 **Specialty Developing**  
**RUC Meeting:** April 2013 **Recommendation:**

**First Identified:** September 2011

**2012 Est Medicare Utilization:**

**2007 Work RVU:**

**2013 Work RVU:**

**2007 NF PE RVU:**

**2013 NF PE RVU:**

**2007 Fac PE RVU**

**2013 Fac PE RVU:**

**RUC Recommendation:** 8.08

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

February 2013

**Result:** Decrease

## Status Report: CMS Requests and Relativity Assessment Issues

---

**73500** Radiologic examination, hip, unilateral; 1 view **Global:** XXX **Issue:** Radiologic Exam-Hip/Pelvis **Screen:** CMS-Other - Utilization over 500,000 / Codes Reported Together 75% or More-Part2 **Complete?** No

**Most Recent RUC Meeting:** January 2012 **Tab** 30 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** April 2011 **2012 Est Medicare Utilization:** 501,943 **2007 Work RVU:** 0.17 **2013 Work RVU:** 0.17  
**2007 NF PE RVU:** 0.52 **2013 NF PE RVU:** 0.63  
**2007 Fac PE RVU** NA **2013 Fac PE RVU:** NA  
**RUC Recommendation:** Refer to CPT to bundle **CPT Action (if applicable):** February 2015  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

---

**73510** Radiologic examination, hip, unilateral; complete, minimum of 2 views **Global:** XXX **Issue:** Radiologic Examination **Screen:** Top 9 Harvard / Low Value-High Volume **Complete?** Yes

**Most Recent RUC Meeting:** October 2009 **Tab** 24 **Specialty Developing Recommendation:** ACR, AAOS, APMA, AOFAS **First Identified:** October 2008 **2012 Est Medicare Utilization:** 2,459,213 **2007 Work RVU:** 0.21 **2013 Work RVU:** 0.21  
**2007 NF PE RVU:** 0.67 **2013 NF PE RVU:** 0.95  
**2007 Fac PE RVU** NA **2013 Fac PE RVU:** NA  
**RUC Recommendation:** 0.21 **CPT Action (if applicable):**  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

---

**73520** Radiologic examination, hips, bilateral, minimum of 2 views of each hip, including anteroposterior view of pelvis **Global:** XXX **Issue:** RAW **Screen:** CMS-Other - Utilization over 250,000 **Complete?** No

**Most Recent RUC Meeting:** **Tab** **Specialty Developing Recommendation:** **First Identified:** April 2013 **2012 Est Medicare Utilization:** 358,547 **2007 Work RVU:** 0.26 **2013 Work RVU:** 0.26  
**2007 NF PE RVU:** 0.76 **2013 NF PE RVU:** 0.95  
**2007 Fac PE RVU** NA **2013 Fac PE RVU:** NA  
**RUC Recommendation:** Review Action Plan **CPT Action (if applicable):**  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

---

# Status Report: CMS Requests and Relativity Assessment Issues

**73542** Radiological examination, sacroiliac joint arthrography, radiological supervision and interpretation **Global:** XXX **Issue:** Sacroiliac Joint Arthrography **Screen:** Different Performing Specialty from Survey **Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab** 45

**Specialty Developing Recommendation:**

ASA, AAPM, AAMPR, NASS, ACR, AUR, ISIS, ASNR

**First Identified:** October 2009

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 0.59

**2013 Work RVU:**

**2007 NF PE RVU:** 1.98

**2013 NF PE RVU:**

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** February 2011

**Referred to CPT Asst** ☒

**Published in CPT Asst:**

**Result:** Deleted from CPT

Deleted from CPT

**73550** Radiologic examination, femur, 2 views

**Global:** XXX

**Issue:** RAW review

**Screen:** CMS-Other - Utilization over 500,000

**Complete?** No

**Most Recent RUC Meeting:** January 2012

**Tab** 30

**Specialty Developing Recommendation:**

AAOS, ACR

**First Identified:** April 2011

**2012 Est Medicare Utilization:** 541,491

**2007 Work RVU:** 0.17

**2013 Work RVU:** 0.17

**2007 NF PE RVU:** 0.61

**2013 NF PE RVU:** 0.66

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** Refer to CPT to bundle

**CPT Action (if applicable):** February 2015

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:**

**73560** Radiologic examination, knee; 1 or 2 views

**Global:** XXX

**Issue:**

**Screen:** Low Value-High Volume

**Complete?** Yes

**Most Recent RUC Meeting:** February 2011

**Tab** 41

**Specialty Developing Recommendation:**

**First Identified:** October 2010

**2012 Est Medicare Utilization:** 2,072,041

**2007 Work RVU:** 0.17

**2013 Work RVU:** 0.17

**2007 NF PE RVU:** 0.58

**2013 NF PE RVU:** 0.74

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** Reaffirmed RUC recommendation

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Maintain

**73562** Radiologic examination, knee; 3 views

**Global:** XXX

**Issue:**

**Screen:** Low Value-High Volume

**Complete?** Yes

**Most Recent RUC Meeting:** February 2011

**Tab** 41

**Specialty Developing Recommendation:**

**First Identified:** October 2010

**2012 Est Medicare Utilization:** 1,991,084

**2007 Work RVU:** 0.18

**2013 Work RVU:** 0.18

**2007 NF PE RVU:** 0.65

**2013 NF PE RVU:** 0.93

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** Reaffirmed RUC recommendation

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Maintain

# Status Report: CMS Requests and Relativity Assessment Issues

**73564** Radiologic examination, knee; complete, 4 or more views

**Global:** XXX

**Issue:**

**Screen:** Low Value-High Volume

**Complete?** Yes

**Most Recent**  
**RUC Meeting:** February 2011

**Tab** 41

**Specialty Developing**  
**Recommendation:**

**First**  
**Identified:** October 2010

**2012 Est**  
**Medicare**  
**Utilization:** 1,149,569

**2007 Work RVU:** 0.22

**2013 Work RVU:** 0.22

**2007 NF PE RVU:** 0.73

**2013 NF PE RVU:** 1.08

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** Reaffirmed RUC recommendation

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**73565** Radiologic examination, knee; both knees, standing, anteroposterior

**Global:** XXX

**Issue:** RAW

**Screen:** CMS-Other - Utilization  
over 250,000

**Complete?** No

**Most Recent**  
**RUC Meeting:**

**Tab**

**Specialty Developing**  
**Recommendation:**

**First**  
**Identified:** April 2013

**2012 Est**  
**Medicare**  
**Utilization:** 340,730

**2007 Work RVU:** 0.17

**2013 Work RVU:** 0.17

**2007 NF PE RVU:** 0.57

**2013 NF PE RVU:** 0.89

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:**

**RUC Recommendation:** Review Action Plan

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**73580** Radiologic examination, knee, arthrography, radiological supervision and interpretation

**Global:** XXX

**Issue:** Contrast X-Ray of Knee  
Joint

**Screen:** High Volume Growth1 /  
CMS Fastest Growing

**Complete?** Yes

**Most Recent**  
**RUC Meeting:** October 2009

**Tab** 40

**Specialty Developing**  
**Recommendation:** AAOS

**First**  
**Identified:** February 2008

**2012 Est**  
**Medicare**  
**Utilization:** 25,853

**2007 Work RVU:** 0.54

**2013 Work RVU:** 0.54

**2007 NF PE RVU:** 2.67

**2013 NF PE RVU:** 3.37

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** CPT Assistant Article published June 2012.

**CPT Action (if applicable):**

**Referred to CPT Asst** ☒

**Published in CPT Asst:** Jun 2012

**73590** Radiologic examination; tibia and fibula, 2 views

**Global:** XXX

**Issue:** RAW

**Screen:** CMS-Other - Utilization  
over 250,000

**Complete?** No

**Most Recent**  
**RUC Meeting:**

**Tab**

**Specialty Developing**  
**Recommendation:**

**First**  
**Identified:** April 2013

**2012 Est**  
**Medicare**  
**Utilization:** 475,854

**2007 Work RVU:** 0.17

**2013 Work RVU:** 0.17

**2007 NF PE RVU:** 0.57

**2013 NF PE RVU:** 0.65

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:**

**RUC Recommendation:** Review Action Plan

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

# Status Report: CMS Requests and Relativity Assessment Issues

**73600** Radiologic examination, ankle; 2 views

**Global:** XXX **Issue:** RAW

**Screen:** CMS-Other - Utilization over 250,000

**Complete?** No

**Most Recent RUC Meeting:** **Tab** **Specialty Developing Recommendation:**

**First Identified:** April 2013

**2012 Est Medicare Utilization:** 255,268

**2007 Work RVU:** 0.16

**2013 Work RVU:** 0.16

**2007 NF PE RVU:** 0.54

**2013 NF PE RVU:** 0.70

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** Review Action Plan

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:**

**73610** Radiologic examination, ankle; complete, minimum of 3 views

**Global:** XXX

**Issue:** Radiologic Examination

**Screen:** Top 9 Harvard / Low Value-High Volume

**Complete?** Yes

**Most Recent RUC Meeting:** October 2009

**Tab** 24

**Specialty Developing Recommendation:** ACR, AAOS, APMA, AOFAS

**First Identified:** October 2008

**2012 Est Medicare Utilization:** 1,179,524

**2007 Work RVU:** 0.17

**2013 Work RVU:** 0.17

**2007 NF PE RVU:** 0.61

**2013 NF PE RVU:** 0.83

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** 0.17

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Maintain

**73620** Radiologic examination, foot; 2 views

**Global:** XXX

**Issue:** X-Ray Exam of Foot

**Screen:** Low Value-High Volume

**Complete?** Yes

**Most Recent RUC Meeting:** April 2011

**Tab** 27

**Specialty Developing Recommendation:** ACR, AAOS, APMA

**First Identified:** October 2010

**2012 Est Medicare Utilization:** 786,552

**2007 Work RVU:** 0.16

**2013 Work RVU:** 0.16

**2007 NF PE RVU:** 0.54

**2013 NF PE RVU:** 0.66

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** 0.16

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Maintain

**73630** Radiologic examination, foot; complete, minimum of 3 views

**Global:** XXX

**Issue:** Radiologic Examination

**Screen:** Top 9 Harvard / Low Value-High Volume

**Complete?** Yes

**Most Recent RUC Meeting:** October 2009

**Tab** 24

**Specialty Developing Recommendation:** ACR, AAOS, APMA, AOFAS

**First Identified:** October 2008

**2012 Est Medicare Utilization:** 2,349,531

**2007 Work RVU:** 0.17

**2013 Work RVU:** 0.17

**2007 NF PE RVU:** 0.6

**2013 NF PE RVU:** 0.77

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** 0.17

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Maintain

## Status Report: CMS Requests and Relativity Assessment Issues

---

<b>73700</b>	<b>Computed tomography, lower extremity; without contrast material</b>	<b>Global:</b> XXX	<b>Issue:</b> CT Lower Extremity	<b>Screen:</b> CMS Fastest Growing	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2009	<b>Tab</b> 25 <b>Specialty Developing Recommendation:</b> ACR	<b>First Identified:</b> October 2008	<b>2012 Est Medicare Utilization:</b> 203,322	<b>2007 Work RVU:</b> 1.09 <b>2007 NF PE RVU:</b> 5.5 <b>2007 Fac PE RVU:</b> NA <b>Result:</b> Maintain	<b>2013 Work RVU:</b> 1.00 <b>2013 NF PE RVU:</b> 5.17 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 1.09		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

---

<b>73701</b>	<b>Computed tomography, lower extremity; with contrast material(s)</b>	<b>Global:</b> XXX	<b>Issue:</b> CT Lower Extremity	<b>Screen:</b> High Volume Growth1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2009	<b>Tab</b> 40 <b>Specialty Developing Recommendation:</b> ACR	<b>First Identified:</b> February 2009	<b>2012 Est Medicare Utilization:</b> 32,936	<b>2007 Work RVU:</b> 1.16 <b>2007 NF PE RVU:</b> 6.6 <b>2007 Fac PE RVU:</b> NA <b>Result:</b> Remove from Screen	<b>2013 Work RVU:</b> 1.16 <b>2013 NF PE RVU:</b> 6.52 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Remove from screen		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

---

<b>73702</b>	<b>Computed tomography, lower extremity; without contrast material, followed by contrast material(s) and further sections</b>	<b>Global:</b> XXX	<b>Issue:</b> CT Lower Extremity	<b>Screen:</b> High Volume Growth1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2009	<b>Tab</b> 40 <b>Specialty Developing Recommendation:</b> ACR	<b>First Identified:</b> February 2009	<b>2012 Est Medicare Utilization:</b> 4,008	<b>2007 Work RVU:</b> 1.22 <b>2007 NF PE RVU:</b> 8.4 <b>2007 Fac PE RVU:</b> NA <b>Result:</b> Remove from Screen	<b>2013 Work RVU:</b> 1.22 <b>2013 NF PE RVU:</b> 8.42 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Remove from screen		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

---

<b>73706</b>	<b>Computed tomographic angiography, lower extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing</b>	<b>Global:</b> XXX	<b>Issue:</b> CT Lower Extremity	<b>Screen:</b> High Volume Growth1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2009	<b>Tab</b> 40 <b>Specialty Developing Recommendation:</b> ACR	<b>First Identified:</b> February 2008	<b>2012 Est Medicare Utilization:</b> 13,293	<b>2007 Work RVU:</b> 1.90 <b>2007 NF PE RVU:</b> 11.61 <b>2007 Fac PE RVU:</b> NA <b>Result:</b> Remove from Screen	<b>2013 Work RVU:</b> 1.90 <b>2013 NF PE RVU:</b> 10.07 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Remove from screen		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

---

## Status Report: CMS Requests and Relativity Assessment Issues

**73721** Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material      **Global:** XXX      **Issue:** MRI of Lower Extremity Joint      **Screen:** MPC List      **Complete?** Yes

**Most Recent RUC Meeting:** January 2012      **Tab** 20      **Specialty Developing Recommendation:** ACR

**First Identified:** October 2010

**2012 Est Medicare Utilization:** 615,673

**2007 Work RVU:** 1.35

**2013 Work RVU:** 1.35

**2007 NF PE RVU:** 12.05

**2013 NF PE RVU:** 6.83

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** 1.35

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**74000** Radiologic examination, abdomen; single anteroposterior view

**Global:** XXX

**Issue:**

**Screen:** Low Value-High Volume

**Complete?** Yes

**Most Recent RUC Meeting:** February 2011      **Tab** 41      **Specialty Developing Recommendation:**

**First Identified:** October 2010

**2012 Est Medicare Utilization:** 2,100,363

**2007 Work RVU:** 0.18

**2013 Work RVU:** 0.18

**2007 NF PE RVU:** 0.55

**2013 NF PE RVU:** 0.53

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** Reaffirmed RUC recommendation

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**74150** Computed tomography, abdomen; without contrast material

**Global:** XXX

**Issue:** CT Abdomen

**Screen:** Codes Reported Together 95% or More / CMS Request - NPRM for 2012

**Complete?** Yes

**Most Recent RUC Meeting:** February 2008      **Tab** S      **Specialty Developing Recommendation:** ACR

**First Identified:** February 2008

**2012 Est Medicare Utilization:** 115,105

**2007 Work RVU:** 1.19

**2013 Work RVU:** 1.19

**2007 NF PE RVU:** 5.97

**2013 NF PE RVU:** 4.02

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** 0.35

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**



## Status Report: CMS Requests and Relativity Assessment Issues

<b>74160</b>	Computed tomography, abdomen; with contrast material(s)		<b>Global:</b> XXX	<b>Issue:</b> CT Abdomen	<b>Screen:</b> Codes Reported Together 95% or More / MPC List / CMS Request - NPRM for 2012	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2008	<b>Tab</b> S	<b>Specialty Developing Recommendation:</b> ACR	<b>First Identified:</b> February 2008	<b>2012 Est Medicare Utilization:</b> 154,980	<b>2007 Work RVU:</b> 1.27 <b>2007 NF PE RVU:</b> 7.53 <b>2007 Fac PE RVU:</b> NA <b>Result:</b> Maintain	<b>2013 Work RVU:</b> 1.27 <b>2013 NF PE RVU:</b> 6.96 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 0.42			<b>CPT Action (if applicable):</b> Referred to CPT Asst <input type="checkbox"/>	October 2009 <b>Published in CPT Asst:</b>		
<b>74170</b>	Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections		<b>Global:</b> XXX	<b>Issue:</b> CT Abdomen	<b>Screen:</b> Codes Reported Together 95% or More / CMS-Other - Utilization over 500,000 / CMS Request - NPRM for 2012	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2012	<b>Tab</b> 34	<b>Specialty Developing Recommendation:</b> ACR	<b>First Identified:</b> February 2008	<b>2012 Est Medicare Utilization:</b> 124,280	<b>2007 Work RVU:</b> 1.40 <b>2007 NF PE RVU:</b> 9.6 <b>2007 Fac PE RVU:</b> NA <b>Result:</b> Maintain	<b>2013 Work RVU:</b> 1.40 <b>2013 NF PE RVU:</b> 8.08 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 1.40			<b>CPT Action (if applicable):</b> Referred to CPT Asst <input type="checkbox"/>	October 2009 <b>Published in CPT Asst:</b>		
<b>74174</b>	Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing		<b>Global:</b> XXX	<b>Issue:</b> CT Angiography-Abdomen and Pelvis	<b>Screen:</b> Codes Reported Together 75% or More-Part1 / CMS Request Final Rule for 2013	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 26	<b>Specialty Developing Recommendation:</b> ACR	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 127,863	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU:</b> <b>Result:</b> Decrease	<b>2013 Work RVU:</b> 2.20 <b>2013 NF PE RVU:</b> 12.55 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 2.20 Interim, Resurvey for October 2013.			<b>CPT Action (if applicable):</b> Referred to CPT Asst <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

## Status Report: CMS Requests and Relativity Assessment Issues

<b>74175</b>	Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing	<b>Global:</b> XXX	<b>Issue:</b> CT Angiography-Abdomen and Pelvis	<b>Screen:</b> CMS Fastest Growing / Codes Reported Together 75% or More-Part1 / CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request Final Rule for 2013	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 26 <b>Specialty Developing Recommendation:</b> ACR	<b>First Identified:</b> October 2008	<b>2012 Est Medicare Utilization:</b> 59,733	<b>2007 Work RVU:</b> 1.90 <b>2007 NF PE RVU:</b> 12.39 <b>2007 Fac PE RVU Result:</b> NA	<b>2013 Work RVU:</b> 1.90 <b>2013 NF PE RVU:</b> 10.08 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 1.90 Interim, Resurvey for October 2013.		<b>CPT Action (if applicable):</b> Referred to CPT Asst <input type="checkbox"/>	<b>Published in CPT Asst:</b> October 2010		
<hr/>					
<b>74176</b>	Computed tomography, abdomen and pelvis; without contrast material	<b>Global:</b> XXX	<b>Issue:</b> CT Abdomen/CT Pelvis	<b>Screen:</b> CMS Fastest Growing	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2010	<b>Tab</b> 16 <b>Specialty Developing Recommendation:</b> ACR	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 1,974,195	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease	<b>2013 Work RVU:</b> 1.74 <b>2013 NF PE RVU:</b> 4.98 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 1.74		<b>CPT Action (if applicable):</b> Referred to CPT Asst <input type="checkbox"/>	<b>Published in CPT Asst:</b> October 2009		
<hr/>					
<b>74177</b>	Computed tomography, abdomen and pelvis; with contrast material(s)	<b>Global:</b> XXX	<b>Issue:</b> CT Abdomen/CT Pelvis	<b>Screen:</b> CMS Fastest Growing	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2010	<b>Tab</b> 16 <b>Specialty Developing Recommendation:</b> ACR	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 2,294,211	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease	<b>2013 Work RVU:</b> 1.82 <b>2013 NF PE RVU:</b> 8.35 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 1.82		<b>CPT Action (if applicable):</b> Referred to CPT Asst <input type="checkbox"/>	<b>Published in CPT Asst:</b> October 2009		

## Status Report: CMS Requests and Relativity Assessment Issues

**74178** Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions **Global:** XXX **Issue:** CT Abdomen/CT Pelvis **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent RUC Meeting:** February 2010 **Tab** 16 **Specialty Developing Recommendation:** ACR

**First Identified:**

**2012 Est Medicare Utilization:** 620,773

**2007 Work RVU:**

**2013 Work RVU:** 2.01

**2007 NF PE RVU:**

**2013 NF PE RVU:** 9.90

**2007 Fac PE RVU**

**2013 Fac PE RVU:** NA

**Result:** Decrease

**RUC Recommendation:** 2.01

**CPT Action (if applicable):** October 2009  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**74230** Swallowing function, with cineradiography/videoradiography

**Global:** XXX **Issue:** RAW

**Screen:** CMS-Other - Utilization over 250,000

**Complete?** No

**Most Recent RUC Meeting:** **Tab** **Specialty Developing Recommendation:**

**First Identified:** April 2013

**2012 Est Medicare Utilization:** 390,125

**2007 Work RVU:** 0.53

**2013 Work RVU:** 0.53

**2007 NF PE RVU:** 1.57

**2013 NF PE RVU:** 2.17

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:**

**RUC Recommendation:** Review Action Plan

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**74247** Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with or without delayed films, with KUB

**Global:** XXX **Issue:** Contrast X-Ray Exams

**Screen:** Harvard Valued - Utilization over 30,000

**Complete?** Yes

**Most Recent RUC Meeting:** September 2011 **Tab** 31 **Specialty Developing Recommendation:** ACR

**First Identified:** April 2011

**2012 Est Medicare Utilization:** 29,316

**2007 Work RVU:** 0.69

**2013 Work RVU:** 0.69

**2007 NF PE RVU:** 2.18

**2013 NF PE RVU:** 3.58

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** 0.69

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**74280** Radiologic examination, colon; air contrast with specific high density barium, with or without glucagon **Global:** XXX **Issue:** Contrast X-Ray Exams **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

**Most Recent RUC Meeting:** September 2011

**Tab** 31 **Specialty Developing Recommendation:** ACR

**First Identified:** April 2011

**2012 Est Medicare Utilization:** 24,130

**2007 Work RVU:** 0.99

**2013 Work RVU:** 0.99

**2007 NF PE RVU:** 3.07

**2013 NF PE RVU:** 5.60

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** 0.99

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**74305** Cholangiography and/or pancreatography; through existing catheter, radiological supervision and interpretation

**Global:** XXX

**Issue:** Introduction of Liver X-ray with Radiological S&I

**Screen:** Codes Reported Together 75% or More-Part2

**Complete?** No

**Most Recent RUC Meeting:** October 2012

**Tab** **Specialty Developing Recommendation:** ACR, SIR

**First Identified:**

**2012 Est Medicare Utilization:** 17,784

**2007 Work RVU:** 0.00

**2013 Work RVU:** 0.00

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** 0.00

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:**

**RUC Recommendation:** Refer to CPT to bundle.

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

CPT 2016 cycle

**Published in CPT Asst:**

**74320** Cholangiography, percutaneous, transhepatic, radiological supervision and interpretation

**Global:** XXX

**Issue:** Introduction of Liver X-ray with Radiological S&I

**Screen:** Codes Reported Together 75% or More-Part2

**Complete?** No

**Most Recent RUC Meeting:** October 2012

**Tab** **Specialty Developing Recommendation:** ACR, SIR

**First Identified:**

**2012 Est Medicare Utilization:** 5,439

**2007 Work RVU:** 0.54

**2013 Work RVU:** 0.54

**2007 NF PE RVU:** 3

**2013 NF PE RVU:** 2.38

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:**

**RUC Recommendation:** Refer to CPT to bundle.

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

CPT 2016 cycle

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**74400** Urography (pyelography), intravenous, with or without KUB, with or without tomography **Global:** XXX **Issue:** Contrast X-Ray Exams **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

**Most Recent RUC Meeting:** September 2011

**Tab** 31

**Specialty Developing Recommendation:** ACR

**First Identified:** April 2011

**2012 Est Medicare Utilization:** 22,126

**2007 Work RVU:** 0.49

**2013 Work RVU:** 0.49

**2007 NF PE RVU:** 2

**2013 NF PE RVU:** 2.88

**2007 Fac PE RVU:** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** 0.49

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Maintain

**74425** Urography, antegrade (pyelostogram, nephrostogram, loopogram), radiological supervision and interpretation **Global:** XXX **Issue:** Introduction of Catheter or Stent - Renal **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** No

**Most Recent RUC Meeting:** October 2012

**Tab**

**Specialty Developing Recommendation:** ACR, SIR

**First Identified:** October 2012

**2012 Est Medicare Utilization:** 43,277

**2007 Work RVU:** 0.00

**2013 Work RVU:** 0.00

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** 0.00

**2007 Fac PE RVU:** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** Refer to CPT to bundle.

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

CPT 2016 cycle

**Published in CPT Asst:**

**Result:**

**74475** Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous, radiological supervision and interpretation **Global:** XXX **Issue:** Introduction of Catheter or Stent - Renal **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** No

**Most Recent RUC Meeting:** October 2012

**Tab**

**Specialty Developing Recommendation:** ACR, SIR

**First Identified:** October 2012

**2012 Est Medicare Utilization:** 22,065

**2007 Work RVU:** 0.54

**2013 Work RVU:** 0.54

**2007 NF PE RVU:** 3.69

**2013 NF PE RVU:** 2.34

**2007 Fac PE RVU:** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** Refer to CPT to bundle.

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

CPT 2016 cycle

**Published in CPT Asst:**

**Result:**

## Status Report: CMS Requests and Relativity Assessment Issues

<b>74480</b>	<b>Introduction of ureteral catheter or stent into ureter through renal pelvis for drainage and/or injection, percutaneous, radiological supervision and interpretation</b>	<b>Global:</b> XXX	<b>Issue:</b> Introduction of Catheter or Stent - Renal	<b>Screen:</b> Codes Reported Together 75% or More-Part2	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b>	<b>Specialty Developing Recommendation:</b> ACR, SIR	<b>First Identified:</b> October 2012	<b>2012 Est Medicare Utilization:</b> 13,746	<b>2007 Work RVU:</b> 0.54 <b>2007 NF PE RVU:</b> 3.69 <b>2007 Fac PE RVU</b> NA <b>2013 Work RVU:</b> 0.54 <b>2013 NF PE RVU:</b> 2.34 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Refer to CPT to bundle.			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>CPT 2016 cycle</b>	<b>Published in CPT Asst:</b>
<hr/>					
<b>75635</b>	<b>Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing</b>	<b>Global:</b> XXX	<b>Issue:</b> CT Angiography	<b>Screen:</b> High Volume Growth1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2011	<b>Tab</b> 10	<b>Specialty Developing Recommendation:</b> ACR	<b>First Identified:</b> February 2008	<b>2012 Est Medicare Utilization:</b> 86,642	<b>2007 Work RVU:</b> 2.40 <b>2007 NF PE RVU:</b> 15.56 <b>2007 Fac PE RVU</b> NA <b>2013 Work RVU:</b> 2.40 <b>2013 NF PE RVU:</b> 10.84 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Remove from Screen			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>
<hr/>					
<b>75650</b>	<b>Angiography, cervicocerebral, catheter, including vessel origin, radiological supervision and interpretation</b>	<b>Global:</b> XXX	<b>Issue:</b> Carotid Angiography	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab</b> 45	<b>Specialty Developing Recommendation:</b> ACC, ACR, ASNR, AUR, SIR, SVS	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 26,613	<b>2007 Work RVU:</b> 1.49 <b>2007 NF PE RVU:</b> 10.66 <b>2007 Fac PE RVU</b> NA <b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>
<b>RUC Recommendation:</b> Deleted from CPT			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>February 2012</b>	<b>Published in CPT Asst:</b>

## Status Report: CMS Requests and Relativity Assessment Issues

<b>75671</b>	<b>Angiography, carotid, cerebral, bilateral, radiological supervision and interpretation</b>			<b>Global:</b> XXX	<b>Issue:</b> Carotid Angiography	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab</b> 45	<b>Specialty Developing Recommendation:</b>	AANS/CNS, ACC, ACR, ASNR, AUR, SIR, SVS	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 29,295	<b>2007 Work RVU:</b> 1.66 <b>2007 NF PE RVU:</b> 11.08 <b>2007 Fac PE RVU:</b> NA	<b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>
<b>RUC Recommendation:</b> Deleted from CPT				<b>CPT Action (if applicable):</b> Referred to CPT Asst <input type="checkbox"/>	February 2012 <b>Published in CPT Asst:</b>	<b>Result:</b> Deleted from CPT	
<hr/>							
<b>75680</b>	<b>Angiography, carotid, cervical, bilateral, radiological supervision and interpretation</b>			<b>Global:</b> XXX	<b>Issue:</b> Carotid Angiography	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab</b> 45	<b>Specialty Developing Recommendation:</b>	AANS/CNS, ACC, ACR, ASNR, AUR, SIR, SVS	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 32,585	<b>2007 Work RVU:</b> 1.66 <b>2007 NF PE RVU:</b> 10.96 <b>2007 Fac PE RVU:</b> NA	<b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>
<b>RUC Recommendation:</b> Deleted from CPT				<b>CPT Action (if applicable):</b> Referred to CPT Asst <input type="checkbox"/>	February 2012 <b>Published in CPT Asst:</b>	<b>Result:</b> Deleted from CPT	
<hr/>							
<b>75722</b>	<b>Angiography, renal, unilateral, selective (including flush aortogram), radiological supervision and interpretation</b>			<b>Global:</b> XXX	<b>Issue:</b> Renal Angiography	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab</b> 45	<b>Specialty Developing Recommendation:</b>	ACC, ACR, ASNR, AUR, SIR, SVS	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> 1.14 <b>2007 NF PE RVU:</b> 10.7 <b>2007 Fac PE RVU:</b> NA	<b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>
<b>RUC Recommendation:</b> Deleted from CPT				<b>CPT Action (if applicable):</b> Referred to CPT Asst <input type="checkbox"/>	February 2011 <b>Published in CPT Asst:</b>	<b>Result:</b> Deleted from CPT	

## Status Report: CMS Requests and Relativity Assessment Issues

**75724** Angiography, renal, bilateral, selective (including flush aortogram), radiological supervision and interpretation **Global:** XXX **Issue:** Renal Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab** 45

**Specialty Developing Recommendation:**

ACC, ACR, ASNR, AUR, SIR, SVS

**First Identified:** February 2010

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 1.49

**2013 Work RVU:**

**2007 NF PE RVU:** 11.15

**2013 NF PE RVU:**

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:**

**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** February 2011

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**75790** Deleted from CPT

**Global:** XXX

**Issue:** Arteriovenous Shunt Imaging

**Screen:** Codes Reported Together 95% or More

**Complete?** Yes

**Most Recent RUC Meeting:** April 2009

**Tab** 9

**Specialty Developing Recommendation:**

SVS, SIR, ACR

**First Identified:** February 2008

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 1.84

**2013 Work RVU:**

**2007 NF PE RVU:** 2.2

**2013 NF PE RVU:**

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:**

**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** February 2009

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**75791** Angiography, arteriovenous shunt (eg, dialysis patient fistula/graft), complete evaluation of dialysis access, including fluoroscopy, image documentation and report (includes injections of contrast and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava), radiological supervision and interpretation

**Global:** XXX

**Issue:** Arteriovenous Shunt Imaging

**Screen:** Codes Reported Together 95% or More

**Complete?** Yes

**Most Recent RUC Meeting:** April 2009

**Tab** 9

**Specialty Developing Recommendation:**

SVS, SIR, ACR

**First Identified:**

**2012 Est Medicare Utilization:** 19,670

**2007 Work RVU:**

**2013 Work RVU:** 1.71

**2007 NF PE RVU:**

**2013 NF PE RVU:** 8.23

**2007 Fac PE RVU**

**2013 Fac PE RVU:** NA

**Result:** Decrease

**RUC Recommendation:** 1.71

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**



## Status Report: CMS Requests and Relativity Assessment Issues

**75885** Percutaneous transhepatic portography with hemodynamic evaluation, radiological supervision and interpretation **Global:** XXX **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

**Most Recent** **Tab** 21 **Specialty Developing** ACR, SIR **First** **2012 Est** **2007 Work RVU:** 1.44 **2013 Work RVU:** 1.44  
**RUC Meeting:** February 2009 **Recommendation:** **Identified:** NA **Medicare** **2007 NF PE RVU:** 10.54 **2013 NF PE RVU:** 3.52  
**Utilization:** 350 **2007 Fac PE RVU** NA **2013 Fac PE RVU:** NA

**RUC Recommendation:** New PE inputs

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** PE Only

**75887** Percutaneous transhepatic portography without hemodynamic evaluation, radiological supervision and interpretation **Global:** XXX **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

**Most Recent** **Tab** 21 **Specialty Developing** ACR, SIR **First** **2012 Est** **2007 Work RVU:** 1.44 **2013 Work RVU:** 1.44  
**RUC Meeting:** February 2009 **Recommendation:** **Identified:** NA **Medicare** **2007 NF PE RVU:** 10.6 **2013 NF PE RVU:** 3.50  
**Utilization:** 366 **2007 Fac PE RVU** NA **2013 Fac PE RVU:** NA

**RUC Recommendation:** New PE inputs

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** PE Only

**75894** Transcatheter therapy, embolization, any method, radiological supervision and interpretation **Global:** XXX **Issue:** Transcatheter Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** No

**Most Recent** **Tab** 45 **Specialty Developing** ACC, ACR, SIR, SVS **First** **2012 Est** **2007 Work RVU:** 0.00 **2013 Work RVU:** 0.00  
**RUC Meeting:** April 2010 **Recommendation:** **Identified:** February 2010 **Medicare** **2007 NF PE RVU:** NA **2013 NF PE RVU:** 0.00  
**Utilization:** 38,385 **2007 Fac PE RVU** NA **2013 Fac PE RVU:** NA

**RUC Recommendation:** Refer to CPT

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

October 2012

**Published in CPT Asst:**

**Result:**

## Status Report: CMS Requests and Relativity Assessment Issues

<b>75896</b>	Transcatheter therapy, infusion, other than for thrombolysis, radiological supervision and interpretation	<b>Global:</b> XXX	<b>Issue:</b> Bundle Thrombolysis	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b> 07 <b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 16,190	<b>2007 Work RVU:</b> 0.00 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> NA <b>Result:</b> Carrier Price	<b>2013 Work RVU:</b> 0.00 <b>2013 NF PE RVU:</b> 0.00 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Carrier Price. Refer to CPT		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	February 2013 <b>Published in CPT Asst:</b>		
<b>75898</b>	Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis	<b>Global:</b> XXX	<b>Issue:</b> Bundle Thrombolysis	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b> 07 <b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 46,903	<b>2007 Work RVU:</b> 0.00 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> NA <b>Result:</b> Carrier Price	<b>2013 Work RVU:</b> 0.00 <b>2013 NF PE RVU:</b> 0.00 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Carrier Price. Refer to CPT		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	February 2013 <b>Published in CPT Asst:</b>		
<b>75940</b>	Percutaneous placement of IVC filter, radiological supervision and interpretation	<b>Global:</b> XXX	<b>Issue:</b> Major Vein Revision	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab</b> 45 <b>Specialty Developing Recommendation:</b> ACR, SIR, SVS	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> 0.00 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> NA <b>Result:</b> Deleted from CPT	<b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>
<b>RUC Recommendation:</b> Deleted from CPT		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	February 2011 <b>Published in CPT Asst:</b>		

## Status Report: CMS Requests and Relativity Assessment Issues

**75960** Transcatheter introduction of intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity artery), percutaneous and/or open, radiological supervision and interpretation, each vessel **Global:** XXX **Issue:** RAW **Screen:** High Volume Growth1 / Codes Reported Together 75% or More-Part1 **Complete?** Yes

**Most Recent RUC Meeting:** October 2012

**Tab** 27

**Specialty Developing Recommendation:** ACC, ACR, SIR, SVS

**First Identified:**

**2012 Est Medicare Utilization:** 54,402

**2007 Work RVU:** 0.00

**2013 Work RVU:** 0.82

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** 2.85

**2007 Fac PE RVU:** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** February 2013

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**75961** Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), radiological supervision and interpretation

**Global:** XXX

**Issue:** Transcatheter Procedures

**Screen:** Codes Reported Together 75% or More-Part1

**Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab** 45

**Specialty Developing Recommendation:** ACC, ACR, SIR, SVS

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 1,575

**2007 Work RVU:** 4.24

**2013 Work RVU:**

**2007 NF PE RVU:** 9.99

**2013 NF PE RVU:**

**2007 Fac PE RVU:** NA

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** June 2011

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**75962** Transluminal balloon angioplasty, peripheral artery other than renal, or other visceral artery, iliac or lower extremity, radiological supervision and interpretation

**Global:** XXX

**Issue:** RAW

**Screen:** High Volume Growth1

**Complete?** Yes

**Most Recent RUC Meeting:** October 2012

**Tab** 27

**Specialty Developing Recommendation:** ACC, ACR, SIR, SVS

**First Identified:**

**2012 Est Medicare Utilization:** 52,710

**2007 Work RVU:** 0.54

**2013 Work RVU:** 0.54

**2007 NF PE RVU:** 12.8

**2013 NF PE RVU:** 3.92

**2007 Fac PE RVU:** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** Remove from screen

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**75964** Transluminal balloon angioplasty, each additional peripheral artery other than renal or other visceral artery, iliac or lower extremity, radiological supervision and interpretation (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab** 07

**Specialty Developing Recommendation:** ACC, ACR, SIR, SVS

**First Identified:**

**2012 Est Medicare Utilization:** 1,686

**2007 Work RVU:** 0.36

**2013 Work RVU:** 0.36

**2007 NF PE RVU:** 6.96

**2013 NF PE RVU:** 2.50

**2007 Fac PE RVU** 6.96

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** Remove from screen

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**75978** Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation

**Global:** XXX

**Issue:** RAW

**Screen:** CMS-Other - Utilization over 250,000

**Complete?** No

**Most Recent RUC Meeting:**

**Tab**

**Specialty Developing Recommendation:**

**First Identified:** April 2013

**2012 Est Medicare Utilization:** 288,785

**2007 Work RVU:** 0.54

**2013 Work RVU:** 0.54

**2007 NF PE RVU:** 12.72

**2013 NF PE RVU:** 3.88

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:**

**RUC Recommendation:** Review Action Plan

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**75980** Percutaneous transhepatic biliary drainage with contrast monitoring, radiological supervision and interpretation

**Global:** XXX

**Issue:** Introduction of Liver X-ray with Radiological S&I

**Screen:** Codes Reported Together 75% or More-Part2

**Complete?** No

**Most Recent RUC Meeting:** October 2012

**Tab**

**Specialty Developing Recommendation:** ACR, SIR

**First Identified:**

**2012 Est Medicare Utilization:** 1,984

**2007 Work RVU:** 0.00

**2013 Work RVU:** 0.00

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** 0.00

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:**

**RUC Recommendation:** Refer to CPT to bundle.

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

<b>75982</b>	<b>Percutaneous placement of drainage catheter for combined internal and external biliary drainage or of a drainage stent for internal biliary drainage in patients with an inoperable mechanical biliary obstruction, radiological supervision and interpretation</b>	<b>Global:</b> XXX	<b>Issue:</b> Introduction of Liver X-ray with Radiological S&I	<b>Screen:</b> Codes Reported Together 75% or More-Part2	<b>Complete?</b> No
<b>Most Recent</b> <b>RUC Meeting:</b> October 2012	<b>Tab</b> <b>Specialty Developing Recommendation:</b> ACR, SIR	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 5,177	<b>2007 Work RVU:</b> 0.00 <b>2007 NF PE RVU:</b> 0 <b>2007 Fac PE RVU</b> 0 <b>Result:</b>	<b>2013 Work RVU:</b> 0.00 <b>2013 NF PE RVU:</b> 0.00 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Refer to CPT to bundle.		<b>CPT Action (if applicable):</b> CPT 2016 cycle <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	
<b>75984</b>	<b>Change of percutaneous tube or drainage catheter with contrast monitoring (eg, genitourinary system, abscess), radiological supervision and interpretation</b>	<b>Global:</b> XXX	<b>Issue:</b> Introduction of Catheter or Stent - Renal	<b>Screen:</b> Codes Reported Together 75% or More-Part2	<b>Complete?</b> No
<b>Most Recent</b> <b>RUC Meeting:</b> October 2012	<b>Tab</b> <b>Specialty Developing Recommendation:</b> ACR, SIR	<b>First Identified:</b> October 2012	<b>2012 Est Medicare Utilization:</b> 57,107	<b>2007 Work RVU:</b> 0.72 <b>2007 NF PE RVU:</b> 2.18 <b>2007 Fac PE RVU</b> NA <b>Result:</b>	<b>2013 Work RVU:</b> 0.72 <b>2013 NF PE RVU:</b> 2.57 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Refer to CPT to bundle.		<b>CPT Action (if applicable):</b> CPT 2016 cycle <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	
<b>75992</b>	<b>Deleted from CPT</b>	<b>Global:</b> XXX	<b>Issue:</b> Transluminal Arthrectomy	<b>Screen:</b> High Volume Growth1	<b>Complete?</b> Yes
<b>Most Recent</b> <b>RUC Meeting:</b> April 2008	<b>Tab</b> 57 <b>Specialty Developing Recommendation:</b> SIR, ACR, SVS	<b>First Identified:</b> February 2008	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> 0.00 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU</b> NA <b>Result:</b> Deleted from CPT	<b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>
<b>RUC Recommendation:</b> Deleted from CPT		<b>CPT Action (if applicable):</b> February 2010 <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	

## Status Report: CMS Requests and Relativity Assessment Issues

### 75993 Deleted from CPT

Global: ZZZ

Issue: Transluminal Arthrectomy

Screen: High Volume Growth1

Complete? Yes

Most Recent  
RUC Meeting: April 2008

Tab 57

Specialty Developing  
Recommendation: SIR, ACR,  
SVS

First  
Identified: February 2008

2012 Est  
Medicare  
Utilization:

2007 Work RVU: 0.00

2013 Work RVU:

2007 NF PE RVU: 0

2013 NF PE RVU:

2007 Fac PE RVU 0

2013 Fac PE RVU:

RUC Recommendation: Deleted from CPT

CPT Action (if applicable): February 2010

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Deleted from CPT

### 75994 Revised to Category III

Global: XXX

Issue: Transluminal Arthrectomy

Screen: High Volume Growth1

Complete? Yes

Most Recent  
RUC Meeting: April 2008

Tab 57

Specialty Developing  
Recommendation: SIR, ACR,  
SVS

First  
Identified: April 2008

2012 Est  
Medicare  
Utilization:

2007 Work RVU: 0.00

2013 Work RVU:

2007 NF PE RVU: 0

2013 NF PE RVU:

2007 Fac PE RVU 0

2013 Fac PE RVU:

RUC Recommendation: Remove from screen

CPT Action (if applicable): February 2010

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Remove from Screen

### 75995 Revised to Category III

Global: XXX

Issue: Transluminal Arthrectomy

Screen: High Volume Growth1

Complete? Yes

Most Recent  
RUC Meeting: April 2008

Tab 57

Specialty Developing  
Recommendation: SIR, ACR,  
SVS

First  
Identified: April 2008

2012 Est  
Medicare  
Utilization:

2007 Work RVU: 0.00

2013 Work RVU:

2007 NF PE RVU: 0

2013 NF PE RVU:

2007 Fac PE RVU 0

2013 Fac PE RVU:

RUC Recommendation: Remove from screen

CPT Action (if applicable): February 2010

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Remove from Screen

### 75996 Revised to Category III

Global: ZZZ

Issue: Transluminal Arthrectomy

Screen: High Volume Growth1

Complete? Yes

Most Recent  
RUC Meeting: April 2008

Tab 57

Specialty Developing  
Recommendation: SIR, ACR,  
SVS

First  
Identified: April 2008

2012 Est  
Medicare  
Utilization:

2007 Work RVU: 0.00

2013 Work RVU:

2007 NF PE RVU: 0

2013 NF PE RVU:

2007 Fac PE RVU 0

2013 Fac PE RVU:

RUC Recommendation: Remove from screen

CPT Action (if applicable): February 2010

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Remove from Screen

## Status Report: CMS Requests and Relativity Assessment Issues

---

<b>76000</b>	Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time, other than 71023 or 71034 (eg, cardiac fluoroscopy)	<b>Global:</b> XXX	<b>Issue:</b>	<b>Screen:</b> Low Value-Billed in Multiple Units	<b>Complete?</b> Yes
--------------	--	--------------------	---------------	---	----------------------

**Most Recent RUC Meeting:** October 2010

**Tab** 73

**Specialty Developing Recommendation:**

**First Identified:** October 2010

**2012 Est Medicare Utilization:** 134,878

**2007 Work RVU:** 0.17

**2013 Work RVU:** 0.17

**2007 NF PE RVU:** 1.68

**2013 NF PE RVU:** 1.37

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** Maintain

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

---

<b>76100</b>	Radiologic examination, single plane body section (eg, tomography), other than with urography	<b>Global:</b> XXX	<b>Issue:</b> Fluroscopy	<b>Screen:</b> CMS Request - Practice Expense Review	<b>Complete?</b> Yes
--------------	---	--------------------	--------------------------	--	----------------------

**Most Recent RUC Meeting:** April 2009

**Tab** 27

**Specialty Developing Recommendation:** ACR, ISIS

**First Identified:** April 2009

**2012 Est Medicare Utilization:** 5,554

**2007 Work RVU:** 0.58

**2013 Work RVU:** 0.58

**2007 NF PE RVU:** 1.93

**2013 NF PE RVU:** 2.41

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** PE Only

**RUC Recommendation:** New PE inputs

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

---

<b>76101</b>	Radiologic examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; unilateral	<b>Global:</b> XXX	<b>Issue:</b> Fluroscopy	<b>Screen:</b> CMS Request - Practice Expense Review	<b>Complete?</b> Yes
--------------	--	--------------------	--------------------------	--	----------------------

**Most Recent RUC Meeting:** April 2009

**Tab** 27

**Specialty Developing Recommendation:** ACR, ISIS

**First Identified:** April 2009

**2012 Est Medicare Utilization:** 576

**2007 Work RVU:** 0.58

**2013 Work RVU:** 0.58

**2007 NF PE RVU:** 2.5

**2013 NF PE RVU:** 3.93

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** PE Only

**RUC Recommendation:** New PE inputs

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

# Status Report: CMS Requests and Relativity Assessment Issues

**76102** Radiologic examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; bilateral **Global:** XXX **Issue:** Fluroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

**Most Recent RUC Meeting:** April 2009 **Tab** 27 **Specialty Developing Recommendation:** ACR, ISIS **First Identified:** April 2009 **2012 Est Medicare Utilization:** 1,028 **2007 Work RVU:** 0.58 **2013 Work RVU:** 0.58 **2007 NF PE RVU:** 3.35 **2013 NF PE RVU:** 5.46 **2007 Fac PE RVU:** NA **2013 Fac PE RVU:** NA **Result:** PE Only

**RUC Recommendation:** New PE inputs

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**76513** Ophthalmic ultrasound, diagnostic; anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy **Global:** XXX **Issue:** Ophthalmic Ultrasound **Screen:** High Volume Growth1 **Complete?** Yes

**Most Recent RUC Meeting:** September 2011 **Tab** 51 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** February 2008 **2012 Est Medicare Utilization:** 17,884 **2007 Work RVU:** 0.66 **2013 Work RVU:** 0.66 **2007 NF PE RVU:** 1.75 **2013 NF PE RVU:** 2.25 **2007 Fac PE RVU:** NA **2013 Fac PE RVU:** NA **Result:** Maintain

**RUC Recommendation:** 0.66 and CPT Assistant article published

**CPT Action (if applicable):** May 2008

**Referred to CPT Asst** ☒

**Published in CPT Asst:** Apr 2013

**76536** Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation **Global:** XXX **Issue:** Soft Tissue Ultrasound **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent RUC Meeting:** April 2009 **Tab** 29 **Specialty Developing Recommendation:** ACR, ASNR, TES, AACE **First Identified:** October 2008 **2012 Est Medicare Utilization:** 694,976 **2007 Work RVU:** 0.56 **2013 Work RVU:** 0.56 **2007 NF PE RVU:** 1.83 **2013 NF PE RVU:** 3.07 **2007 Fac PE RVU:** NA **2013 Fac PE RVU:** NA **Result:** Maintain

**RUC Recommendation:** 0.56

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**76645** Ultrasound, breast(s) (unilateral or bilateral), real time with image documentation **Global:** XXX **Issue:** Research Subcommittee **Screen:** CMS-Other - Utilization over 500,000 **Complete?** No

**Most Recent RUC Meeting:** January 2013 **Tab** 33 **Specialty Developing Recommendation:** ACR, ASBS **First Identified:** April 2011 **2012 Est Medicare Utilization:** 868,726 **2007 Work RVU:** 0.54 **2013 Work RVU:** 0.54 **2007 NF PE RVU:** 1.41 **2013 NF PE RVU:** 2.36 **2007 Fac PE RVU:** NA **2013 Fac PE RVU:** NA **Result:**

**RUC Recommendation:** Survey for work and PE October 2013

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**



# Status Report: CMS Requests and Relativity Assessment Issues

<b>76700</b>	<b>Ultrasound, abdominal, real time with image documentation; complete</b>	<b>Global:</b> XXX	<b>Issue:</b>	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>Most Recent</b>	<b>Tab 41</b>	<b>Specialty Developing</b>	<b>First</b>	<b>2012 Est</b>	<b>2007 Work RVU:</b> 0.81
<b>RUC Meeting:</b> February 2011		<b>Recommendation:</b>	<b>Identified:</b> October 2010	<b>Medicare</b>	<b>2013 Work RVU:</b> 0.81
				<b>Utilization:</b> 1,037,178	<b>2007 NF PE RVU:</b> 2.39
					<b>2013 NF PE RVU:</b> 3.35
					<b>2007 Fac PE RVU</b> NA
<b>RUC Recommendation:</b> Reaffirmed RUC recommendation			<b>CPT Action (if applicable):</b>	<b>Result:</b> Maintain	<b>2013 Fac PE RVU:</b> NA
			<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	

<b>76705</b>	<b>Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)</b>	<b>Global:</b> XXX	<b>Issue:</b> Research Subcommittee	<b>Screen:</b> CMS-Other - Utilization over 500,000	<b>Complete?</b> No
<b>Most Recent</b>	<b>Tab 33</b>	<b>Specialty Developing</b>	<b>First</b>	<b>2012 Est</b>	<b>2007 Work RVU:</b> 0.59
<b>RUC Meeting:</b> January 2013		<b>Recommendation:</b> ACR, ASBS	<b>Identified:</b> April 2011	<b>Medicare</b>	<b>2013 Work RVU:</b> 0.59
				<b>Utilization:</b> 984,857	<b>2007 NF PE RVU:</b> 1.77
					<b>2013 NF PE RVU:</b> 2.61
					<b>2007 Fac PE RVU</b> NA
<b>RUC Recommendation:</b> Survey for work and PE October 2013			<b>CPT Action (if applicable):</b>	<b>Result:</b>	<b>2013 Fac PE RVU:</b> NA
			<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	

<b>76770</b>	<b>Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; complete</b>	<b>Global:</b> XXX	<b>Issue:</b> Research Subcommittee	<b>Screen:</b> CMS-Other - Utilization over 500,000	<b>Complete?</b> No
<b>Most Recent</b>	<b>Tab 30</b>	<b>Specialty Developing</b>	<b>First</b>	<b>2012 Est</b>	<b>2007 Work RVU:</b> 0.74
<b>RUC Meeting:</b> January 2013		<b>Recommendation:</b> ACR, ASBS	<b>Identified:</b> April 2011	<b>Medicare</b>	<b>2013 Work RVU:</b> 0.74
				<b>Utilization:</b> 1,174,514	<b>2007 NF PE RVU:</b> 2.36
					<b>2013 NF PE RVU:</b> 3.18
					<b>2007 Fac PE RVU</b> NA
<b>RUC Recommendation:</b> Survey for work and PE October 2013			<b>CPT Action (if applicable):</b>	<b>Result:</b>	<b>2013 Fac PE RVU:</b> NA
			<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	

<b>76775</b>	<b>Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited</b>	<b>Global:</b> XXX	<b>Issue:</b> Research Subcommittee	<b>Screen:</b> CMS-Other - Utilization over 500,000	<b>Complete?</b> No
<b>Most Recent</b>	<b>Tab 30</b>	<b>Specialty Developing</b>	<b>First</b>	<b>2012 Est</b>	<b>2007 Work RVU:</b> 0.58
<b>RUC Meeting:</b> January 2013		<b>Recommendation:</b> ACR, ASBS	<b>Identified:</b> April 2011	<b>Medicare</b>	<b>2013 Work RVU:</b> 0.58
				<b>Utilization:</b> 737,123	<b>2007 NF PE RVU:</b> 1.81
					<b>2013 NF PE RVU:</b> 2.64
					<b>2007 Fac PE RVU</b> NA
<b>RUC Recommendation:</b> Survey for work and PE October 2013			<b>CPT Action (if applicable):</b>	<b>Result:</b>	<b>2013 Fac PE RVU:</b> NA
			<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	

## Status Report: CMS Requests and Relativity Assessment Issues

<b>76819</b>	<b>Fetal biophysical profile; without non-stress testing</b>	<b>Global:</b> XXX	<b>Issue:</b> RAW	<b>Screen:</b> High Volume Growth2	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> April 2013	<b>2012 Est Medicare Utilization:</b> 11,622	<b>2007 Work RVU:</b> 0.77 <b>2007 NF PE RVU:</b> 1.81 <b>2007 Fac PE RVU</b> NA <b>Result:</b>
<b>RUC Recommendation:</b> Review Action Plan			<b>CPT Action (if applicable):</b>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 0.77 <b>2013 NF PE RVU:</b> 1.88 <b>2013 Fac PE RVU:</b> NA
			<b>Referred to CPT Asst</b> <input type="checkbox"/>		

<b>76830</b>	<b>Ultrasound, transvaginal</b>	<b>Global:</b> XXX	<b>Issue:</b> Transvaginal and Transrectal Ultrasound	<b>Screen:</b> CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2012	<b>Tab</b> 44	<b>Specialty Developing Recommendation:</b> ACOG, ACR, AUA	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 472,382	<b>2007 Work RVU:</b> 0.69 <b>2007 NF PE RVU:</b> 1.97 <b>2007 Fac PE RVU</b> NA <b>Result:</b> Maintain
<b>RUC Recommendation:</b> 0.69			<b>CPT Action (if applicable):</b>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 0.69 <b>2013 NF PE RVU:</b> 1.51 <b>2013 Fac PE RVU:</b> NA
			<b>Referred to CPT Asst</b> <input type="checkbox"/>		

<b>76856</b>	<b>Ultrasound, pelvic (nonobstetric), real time with image documentation; complete</b>	<b>Global:</b> XXX	<b>Issue:</b> Research Subcommittee	<b>Screen:</b> CMS-Other - Utilization over 500,000	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> January 2013	<b>Tab</b> 30	<b>Specialty Developing Recommendation:</b> ACR, ASBS	<b>First Identified:</b> April 2011	<b>2012 Est Medicare Utilization:</b> 524,102	<b>2007 Work RVU:</b> 0.69 <b>2007 NF PE RVU:</b> 1.99 <b>2007 Fac PE RVU</b> NA <b>Result:</b>
<b>RUC Recommendation:</b> Survey for work and PE October 2013			<b>CPT Action (if applicable):</b>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 0.69 <b>2013 NF PE RVU:</b> 3.00 <b>2013 Fac PE RVU:</b> NA
			<b>Referred to CPT Asst</b> <input type="checkbox"/>		

<b>76857</b>	<b>Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)</b>	<b>Global:</b> XXX	<b>Issue:</b> RAW	<b>Screen:</b> CMS-Other - Utilization over 250,000	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> April 2013	<b>2012 Est Medicare Utilization:</b> 255,678	<b>2007 Work RVU:</b> 0.38 <b>2007 NF PE RVU:</b> 1.99 <b>2007 Fac PE RVU</b> NA <b>Result:</b>
<b>RUC Recommendation:</b> Review Action Plan			<b>CPT Action (if applicable):</b>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 0.38 <b>2013 NF PE RVU:</b> 2.44 <b>2013 Fac PE RVU:</b> NA
			<b>Referred to CPT Asst</b> <input type="checkbox"/>		

# Status Report: CMS Requests and Relativity Assessment Issues

**76872** Ultrasound, transrectal; **Global:** XXX **Issue:** Transvaginal and Transrectal Ultrasound **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

**Most Recent RUC Meeting:** April 2012 **Tab** 44 **Specialty Developing Recommendation:** ACOG, ACR, AUA **First Identified:** September 2011 **2012 Est Medicare Utilization:** 225,847 **2007 Work RVU:** 0.69 **2013 Work RVU:** 0.69 **2007 NF PE RVU:** 2.52 **2013 NF PE RVU:** 1.42 **2007 Fac PE RVU:** NA **2013 Fac PE RVU:** NA **Result:** Maintain

**RUC Recommendation:** 0.69 **CPT Action (if applicable):** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

**76880** Deleted from CPT **Global:** XXX **Issue:** Lower Extremity Ultrasound **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent RUC Meeting:** October 2009 **Tab** 26 **Specialty Developing Recommendation:** APMA, ACR **First Identified:** October 2008 **2012 Est Medicare Utilization:** **2007 Work RVU:** 0.59 **2013 Work RVU:** **2007 NF PE RVU:** 1.97 **2013 NF PE RVU:** **2007 Fac PE RVU:** NA **2013 Fac PE RVU:** **Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT **CPT Action (if applicable):** February 2010 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

**76881** Ultrasound, extremity, nonvascular, real-time with image documentation; complete **Global:** XXX **Issue:** Ultrasound of Extremity **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent RUC Meeting:** April 2010 **Tab** 17 **Specialty Developing Recommendation:** AAPMR, APMA, ACR **First Identified:** April 2010 **2012 Est Medicare Utilization:** 142,878 **2007 Work RVU:** **2013 Work RVU:** 0.63 **2007 NF PE RVU:** **2013 NF PE RVU:** 2.98 **2007 Fac PE RVU:** **2013 Fac PE RVU:** NA **Result:** Decrease

**RUC Recommendation:** 0.72 **CPT Action (if applicable):** February 2010 **Referred to CPT Asst** ☒ **Published in CPT Asst:** Clinical Examples

**76882** Ultrasound, extremity, nonvascular, real-time with image documentation; limited, anatomic specific **Global:** XXX **Issue:** Ultrasound of Extremity **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent RUC Meeting:** April 2010 **Tab** 17 **Specialty Developing Recommendation:** AAPMR, APMA, ACR **First Identified:** April 2010 **2012 Est Medicare Utilization:** 177,605 **2007 Work RVU:** **2013 Work RVU:** 0.49 **2007 NF PE RVU:** **2013 NF PE RVU:** 0.50 **2007 Fac PE RVU:** **2013 Fac PE RVU:** NA **Result:** Decrease

**RUC Recommendation:** 0.50 **CPT Action (if applicable):** February 2010 **Referred to CPT Asst** ☒ **Published in CPT Asst:** Clinical Examples

## Status Report: CMS Requests and Relativity Assessment Issues

76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation			Global: XXX	Issue: RAW review	Screen: CMS-Other - Utilization over 500,000	Complete?	No												
Most Recent RUC Meeting:	January 2013	Tab 30	Specialty Developing Recommendation:	ACR, AACE, AAPM, AAOS, ASA, AUA, ACRh, ACRO, SIR, TES, ASIPP	First Identified:	April 2011	2012 Est Medicare Utilization:	1,686,134	2007 Work RVU:	0.67	2013 Work RVU:	0.67	2007 NF PE RVU:	3.43	2013 NF PE RVU:	5.41	2007 Fac PE RVU	NA	2013 Fac PE RVU:	NA
RUC Recommendation:	Review survey at Research Sub Oct 2013. Survey for work and PE time certain April 2014.				CPT Action (if applicable):				Result:											
				Referred to CPT Asst				<input type="checkbox"/>	Published in CPT Asst:											
<hr/>																				
76950	Ultrasonic guidance for placement of radiation therapy fields				Global: XXX	Issue: IMRT with Ultrasound Guidance	Screen: Codes Reported Together 75% or More-Part1	Complete?	Yes											
Most Recent RUC Meeting:	October 2010	Tab 14	Specialty Developing Recommendation:	ACRO, ASTRO	First Identified:	February 2010	2012 Est Medicare Utilization:	36,568	2007 Work RVU:	0.58	2013 Work RVU:	0.58	2007 NF PE RVU:	1.43	2013 NF PE RVU:	0.88	2007 Fac PE RVU	NA	2013 Fac PE RVU:	NA
RUC Recommendation:	New PE Inputs				CPT Action (if applicable):				Result: PE Only											
				Referred to CPT Asst				<input type="checkbox"/>	Published in CPT Asst:											
<hr/>																				
76970	Ultrasound study follow-up (specify)				Global: XXX	Issue: IMRT with Ultrasound Guidance	Screen: High Volume Growth1	Complete?	Yes											
Most Recent RUC Meeting:	February 2009	Tab 38	Specialty Developing Recommendation:	ACS, ACR, AACE	First Identified:	February 2008	2012 Est Medicare Utilization:	16,848	2007 Work RVU:	0.40	2013 Work RVU:	0.40	2007 NF PE RVU:	1.41	2013 NF PE RVU:	2.57	2007 Fac PE RVU	NA	2013 Fac PE RVU:	NA
RUC Recommendation:	Remove from screen - RUC articulated concerns regarding claims reporting to CMS				CPT Action (if applicable):				Result: Remove from Screen											
				Referred to CPT Asst				<input type="checkbox"/>	Published in CPT Asst:											

## Status Report: CMS Requests and Relativity Assessment Issues

**77001** Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)

**Global:** ZZZ **Issue:** Fluoroscopic Guidance **Screen:** MPC List / CMS Request Final Rule for 2013 **Complete?** Yes

**Most Recent RUC Meeting:** April 2013

**Tab** 27

**Specialty Developing Recommendation:**

**First Identified:** January 2012

**2012 Est Medicare Utilization:** 457,185

**2007 Work RVU:** 0.38

**2013 Work RVU:** 0.38

**2007 NF PE RVU:** 1.73

**2013 NF PE RVU:** 3.14

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** 0.38

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**77002** Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)

**Global:** XXX

**Issue:** Fluoroscopic Guidance

**Screen:** MPC List / CMS Request Final Rule for 2013

**Complete?** Yes

**Most Recent RUC Meeting:** April 2013

**Tab** 27

**Specialty Developing Recommendation:**

**First Identified:** January 2012

**2012 Est Medicare Utilization:** 306,403

**2007 Work RVU:** 0.54

**2013 Work RVU:** 0.54

**2007 NF PE RVU:** 1.4

**2013 NF PE RVU:** 1.77

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** 0.54

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**77003** Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural or subarachnoid)

**Global:** XXX

**Issue:** Fluoroscopic Guidance

**Screen:** MPC List / CMS Request Final Rule for 2013

**Complete?** Yes

**Most Recent RUC Meeting:** April 2013

**Tab** 27

**Specialty Developing Recommendation:**

AAPM, AAPMR, ASA, ASIPP, NASS, SIR

**First Identified:** October 2010

**2012 Est Medicare Utilization:** 1,082,865

**2007 Work RVU:** 0.60

**2013 Work RVU:** 0.60

**2007 NF PE RVU:** 1.28

**2013 NF PE RVU:** 2.18

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** 0.60

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

# Status Report: CMS Requests and Relativity Assessment Issues

77011	Computed tomography guidance for stereotactic localization			Global: XXX	Issue: IMRT with CT Guidance	Screen: CMS Request - Practice Expense Review	Complete? Yes
Most Recent RUC Meeting: October 2010	Tab 15	Specialty Developing Recommendation: ASTRO, ACRO	First Identified:	2012 Est Medicare Utilization: 4,532	2007 Work RVU: 1.21	2013 Work RVU: 1.21	
					2007 NF PE RVU: 11.38	2013 NF PE RVU: 5.40	
					2007 Fac PE RVU NA	2013 Fac PE RVU: NA	
RUC Recommendation: New PE inputs			CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: PE Only		
77014	Computed tomography guidance for placement of radiation therapy fields			Global: XXX	Issue: IMRT with CT Guidance	Screen: CMS Request - Practice Expense Review / CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes	Complete? No
Most Recent RUC Meeting: January 2012	Tab 30	Specialty Developing Recommendation: ASTRO, ACR	First Identified: October 2010	2012 Est Medicare Utilization: 1,144,832	2007 Work RVU: 0.85	2013 Work RVU: 0.85	
					2007 NF PE RVU: 3.53	2013 NF PE RVU: 2.76	
					2007 Fac PE RVU NA	2013 Fac PE RVU: NA	
RUC Recommendation: Refer to CPT			CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>	May 2013 Published in CPT Asst:	Result:		
77031	Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation			Global: XXX	Issue: Breast Biopsy	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: April 2013	Tab 04	Specialty Developing Recommendation:	First Identified: January 2012	2012 Est Medicare Utilization: 65,427	2007 Work RVU: 1.59	2013 Work RVU: 1.59	
					2007 NF PE RVU: 6.19	2013 NF PE RVU: 2.10	
					2007 Fac PE RVU NA	2013 Fac PE RVU: NA	
RUC Recommendation: Deleted from CPT			CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>	October 2012 Published in CPT Asst:	Result: Deleted from CPT		

# Status Report: CMS Requests and Relativity Assessment Issues

**77032** Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation **Global:** XXX **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

**Most Recent RUC Meeting:** April 2013

**Tab** 04

**Specialty Developing Recommendation:**

**First Identified:** January 2012

**2012 Est Medicare Utilization:** 34,625

**2007 Work RVU:** 0.56

**2013 Work RVU:** 0.56

**2007 NF PE RVU:** 1.26

**2013 NF PE RVU:** 0.94

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2012  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Deleted from CPT

**77052** Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further review for interpretation, with or without digitization of film radiographic images; screening mammography (List separately in addition to code for primary procedure)

**Global:** ZZZ

**Issue:**

**Screen:** Low Value-High Volume

**Complete?** Yes

**Most Recent RUC Meeting:** February 2011

**Tab** 41

**Specialty Developing Recommendation:**

**First Identified:** October 2010

**2012 Est Medicare Utilization:** 5,290,878

**2007 Work RVU:** 0.06

**2013 Work RVU:** 0.06

**2007 NF PE RVU:** 0.38

**2013 NF PE RVU:** 0.22

**2007 Fac PE RVU** 0.38

**2013 Fac PE RVU:** NA

**RUC Recommendation:** Reaffirmed RUC recommendation

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Maintain

**77079** Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)

**Global:** XXX

**Issue:** CT Bone Density Study

**Screen:** Different Performing Specialty from Survey

**Complete?** Yes

**Most Recent RUC Meeting:** February 2010

**Tab** 31

**Specialty Developing Recommendation:** ACR, AAFP, ACP

**First Identified:** October 2009

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 0.22

**2013 Work RVU:**

**2007 NF PE RVU:** 2.45

**2013 NF PE RVU:**

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2010  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Deleted from CPT

## Status Report: CMS Requests and Relativity Assessment Issues

<b>77080</b>	<b>Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)</b>	<b>Global:</b> XXX	<b>Issue:</b> Dual-energy X-ray Absorptiometry	<b>Screen:</b> CMS Request - NPRM for 2012 / Codes Reported Together 75% or More-Part2	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> January 2012	<b>Tab</b> 23	<b>Specialty Developing Recommendation:</b> AACE, ACR, ACRh, TES	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 2,306,826	<b>2007 Work RVU:</b> 0.20 <b>2007 NF PE RVU:</b> 2.59 <b>2007 Fac PE RVU</b> NA <b>Result:</b> Maintain <b>2013 Work RVU:</b> 0.20 <b>2013 NF PE RVU:</b> 1.26 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Refer to CPT to bundle (0.20)		<b>CPT Action (if applicable):</b> 2015 CPT cycle <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	
<b>77082</b>	<b>Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; vertebral fracture assessment</b>	<b>Global:</b> XXX	<b>Issue:</b> Dual-energy X-ray Absorptiometry	<b>Screen:</b> CMS Request - NPRM for 2012 / Codes Reported Together 75% or More-Part2	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> January 2012	<b>Tab</b> 23	<b>Specialty Developing Recommendation:</b> AACE, ACR, ACRh, TES	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 157,214	<b>2007 Work RVU:</b> 0.17 <b>2007 NF PE RVU:</b> 0.71 <b>2007 Fac PE RVU</b> NA <b>Result:</b> Maintain <b>2013 Work RVU:</b> 0.17 <b>2013 NF PE RVU:</b> 0.65 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Refer to CPT to bundle (0.17)		<b>CPT Action (if applicable):</b> 2015 CPT cycle <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	
<b>77083</b>	<b>Radiographic absorptiometry (eg, photodensitometry, radiogrammetry), 1 or more sites</b>	<b>Global:</b> XXX	<b>Issue:</b> Radiographic Absorptiometry	<b>Screen:</b> Different Performing Specialty from Survey	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2010	<b>Tab</b> 31	<b>Specialty Developing Recommendation:</b> ACR, ACP	<b>First Identified:</b> October 2009	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> 0.20 <b>2007 NF PE RVU:</b> 0.71 <b>2007 Fac PE RVU</b> NA <b>Result:</b> Deleted from CPT <b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>
<b>RUC Recommendation:</b> Deleted from CPT		<b>CPT Action (if applicable):</b> October 2010 <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	



## Status Report: CMS Requests and Relativity Assessment Issues

<b>77280</b>	Therapeutic radiology simulation-aided field setting; simple			<b>Global:</b> XXX	<b>Issue:</b> Set Radiation Therapy Field	<b>Screen:</b> Harvard Valued - Utilization over 30,000 / Services with Stand-Alone PE Procedure Time	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2013	<b>Tab</b> 14	<b>Specialty Developing Recommendation:</b>	ASTRO	<b>First Identified:</b> April 2011	<b>2012 Est Medicare Utilization:</b> 277,791	<b>2007 Work RVU:</b> 0.70 <b>2007 NF PE RVU:</b> 3.89 <b>2007 Fac PE RVU</b> NA <b>Result:</b> Maintain	<b>2013 Work RVU:</b> 0.70 <b>2013 NF PE RVU:</b> 4.58 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 0.70				<b>CPT Action (if applicable):</b> Referred to CPT Asst <input type="checkbox"/>	October 2012 <b>Published in CPT Asst:</b>		
<hr/>							
<b>77285</b>	Therapeutic radiology simulation-aided field setting; intermediate			<b>Global:</b> XXX	<b>Issue:</b> Respiratory Motion Management Simulation	<b>Screen:</b> Harvard Valued - Utilization over 30,000 / Services with Stand-Alone PE Procedure Time	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2013	<b>Tab</b> 14	<b>Specialty Developing Recommendation:</b>	ASTRO	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 4,173	<b>2007 Work RVU:</b> 1.05 <b>2007 NF PE RVU:</b> 6.45 <b>2007 Fac PE RVU</b> NA <b>Result:</b> Maintain	<b>2013 Work RVU:</b> 1.05 <b>2013 NF PE RVU:</b> 8.30 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 1.05				<b>CPT Action (if applicable):</b> Referred to CPT Asst <input type="checkbox"/>	October 2012 <b>Published in CPT Asst:</b>		
<hr/>							
<b>77290</b>	Therapeutic radiology simulation-aided field setting; complex			<b>Global:</b> XXX	<b>Issue:</b> Respiratory Motion Management Simulation	<b>Screen:</b> MPC List / Harvard Valued - Utilization over 30,000 / Services with Stand-Alone PE Procedure Time	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2013	<b>Tab</b> 14	<b>Specialty Developing Recommendation:</b>	ASTRO	<b>First Identified:</b> October 2010	<b>2012 Est Medicare Utilization:</b> 330,013	<b>2007 Work RVU:</b> 1.56 <b>2007 NF PE RVU:</b> 8.63 <b>2007 Fac PE RVU</b> NA <b>Result:</b> Maintain	<b>2013 Work RVU:</b> 1.56 <b>2013 NF PE RVU:</b> 13.98 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 1.56				<b>CPT Action (if applicable):</b> Referred to CPT Asst <input type="checkbox"/>	October 2012 <b>Published in CPT Asst:</b>		

## Status Report: CMS Requests and Relativity Assessment Issues

<b>77295</b>	Therapeutic radiology simulation-aided field setting; 3-dimensional			<b>Global:</b> XXX	<b>Issue:</b> Respiratory Motion Management Simulation	<b>Screen:</b> Harvard Valued - Utilization over 30,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2013	<b>Tab</b> 14	<b>Specialty Developing Recommendation:</b>	ASTRO	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 138,825	<b>2007 Work RVU:</b> 4.56 <b>2007 NF PE RVU:</b> 23.92 <b>2007 Fac PE RVU:</b> NA <b>Result:</b> Decrease	<b>2013 Work RVU:</b> 4.56 <b>2013 NF PE RVU:</b> 8.25 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 4.29				<b>CPT Action (if applicable):</b> Referred to CPT Asst <input type="checkbox"/>	October 2012 <b>Published in CPT Asst:</b>		

<b>772X1X</b>				<b>Global:</b>	<b>Issue:</b> Respiratory Motion Management Simulation	<b>Screen:</b> Harvard Valued - Utilization over 30,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2013	<b>Tab</b> 14	<b>Specialty Developing Recommendation:</b>	ASTRO	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU:</b> <b>Result:</b> Decrease	<b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>
<b>RUC Recommendation:</b> 2.00				<b>CPT Action (if applicable):</b> Referred to CPT Asst <input type="checkbox"/>	October 2012 <b>Published in CPT Asst:</b>		

<b>77300</b>	Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician			<b>Global:</b> XXX	<b>Issue:</b> Radiation Isodose Planning	<b>Screen:</b> MPC List / Codes Reported Together 75% or More-Part2	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> February 2011	<b>Tab</b> 41	<b>Specialty Developing Recommendation:</b>	ASTRO	<b>First Identified:</b> October 2010	<b>2012 Est Medicare Utilization:</b> 1,690,478	<b>2007 Work RVU:</b> 0.62 <b>2007 NF PE RVU:</b> 1.45 <b>2007 Fac PE RVU:</b> NA <b>Result:</b> Maintain	<b>2013 Work RVU:</b> 0.62 <b>2013 NF PE RVU:</b> 1.30 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Refer to CPT to bundle.				<b>CPT Action (if applicable):</b> Referred to CPT Asst <input type="checkbox"/>	CPT 2015 cycle <b>Published in CPT Asst:</b>		

## Status Report: CMS Requests and Relativity Assessment Issues

<b>77301</b>	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications	<b>Global:</b> XXX	<b>Issue:</b> IMRT - PE Only	<b>Screen:</b> CMS Fastest Growing / CMS Request - Practice Expense Review / CMS High Expenditure Procedural Codes / Services with Stand-Alone PE Procedure Time	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 28	<b>Specialty Developing Recommendation:</b> ASTRO	<b>First Identified:</b> October 2008	<b>2012 Est Medicare Utilization:</b> 93,741	<b>2007 Work RVU:</b> 7.99 <b>2007 NF PE RVU:</b> 37.25 <b>2007 Fac PE RVU:</b> NA <b>2013 Work RVU:</b> 7.99 <b>2013 NF PE RVU:</b> 49.88 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> New PE Inputs. 7.99. CPT Assistant article published.			<b>CPT Action (if applicable):</b>	<b>Referred to CPT Asst</b> <input checked="" type="checkbox"/>	<b>Published in CPT Asst:</b> Nov 2009
<b>77305</b>	Teletherapy, isodose plan (whether hand or computer calculated); simple (1 or 2 parallel opposed unmodified ports directed to a single area of interest)	<b>Global:</b> XXX	<b>Issue:</b> Radiation Isodose Planning	<b>Screen:</b> Codes Reported Together 75% or More-Part2	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b>	<b>Specialty Developing Recommendation:</b> ASTRO	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 5,392	<b>2007 Work RVU:</b> 0.70 <b>2007 NF PE RVU:</b> 1.79 <b>2007 Fac PE RVU:</b> NA <b>2013 Work RVU:</b> 0.70 <b>2013 NF PE RVU:</b> 0.98 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Refer to CPT to bundle.			<b>CPT Action (if applicable):</b> 2015 CPT cycle	<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>
<b>77310</b>	Teletherapy, isodose plan (whether hand or computer calculated); intermediate (3 or more treatment ports directed to a single area of interest)	<b>Global:</b> XXX	<b>Issue:</b> Radiation Isodose Planning	<b>Screen:</b> Codes Reported Together 75% or More-Part2	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b>	<b>Specialty Developing Recommendation:</b> ASTRO	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 1,743	<b>2007 Work RVU:</b> 1.05 <b>2007 NF PE RVU:</b> 2.32 <b>2007 Fac PE RVU:</b> NA <b>2013 Work RVU:</b> 1.05 <b>2013 NF PE RVU:</b> 1.37 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Refer to CPT to bundle.			<b>CPT Action (if applicable):</b> 2015 CPT cycle	<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>

## Status Report: CMS Requests and Relativity Assessment Issues

**77315** Teletherapy, isodose plan (whether hand or computer calculated); complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex blocking, rotational beam, or special beam considerations) **Global:** XXX **Issue:** Radiation Isodose Planning **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** No

**Most Recent RUC Meeting:** October 2012

**Tab**

**Specialty Developing Recommendation:** ASTRO

**First Identified:**

**2012 Est Medicare Utilization:** 78,630

**2007 Work RVU:** 1.56

**2013 Work RVU:** 1.56

**2007 NF PE RVU:** 2.9

**2013 NF PE RVU:** 2.29

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** Refer to CPT to bundle.

**CPT Action (if applicable):**

2015 CPT cycle

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:**

**77327** Brachytherapy isodose plan; intermediate (multiplane dosage calculations, application involving 5 to 10 sources/ribbons, remote afterloading brachytherapy, 9 to 12 sources)

**Global:** XXX

**Issue:** Radiation Isodose Planning

**Screen:** Codes Reported Together 75% or More-Part2

**Complete?** No

**Most Recent RUC Meeting:** October 2012

**Tab**

**Specialty Developing Recommendation:** ASTRO

**First Identified:**

**2012 Est Medicare Utilization:** 2,740

**2007 Work RVU:** 1.39

**2013 Work RVU:** 1.39

**2007 NF PE RVU:** 3.97

**2013 NF PE RVU:** 4.50

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** Refer to CPT to bundle.

**CPT Action (if applicable):**

2015 CPT cycle

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:**

**77334** Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)

**Global:** XXX

**Issue:**

**Screen:** MPC List

**Complete?** Yes

**Most Recent RUC Meeting:** February 2011

**Tab** 41

**Specialty Developing Recommendation:**

**First Identified:** October 2010

**2012 Est Medicare Utilization:** 851,967

**2007 Work RVU:** 1.24

**2013 Work RVU:** 1.24

**2007 NF PE RVU:** 3.43

**2013 NF PE RVU:** 3.11

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** Reaffirmed RUC recommendation

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Maintain

## Status Report: CMS Requests and Relativity Assessment Issues

<b>77336</b>	Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy	<b>Global:</b> XXX	<b>Issue:</b> Continuing Medical Physics Consultation-PE Only	<b>Screen:</b> CMS Request Final Rule for 2013	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 31 <b>Specialty Developing Recommendation:</b> ASTRO	<b>First Identified:</b> October 2012	<b>2012 Est Medicare Utilization:</b> 502,634	<b>2007 Work RVU:</b> 0.00 <b>2007 NF PE RVU:</b> 2.52 <b>2007 Fac PE RVU Result:</b> PE Only	<b>2013 Work RVU:</b> 0.00 <b>2013 NF PE RVU:</b> 1.28 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> New PE Inputs		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		
<b>77338</b>	Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan	<b>Global:</b> XXX	<b>Issue:</b> IMRT - PE Only	<b>Screen:</b> Services with Stand-Alone PE Procedure Time	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 28 <b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> October 2012	<b>2012 Est Medicare Utilization:</b> 113,647	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> PE Only	<b>2013 Work RVU:</b> 4.29 <b>2013 NF PE RVU:</b> 10.17 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> New PE Inputs		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		
<b>77371</b>	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based	<b>Global:</b> XXX	<b>Issue:</b> Radiation Treatment Delivery, Stereotactic Radiosurgery	<b>Screen:</b> CMS Request - Practice Expense Review	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2009	<b>Tab</b> 30 <b>Specialty Developing Recommendation:</b> ASTRO	<b>First Identified:</b> NA	<b>2012 Est Medicare Utilization:</b> 48	<b>2007 Work RVU:</b> 0.00 <b>2007 NF PE RVU:</b> 30.25 <b>2007 Fac PE RVU Result:</b> PE Only	<b>2013 Work RVU:</b> 0.00 <b>2013 NF PE RVU:</b> 0.00 <b>2013 Fac PE RVU:</b> 0.00
<b>RUC Recommendation:</b> New PE inputs		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

# Status Report: CMS Requests and Relativity Assessment Issues

**77372** Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based **Global:** XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

**Most Recent RUC Meeting:** April 2013

**Tab** 29

**Specialty Developing Recommendation:**

**First Identified:**

**2012 Est Medicare Utilization:** 854

**2007 Work RVU:** 0.00

**2013 Work RVU:** 0.00

**2007 NF PE RVU:** 22.93

**2013 NF PE RVU:** 23.02

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** PE Only

**RUC Recommendation:** New PE Inputs

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**77373** Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions **Global:** XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

**Most Recent RUC Meeting:** January 2013

**Tab** 27

**Specialty Developing Recommendation:** ACR, ASTRO, ACRO

**First Identified:** July 2012

**2012 Est Medicare Utilization:** 14,311

**2007 Work RVU:** 0.00

**2013 Work RVU:** 0.00

**2007 NF PE RVU:** 42.87

**2013 NF PE RVU:** 37.22

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** PE Only

**RUC Recommendation:** New PE inputs

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**77402** Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; up to 5 MeV **Global:** XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** No

**Most Recent RUC Meeting:** April 2013

**Tab** 29

**Specialty Developing Recommendation:**

**First Identified:** October 2012

**2012 Est Medicare Utilization:** 22,902

**2007 Work RVU:** 0.00

**2013 Work RVU:** 0.00

**2007 NF PE RVU:** 2.37

**2013 NF PE RVU:** 4.55

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:**

**RUC Recommendation:** Refer to CPT

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**77403** Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 6-10 MeV

**Global:** XXX

**Issue:** Radiation Treatment Delivery - PE Only

**Screen:** Services with Stand-Alone PE Procedure Time

**Complete?** No

**Most Recent RUC Meeting:** April 2013

**Tab** 29

**Specialty Developing Recommendation:**

**First Identified:**

**2012 Est Medicare Utilization:** 11,520

**2007 Work RVU:** 0.00

**2013 Work RVU:** 0.00

**2007 NF PE RVU:** 2.27

**2013 NF PE RVU:** 3.75

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** Refer to CPT

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:**

**77404** Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 11-19 MeV

**Global:** XXX

**Issue:** Radiation Treatment Delivery - PE Only

**Screen:** Services with Stand-Alone PE Procedure Time

**Complete?** No

**Most Recent RUC Meeting:** April 2013

**Tab** 29

**Specialty Developing Recommendation:**

**First Identified:**

**2012 Est Medicare Utilization:** 5,861

**2007 Work RVU:** 0.00

**2013 Work RVU:** 0.00

**2007 NF PE RVU:** 2.38

**2013 NF PE RVU:** 4.17

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** Refer to CPT

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:**

**77406** Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 20 MeV or greater

**Global:** XXX

**Issue:** Radiation Treatment Delivery - PE Only

**Screen:** Services with Stand-Alone PE Procedure Time

**Complete?** No

**Most Recent RUC Meeting:** April 2013

**Tab** 29

**Specialty Developing Recommendation:**

**First Identified:**

**2012 Est Medicare Utilization:** 935

**2007 Work RVU:** 0.00

**2013 Work RVU:** 0.00

**2007 NF PE RVU:** 2.38

**2013 NF PE RVU:** 4.17

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** Refer to CPT

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:**

## Status Report: CMS Requests and Relativity Assessment Issues

**77407** Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; up to 5 MeV      **Global:** XXX      **Issue:** Radiation Treatment Delivery - PE Only      **Screen:** Services with Stand-Alone PE Procedure Time      **Complete?** No

**Most Recent RUC Meeting:** April 2013

**Tab** 29

**Specialty Developing Recommendation:**

**First Identified:**

**2012 Est Medicare Utilization:** 4,948

**2007 Work RVU:** 0.00

**2013 Work RVU:** 0.00

**2007 NF PE RVU:** 2.93

**2013 NF PE RVU:** 6.63

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** Refer to CPT

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:**

**77408** Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 6-10 MeV      **Global:** XXX      **Issue:** Radiation Treatment Delivery - PE Only      **Screen:** Services with Stand-Alone PE Procedure Time      **Complete?** No

**Most Recent RUC Meeting:** April 2013

**Tab** 29

**Specialty Developing Recommendation:**

**First Identified:**

**2012 Est Medicare Utilization:** 3,795

**2007 Work RVU:** 0.00

**2013 Work RVU:** 0.00

**2007 NF PE RVU:** 2.87

**2013 NF PE RVU:** 5.17

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** Refer to CPT

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:**

**77409** Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 11-19 MeV      **Global:** XXX      **Issue:** Radiation Treatment Delivery - PE Only      **Screen:** Services with Stand-Alone PE Procedure Time      **Complete?** No

**Most Recent RUC Meeting:** April 2013

**Tab** 29

**Specialty Developing Recommendation:**

**First Identified:**

**2012 Est Medicare Utilization:** 1,613

**2007 Work RVU:** 0.00

**2013 Work RVU:** 0.00

**2007 NF PE RVU:** 3.02

**2013 NF PE RVU:** 5.76

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** Refer to CPT

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:**



## Status Report: CMS Requests and Relativity Assessment Issues

---

<b>77411</b>	<b>Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 20 MeV or greater</b>	<b>Global:</b> XXX	<b>Issue:</b> Radiation Treatment Delivery - PE Only	<b>Screen:</b> Services with Stand-Alone PE Procedure Time	<b>Complete?</b> No
--------------	--	--------------------	--	--	---------------------

**Most Recent RUC Meeting:** April 2013

**Tab** 29

**Specialty Developing Recommendation:**

**First Identified:**

**2012 Est Medicare Utilization:** 216

**2007 Work RVU:** 0.00

**2013 Work RVU:** 0.00

**2007 NF PE RVU:** 3.01

**2013 NF PE RVU:** 5.79

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** Refer to CPT

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:**

---

<b>77412</b>	<b>Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; up to 5 MeV</b>	<b>Global:</b> XXX	<b>Issue:</b> Radiation Treatment Delivery - PE Only	<b>Screen:</b> Services with Stand-Alone PE Procedure Time	<b>Complete?</b> No
--------------	---	--------------------	--	--	---------------------

**Most Recent RUC Meeting:** April 2013

**Tab** 29

**Specialty Developing Recommendation:**

**First Identified:**

**2012 Est Medicare Utilization:** 2,975

**2007 Work RVU:** 0.00

**2013 Work RVU:** 0.00

**2007 NF PE RVU:** 3.46

**2013 NF PE RVU:** 7.05

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** Refer to CPT

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:**

---

<b>77413</b>	<b>Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 6-10 MeV</b>	<b>Global:</b> XXX	<b>Issue:</b> Radiation Treatment Delivery - PE Only	<b>Screen:</b> Services with Stand-Alone PE Procedure Time	<b>Complete?</b> No
--------------	--	--------------------	--	--	---------------------

**Most Recent RUC Meeting:** April 2013

**Tab** 29

**Specialty Developing Recommendation:**

**First Identified:**

**2012 Est Medicare Utilization:** 557,172

**2007 Work RVU:** 0.00

**2013 Work RVU:** 0.00

**2007 NF PE RVU:** 3.46

**2013 NF PE RVU:** 6.79

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** Refer to CPT

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:**

## Status Report: CMS Requests and Relativity Assessment Issues

**77414** Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 11-19 MeV **Global:** XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** No

**Most Recent RUC Meeting:** April 2013

**Tab** 29

**Specialty Developing Recommendation:**

**First Identified:**

**2012 Est Medicare Utilization:** 415,199

**2007 Work RVU:** 0.00

**2013 Work RVU:** 0.00

**2007 NF PE RVU:** 3.68

**2013 NF PE RVU:** 7.64

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** Refer to CPT

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:**

**77416** Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 20 MeV or greater

**Global:** XXX

**Issue:** Radiation Treatment Delivery - PE Only

**Screen:** Services with Stand-Alone PE Procedure Time

**Complete?** No

**Most Recent RUC Meeting:** April 2013

**Tab** 29

**Specialty Developing Recommendation:**

**First Identified:**

**2012 Est Medicare Utilization:** 53,418

**2007 Work RVU:** 0.00

**2013 Work RVU:** 0.00

**2007 NF PE RVU:** 3.68

**2013 NF PE RVU:** 7.63

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** Refer to CPT

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:**

**77417** Therapeutic radiology port film(s)

**Global:** XXX

**Issue:** Radiation Treatment Delivery - PE Only

**Screen:** Services with Stand-Alone PE Procedure Time

**Complete?** No

**Most Recent RUC Meeting:** April 2013

**Tab** 29

**Specialty Developing Recommendation:**

**First Identified:**

**2012 Est Medicare Utilization:** 154,577

**2007 Work RVU:** 0.00

**2013 Work RVU:** 0.00

**2007 NF PE RVU:** 0.53

**2013 NF PE RVU:** 0.41

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** Refer to CPT

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:**

# Status Report: CMS Requests and Relativity Assessment Issues

<b>77418</b>	<b>Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session</b>	<b>Global:</b> XXX	<b>Issue:</b> Radiation Treatment Delivery - PE Only	<b>Screen:</b> CMS Fastest Growing / Services with Stand-Alone PE Procedure Time / Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2013	<b>Tab 27</b>	<b>Specialty Developing Recommendation:</b> ACR, ASTRO, ACRO	<b>First Identified:</b> October 2008	<b>2012 Est Medicare Utilization:</b> 1,387,077	<b>2007 Work RVU:</b> 0.00 <b>2007 NF PE RVU:</b> 16.8 <b>2007 Fac PE RVU</b> NA <b>Result:</b> PE Only <b>Published in CPT Asst:</b> Nov 2009 and Q&A
<b>RUC Recommendation:</b> New PE inputs			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input checked="" type="checkbox"/>		<b>2013 Work RVU:</b> 0.00 <b>2013 NF PE RVU:</b> 11.91 <b>2013 Fac PE RVU:</b> NA
<hr/>					
<b>77421</b>	<b>Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy</b>	<b>Global:</b> XXX	<b>Issue:</b> IMRT with Stereotopic X-ray Guidance	<b>Screen:</b> Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes / High Volume Growth2	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> January 2012	<b>Tab 30</b>	<b>Specialty Developing Recommendation:</b> ASTRO	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 1,339,238	<b>2007 Work RVU:</b> 0.39 <b>2007 NF PE RVU:</b> 3.11 <b>2007 Fac PE RVU</b> NA <b>Result:</b> PE Only
<b>RUC Recommendation:</b> Review action plan. January 2012=Refer to CPT. New PE inputs Feb 2010.			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 0.39 <b>2013 NF PE RVU:</b> 1.78 <b>2013 Fac PE RVU:</b> NA
<hr/>					
<b>77427</b>	<b>Radiation treatment management, 5 treatments</b>	<b>Global:</b> XXX	<b>Issue:</b> Radiation Treatment Management	<b>Screen:</b> Site of Service Anomaly	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2009	<b>Tab 27</b>	<b>Specialty Developing Recommendation:</b> ASTRO	<b>First Identified:</b> September 2007	<b>2012 Est Medicare Utilization:</b> 1,149,067	<b>2007 Work RVU:</b> 3.70 <b>2007 NF PE RVU:</b> 1.15 <b>2007 Fac PE RVU</b> 1.15 <b>Result:</b> Decrease
<b>RUC Recommendation:</b> 3.45			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 3.37 <b>2013 NF PE RVU:</b> 1.60 <b>2013 Fac PE RVU:</b> 1.60

## Status Report: CMS Requests and Relativity Assessment Issues

**77600** Hyperthermia, externally generated; superficial (ie, heating to a depth of 4 cm or less) **Global:** XXX **Issue:** Hyperthermia - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

**Most Recent RUC Meeting:** April 2013

**Tab** 30

**Specialty Developing Recommendation:**

**First Identified:** October 2012

**2012 Est Medicare Utilization:** 2,822

**2007 Work RVU:** 1.56

**2013 Work RVU:** 1.56

**2007 NF PE RVU:** 5.09

**2013 NF PE RVU:** 11.02

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** PE Only

**RUC Recommendation:** New PE Inputs

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**77778** Interstitial radiation source application; complex

**Global:** 090

**Issue:** Clinical Brachytherapy

**Screen:** Codes Reported Together 75% or More-Part2

**Complete?** No

**Most Recent RUC Meeting:** October 2012

**Tab**

**Specialty Developing Recommendation:** ASTRO

**First Identified:** October 2012

**2012 Est Medicare Utilization:** 7,587

**2007 Work RVU:** 11.23

**2013 Work RVU:** 11.32

**2007 NF PE RVU:** 9.38

**2013 NF PE RVU:** 13.09

**2007 Fac PE RVU** 9.38

**2013 Fac PE RVU:** NA

**Result:**

**RUC Recommendation:** Refer to CPT

**CPT Action (if applicable):**

CPT 2015 cycle

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**77781** Deleted from CPT

**Global:** XXX

**Issue:** Brachytherapy

**Screen:** CMS Fastest Growing

**Complete?** Yes

**Most Recent RUC Meeting:** October 2008

**Tab** 26

**Specialty Developing Recommendation:** ASTRO

**First Identified:** October 2008

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 1.21

**2013 Work RVU:**

**2007 NF PE RVU:** 16.73

**2013 NF PE RVU:**

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:**

**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):**

February 2008

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**77782 Deleted from CPT**

**Global:** XXX **Issue:** Brachytherapy

**Screen:** High Volume Growth1 /  
CMS Fastest Growing

**Complete?** Yes

**Most Recent  
RUC Meeting:** February 2008

**Tab** S

**Specialty Developing  
Recommendation:** ASTRO

**First  
Identified:** February 2008

**2012 Est  
Medicare  
Utilization:**

**2007 Work RVU:** 2.04

**2013 Work RVU:**

**2007 NF PE RVU:** 18.94

**2013 NF PE RVU:**

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** February 2008

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Deleted from CPT

**77784 Deleted from CPT**

**Global:** XXX **Issue:** Brachytherapy

**Screen:** CMS Fastest Growing

**Complete?** Yes

**Most Recent  
RUC Meeting:** February 2008

**Tab** S

**Specialty Developing  
Recommendation:** ASTRO

**First  
Identified:** February 2008

**2012 Est  
Medicare  
Utilization:**

**2007 Work RVU:** 5.15

**2013 Work RVU:**

**2007 NF PE RVU:** 28.04

**2013 NF PE RVU:**

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** February 2008

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Deleted from CPT

**77785 Remote afterloading high dose rate radionuclide brachytherapy; 1 channel**

**Global:** XXX **Issue:** High Dose Rate  
Brachytherapy-PE Only

**Screen:** High Volume Growth1 /  
CMS Fastest  
Growing/CMS Request -  
Practice Expense /  
Services with Stand-  
Alone PE Procedure  
Time

**Complete?** Yes

**Most Recent  
RUC Meeting:** April 2013

**Tab** 32

**Specialty Developing  
Recommendation:** ASTRO

**First  
Identified:**

**2012 Est  
Medicare  
Utilization:** 21,888

**2007 Work RVU:**

**2013 Work RVU:** 1.42

**2007 NF PE RVU:**

**2013 NF PE RVU:** 5.85

**2007 Fac PE RVU**

**2013 Fac PE RVU:** NA

**RUC Recommendation:** 1.42 and new PE inputs

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

## Status Report: CMS Requests and Relativity Assessment Issues

<b>77786</b>	<b>Remote afterloading high dose rate radionuclide brachytherapy; 2-12 channels</b>	<b>Global:</b> XXX	<b>Issue:</b> High Dose Rate Brachytherapy-PE Only	<b>Screen:</b> High Volume Growth1 / CMS Fastest Growing/CMS Request - Practice Expense / Services with Stand-Alone PE Procedure Time	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 32	<b>Specialty Developing Recommendation:</b> ASTRO	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 32,946	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease <b>2013 Work RVU:</b> 3.25 <b>2013 NF PE RVU:</b> 12.91 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 3.25 and new PE inputs			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>

<b>77787</b>	<b>Remote afterloading high dose rate radionuclide brachytherapy; over 12 channels</b>	<b>Global:</b> XXX	<b>Issue:</b> High Dose Rate Brachytherapy-PE Only	<b>Screen:</b> High Volume Growth1 / CMS Fastest Growing/CMS Request - Practice Expense / Services with Stand-Alone PE Procedure Time / Codes Reported Together 75% or More-Part2	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 32	<b>Specialty Developing Recommendation:</b> ASTRO	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 6,485	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease <b>2013 Work RVU:</b> 4.89 <b>2013 NF PE RVU:</b> 22.86 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Refer to CPT. New PE Inputs			<b>CPT Action (if applicable):</b> CPT 2015 cycle <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>

<b>77790</b>	<b>Supervision, handling, loading of radiation source</b>	<b>Global:</b> XXX	<b>Issue:</b> Clinical Brachytherapy	<b>Screen:</b> Codes Reported Together 75% or More-Part2	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b>	<b>Specialty Developing Recommendation:</b> ASTRO	<b>First Identified:</b> October 2012	<b>2012 Est Medicare Utilization:</b> 8,484	<b>2007 Work RVU:</b> 1.05 <b>2007 NF PE RVU:</b> 1 <b>2007 Fac PE RVU Result:</b> <b>2013 Work RVU:</b> 1.05 <b>2013 NF PE RVU:</b> 1.68 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Refer to CPT			<b>CPT Action (if applicable):</b> CPT 2015 cycle <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>

# Status Report: CMS Requests and Relativity Assessment Issues

## 78000 Thyroid uptake; single determination

Global: XXX

Issue: Thyroid Uptake/Imaging

Screen: Harvard Valued -  
Utilization over 30,000

Complete? Yes

Most Recent  
RUC Meeting: April 2012

Tab 22

Specialty Developing  
Recommendation:

ACR, ACNM,  
SNM

First  
Identified:

2012 Est  
Medicare  
Utilization: 931

2007 Work RVU: 0.19

2013 Work RVU:

2007 NF PE RVU: 1.21

2013 NF PE RVU:

2007 Fac PE RVU NA

2013 Fac PE RVU:

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

CPT Action (if applicable): February 2012

Referred to CPT Asst ☐

Published in CPT Asst:

## 78001 Thyroid uptake; multiple determinations

Global: XXX

Issue: Thyroid Uptake/Imaging

Screen: Harvard Valued -  
Utilization over 30,000

Complete? Yes

Most Recent  
RUC Meeting: April 2012

Tab 22

Specialty Developing  
Recommendation:

ACR, ACNM,  
SNM

First  
Identified:

2012 Est  
Medicare  
Utilization: 630

2007 Work RVU: 0.26

2013 Work RVU:

2007 NF PE RVU: 1.59

2013 NF PE RVU:

2007 Fac PE RVU NA

2013 Fac PE RVU:

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

CPT Action (if applicable): February 2012

Referred to CPT Asst ☐

Published in CPT Asst:

## 78003 Thyroid uptake; stimulation, suppression or discharge (not including initial uptake studies)

Global: XXX

Issue: Thyroid Uptake/Imaging

Screen: Harvard Valued -  
Utilization over 30,000

Complete? Yes

Most Recent  
RUC Meeting: April 2012

Tab 22

Specialty Developing  
Recommendation:

ACR, ACNM,  
SNM

First  
Identified:

2012 Est  
Medicare  
Utilization: 22

2007 Work RVU: 0.33

2013 Work RVU:

2007 NF PE RVU: 1.26

2013 NF PE RVU:

2007 Fac PE RVU NA

2013 Fac PE RVU:

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

CPT Action (if applicable): February 2012

Referred to CPT Asst ☐

Published in CPT Asst:

## 78006 Thyroid imaging, with uptake; single determination

Global: XXX

Issue: Thyroid Uptake/Imaging

Screen: Harvard Valued -  
Utilization over 30,000

Complete? Yes

Most Recent  
RUC Meeting: April 2012

Tab 22

Specialty Developing  
Recommendation:

ACR, ACNM,  
SNM

First  
Identified:

2012 Est  
Medicare  
Utilization: 16,272

2007 Work RVU: 0.49

2013 Work RVU:

2007 NF PE RVU: 3.38

2013 NF PE RVU:

2007 Fac PE RVU NA

2013 Fac PE RVU:

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

CPT Action (if applicable): February 2012

Referred to CPT Asst ☐

Published in CPT Asst:

# Status Report: CMS Requests and Relativity Assessment Issues

**78007** Thyroid imaging, with uptake; multiple determinations **Global:** XXX **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

**Most Recent RUC Meeting:** April 2012 **Tab** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** April 2011 **2012 Est Medicare Utilization:** 24,657 **2007 Work RVU:** 0.50 **2013 Work RVU:** **2007 NF PE RVU:** 2.76 **2013 NF PE RVU:** **2007 Fac PE RVU:** NA **2013 Fac PE RVU:** **RUC Recommendation:** Deleted from CPT **CPT Action (if applicable):** February 2012 **Result:** Deleted from CPT **Referred to CPT Asst** ☐ **Published in CPT Asst:**

**78010** Thyroid imaging; only **Global:** XXX **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

**Most Recent RUC Meeting:** April 2012 **Tab** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2012 Est Medicare Utilization:** 4,310 **2007 Work RVU:** 0.39 **2013 Work RVU:** **2007 NF PE RVU:** 2.45 **2013 NF PE RVU:** **2007 Fac PE RVU:** NA **2013 Fac PE RVU:** **RUC Recommendation:** Deleted from CPT **CPT Action (if applicable):** February 2012 **Result:** Deleted from CPT **Referred to CPT Asst** ☐ **Published in CPT Asst:**

**78011** Thyroid imaging; with vascular flow **Global:** XXX **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

**Most Recent RUC Meeting:** April 2012 **Tab** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2012 Est Medicare Utilization:** 83 **2007 Work RVU:** 0.45 **2013 Work RVU:** **2007 NF PE RVU:** 2.99 **2013 NF PE RVU:** **2007 Fac PE RVU:** NA **2013 Fac PE RVU:** **RUC Recommendation:** Deleted from CPT **CPT Action (if applicable):** February 2012 **Result:** Deleted from CPT **Referred to CPT Asst** ☐ **Published in CPT Asst:**

**78012** Thyroid uptake, single or multiple quantitative measurement(s) (including stimulation, suppression, or discharge, when performed) **Global:** XXX **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

**Most Recent RUC Meeting:** April 2012 **Tab** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2012 Est Medicare Utilization:** **2007 Work RVU:** **2013 Work RVU:** 0.19 **2007 NF PE RVU:** **2013 NF PE RVU:** 2.23 **2007 Fac PE RVU:** **2013 Fac PE RVU:** NA **RUC Recommendation:** 0.19 **CPT Action (if applicable):** February 2012 **Result:** Decrease **Referred to CPT Asst** ☐ **Published in CPT Asst:**



## Status Report: CMS Requests and Relativity Assessment Issues

---

<b>78013</b>	<b>Thyroid imaging (including vascular flow, when performed);</b>	<b>Global:</b> XXX	<b>Issue:</b> Thyroid Uptake/Imaging	<b>Screen:</b> Harvard Valued - Utilization over 30,000	<b>Complete?</b> Yes
--------------	---	--------------------	--------------------------------------	---	----------------------

**Most Recent RUC Meeting:** April 2012

**Tab** 22

**Specialty Developing Recommendation:**

ACR, ACNM, SNM

**First Identified:**

**2012 Est Medicare Utilization:**

**2007 Work RVU:**

**2013 Work RVU:** 0.37

**2007 NF PE RVU:**

**2013 NF PE RVU:** 5.76

**2007 Fac PE RVU**

**2013 Fac PE RVU:** NA

**RUC Recommendation:** 0.37

**CPT Action (if applicable):** February 2012

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

---

**78014** **Thyroid imaging (including vascular flow, when performed); with single or multiple uptake(s) quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)**

**Global:** XXX

**Issue:** Thyroid Uptake/Imaging

**Screen:** Harvard Valued - Utilization over 30,000

**Complete?** Yes

**Most Recent RUC Meeting:** April 2012

**Tab** 22

**Specialty Developing Recommendation:**

ACR, ACNM, SNM

**First Identified:**

**2012 Est Medicare Utilization:**

**2007 Work RVU:**

**2013 Work RVU:** 0.50

**2007 NF PE RVU:**

**2013 NF PE RVU:** 6.57

**2007 Fac PE RVU**

**2013 Fac PE RVU:** NA

**RUC Recommendation:** 0.50

**CPT Action (if applicable):** February 2012

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

---

**78070** **Parathyroid planar imaging (including subtraction, when performed);**

**Global:** XXX

**Issue:** Parathyroid Imaging

**Screen:** Harvard Valued - Utilization over 30,000

**Complete?** Yes

**Most Recent RUC Meeting:** April 2012

**Tab** 23

**Specialty Developing Recommendation:**

ACR, ACNM, SNM

**First Identified:** April 2011

**2012 Est Medicare Utilization:** 26,807

**2007 Work RVU:** 0.82

**2013 Work RVU:** 0.80

**2007 NF PE RVU:** 4.21

**2013 NF PE RVU:** 8.15

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** 0.80

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

## Status Report: CMS Requests and Relativity Assessment Issues

**78071** Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT) **Global:** XXX **Issue:** Parathyroid Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

**Most Recent RUC Meeting:** April 2012

**Tab** 23

**Specialty Developing Recommendation:**

ACR, ACNM, SNM

**First Identified:** April 2011

**2012 Est Medicare Utilization:**

**2007 Work RVU:**

**2013 Work RVU:** 1.20

**2007 NF PE RVU:**

**2013 NF PE RVU:** 9.34

**2007 Fac PE RVU**

**2013 Fac PE RVU:** NA

**Result:** Decrease

**RUC Recommendation:** 1.20

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**78072** Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization

**Global:** YYY

**Issue:** Parathyroid Imaging

**Screen:** Harvard Valued - Utilization over 30,000

**Complete?** Yes

**Most Recent RUC Meeting:** April 2012

**Tab** 23

**Specialty Developing Recommendation:**

ACR, ACNM, SNM

**First Identified:** April 2011

**2012 Est Medicare Utilization:**

**2007 Work RVU:**

**2013 Work RVU:** 0.00

**2007 NF PE RVU:**

**2013 NF PE RVU:** 0.00

**2007 Fac PE RVU**

**2013 Fac PE RVU:** NA

**Result:** Decrease

**RUC Recommendation:** 1.60

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**78223** Hepatobiliary ductal system imaging, including gallbladder, with or without pharmacologic intervention, with or without quantitative measurement of gallbladder function

**Global:** XXX

**Issue:** Hepatobiliary Ductal System Imaging

**Screen:** Harvard Valued - Utilization over 100,000

**Complete?** Yes

**Most Recent RUC Meeting:** February 2011

**Tab** 12

**Specialty Developing Recommendation:**

ACR, SNM

**First Identified:** October 2009

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 0.84

**2013 Work RVU:**

**2007 NF PE RVU:** 4.95

**2013 NF PE RVU:**

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:**

**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

# Status Report: CMS Requests and Relativity Assessment Issues

---

<b>78226</b>	<b>Hepatobiliary system imaging, including gallbladder when present;</b>	<b>Global:</b> XXX	<b>Issue:</b> Hepatobiliary System Imaging	<b>Screen:</b> Harvard Valued - Utilization over 100,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2011	<b>Tab</b> 12	<b>Specialty Developing Recommendation:</b> ACR, SNM, ACNM	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 55,072	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU</b> <b>Result:</b> Decrease
<b>RUC Recommendation:</b> 0.74			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 0.74 <b>2013 NF PE RVU:</b> 10.64 <b>2013 Fac PE RVU:</b> NA

---

<b>78227</b>	<b>Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed</b>	<b>Global:</b> XXX	<b>Issue:</b> Hepatobiliary System Imaging	<b>Screen:</b> Harvard Valued - Utilization over 100,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2011	<b>Tab</b> 12	<b>Specialty Developing Recommendation:</b> ACR, SNM, ACNM	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 120,737	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU</b> <b>Result:</b> Decrease
<b>RUC Recommendation:</b> 0.90			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 0.90 <b>2013 NF PE RVU:</b> 14.52 <b>2013 Fac PE RVU:</b> NA

---

<b>78278</b>	<b>Acute gastrointestinal blood loss imaging</b>	<b>Global:</b> XXX	<b>Issue:</b> Acute GI Blood Loss Imaging	<b>Screen:</b> Harvard Valued - Utilization over 30,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> September 2011	<b>Tab</b> 34	<b>Specialty Developing Recommendation:</b> ACR, SNM, ACNM	<b>First Identified:</b> April 2011	<b>2012 Est Medicare Utilization:</b> 36,891	<b>2007 Work RVU:</b> 0.99 <b>2007 NF PE RVU:</b> 5.92 <b>2007 Fac PE RVU</b> NA <b>Result:</b> Maintain
<b>RUC Recommendation:</b> 0.99			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 0.99 <b>2013 NF PE RVU:</b> 9.49 <b>2013 Fac PE RVU:</b> NA

---

## Status Report: CMS Requests and Relativity Assessment Issues

78451	Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)	Global: XXX	Issue: Myocardial Perfusion Imaging	Screen: Codes Reported Together 95% or More	Complete? Yes
Most Recent RUC Meeting: February 2009	Tab 16 Specialty Developing Recommendation: SNM, ACR, ASNC, ACC	First Identified: NA	2012 Est Medicare Utilization: 51,736	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Increase	2013 Work RVU: 1.38 2013 NF PE RVU: 9.13 2013 Fac PE RVU: NA
RUC Recommendation: 1.40	CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:		
78452	Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection	Global: XXX	Issue: Myocardial Perfusion Imaging	Screen: Codes Reported Together 95% or More	Complete? Yes
Most Recent RUC Meeting: February 2009	Tab 16 Specialty Developing Recommendation: SNM, ACR, ASNC, ACC	First Identified: NA	2012 Est Medicare Utilization: 2,307,970	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2013 Work RVU: 1.62 2013 NF PE RVU: 13.05 2013 Fac PE RVU: NA
RUC Recommendation: 1.75	CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:		
78453	Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)	Global: XXX	Issue: Myocardial Perfusion Imaging	Screen: Codes Reported Together 95% or More	Complete? Yes
Most Recent RUC Meeting: February 2009	Tab 16 Specialty Developing Recommendation: SNM, ACR, ASNC, ACC	First Identified: NA	2012 Est Medicare Utilization: 1,976	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2013 Work RVU: 1.00 2013 NF PE RVU: 8.12 2013 Fac PE RVU: NA
RUC Recommendation: 1.00	CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:		

## Status Report: CMS Requests and Relativity Assessment Issues

**78454** Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection **Global:** XXX **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

**Most Recent RUC Meeting:** February 2009 **Tab** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** NA **2012 Est Medicare Utilization:** 14,814 **2007 Work RVU:** **2013 Work RVU:** 1.34 **2007 NF PE RVU:** **2013 NF PE RVU:** 11.80 **2007 Fac PE RVU Result:** Decrease **2013 Fac PE RVU:** NA **RUC Recommendation:** 1.34 **CPT Action (if applicable):** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

**78460** Deleted from CPT **Global:** XXX **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

**Most Recent RUC Meeting:** February 2009 **Tab** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** **2012 Est Medicare Utilization:** **2007 Work RVU:** 0.86 **2013 Work RVU:** **2007 NF PE RVU:** 3.1 **2013 NF PE RVU:** **2007 Fac PE RVU** NA **2013 Fac PE RVU:** **RUC Recommendation:** Deleted from CPT **CPT Action (if applicable):** October 2008 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

**78461** Deleted from CPT **Global:** XXX **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

**Most Recent RUC Meeting:** February 2009 **Tab** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** **2012 Est Medicare Utilization:** **2007 Work RVU:** 1.23 **2013 Work RVU:** **2007 NF PE RVU:** 4.81 **2013 NF PE RVU:** **2007 Fac PE RVU** NA **2013 Fac PE RVU:** **RUC Recommendation:** Deleted from CPT **CPT Action (if applicable):** October 2008 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**78464 Deleted from CPT**

**Global:** XXX

**Issue:** Myocardial Perfusion Imaging

**Screen:** Codes Reported Together 95% or More

**Complete?** Yes

**Most Recent RUC Meeting:** February 2009

**Tab** 16

**Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC

**First Identified:**

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 1.09

**2013 Work RVU:**

**2007 NF PE RVU:** 7.03

**2013 NF PE RVU:**

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:**

**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2008

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**78465 Deleted from CPT**

**Global:** XXX

**Issue:** Myocardial Perfusion Imaging

**Screen:** Codes Reported Together 95% or More

**Complete?** Yes

**Most Recent RUC Meeting:** February 2009

**Tab** 16

**Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC

**First Identified:** February 2008

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 1.46

**2013 Work RVU:**

**2007 NF PE RVU:** 12.08

**2013 NF PE RVU:**

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:**

**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2008

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**78472 Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without additional quantitative processing**

**Global:** XXX

**Issue:** Cardiac Blood Pool Imaging

**Screen:** Harvard Valued - Utilization over 30,000

**Complete?** Yes

**Most Recent RUC Meeting:** September 2011

**Tab** 35

**Specialty Developing Recommendation:** ACC, ACR, SNM, ACNM

**First Identified:** April 2011

**2012 Est Medicare Utilization:** 37,531

**2007 Work RVU:** 0.98

**2013 Work RVU:** 0.98

**2007 NF PE RVU:** 5.87

**2013 NF PE RVU:** 5.96

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** 0.98

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

# Status Report: CMS Requests and Relativity Assessment Issues

**78478 Deleted from CPT**

**Global:** XXX

**Issue:** Myocardial Perfusion Imaging

**Screen:** Codes Reported Together 95% or More

**Complete?** Yes

**Most Recent RUC Meeting:** February 2009

**Tab** 16

**Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC

**First Identified:** February 2008

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 0.50

**2013 Work RVU:**

**2007 NF PE RVU:** 1.54

**2013 NF PE RVU:**

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2008

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Deleted from CPT

**78480 Deleted from CPT**

**Global:** XXX

**Issue:** Myocardial Perfusion Imaging

**Screen:** Codes Reported Together 95% or More

**Complete?** Yes

**Most Recent RUC Meeting:** February 2009

**Tab** 16

**Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC

**First Identified:** February 2008

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 0.30

**2013 Work RVU:**

**2007 NF PE RVU:** 1.51

**2013 NF PE RVU:**

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2008

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Deleted from CPT

**78579 Pulmonary ventilation imaging (eg, aerosol or gas)**

**Global:** XXX

**Issue:** Pulmonary Imaging

**Screen:** Harvard Valued - Utilization over 100,000

**Complete?** Yes

**Most Recent RUC Meeting:** February 2011

**Tab** 13

**Specialty Developing Recommendation:** ACR, SNM

**First Identified:**

**2012 Est Medicare Utilization:** 2,468

**2007 Work RVU:**

**2013 Work RVU:** 0.49

**2007 NF PE RVU:**

**2013 NF PE RVU:** 6.01

**2007 Fac PE RVU**

**2013 Fac PE RVU:** NA

**RUC Recommendation:** 0.49

**CPT Action (if applicable):** October 2010

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**78580 Pulmonary perfusion imaging (eg, particulate)**

**Global:** XXX

**Issue:** Pulmonary Imaging

**Screen:** Harvard Valued - Utilization over 100,000

**Complete?** Yes

**Most Recent RUC Meeting:** February 2011

**Tab** 13

**Specialty Developing Recommendation:** SNM, ACR

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 21,656

**2007 Work RVU:** 0.74

**2013 Work RVU:** 0.74

**2007 NF PE RVU:** 3.97

**2013 NF PE RVU:** 6.39

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** 0.74

**CPT Action (if applicable):** October 2010

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Maintain

# Status Report: CMS Requests and Relativity Assessment Issues

**78582 Pulmonary ventilation (eg, aerosol or gas) and perfusion imaging** **Global:** XXX **Issue:** Pulmonary Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** February 2011 **Tab** 13 **Specialty Developing Recommendation:** ACR, SNM **First Identified:** **2012 Est Medicare Utilization:** 244,363 **2007 Work RVU:** **2013 Work RVU:** 1.07 **2007 NF PE RVU:** **2013 NF PE RVU:** 10.37 **2007 Fac PE RVU** **2013 Fac PE RVU:** NA **Result:** Decrease

**RUC Recommendation:** 1.07 **CPT Action (if applicable):** October 2010 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

**78584 Pulmonary perfusion imaging, particulate, with ventilation; single breath** **Global:** XXX **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** February 2010 **Tab** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2012 Est Medicare Utilization:** **2007 Work RVU:** 0.99 **2013 Work RVU:** **2007 NF PE RVU:** 3.34 **2013 NF PE RVU:** **2007 Fac PE RVU** NA **2013 Fac PE RVU:** **Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT **CPT Action (if applicable):** October 2010 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

**78585 Pulmonary perfusion imaging, particulate, with ventilation; rebreathing and washout, with or without single breath** **Global:** XXX **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** February 2010 **Tab** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** October 2009 **2012 Est Medicare Utilization:** **2007 Work RVU:** 1.09 **2013 Work RVU:** **2007 NF PE RVU:** 6.53 **2013 NF PE RVU:** **2007 Fac PE RVU** NA **2013 Fac PE RVU:** **Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT **CPT Action (if applicable):** October 2010 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

**78586 Pulmonary ventilation imaging, aerosol; single projection** **Global:** XXX **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** February 2010 **Tab** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2012 Est Medicare Utilization:** **2007 Work RVU:** 0.40 **2013 Work RVU:** **2007 NF PE RVU:** 3.02 **2013 NF PE RVU:** **2007 Fac PE RVU** NA **2013 Fac PE RVU:** **Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT **CPT Action (if applicable):** October 2010 **Referred to CPT Asst** ☐ **Published in CPT Asst:**



# Status Report: CMS Requests and Relativity Assessment Issues

**78587 Deleted from CPT** **Global:** XXX **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** February 2010 **Tab** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2012 Est Medicare Utilization:** **2007 Work RVU:** 0.49 **2013 Work RVU:** **2007 NF PE RVU:** 3.51 **2013 NF PE RVU:** **2007 Fac PE RVU:** NA **2013 Fac PE RVU:** **Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT **CPT Action (if applicable):** October 2010 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

**78588 Deleted from CPT** **Global:** XXX **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** February 2010 **Tab** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2012 Est Medicare Utilization:** **2007 Work RVU:** 1.09 **2013 Work RVU:** **2007 NF PE RVU:** 4.7 **2013 NF PE RVU:** **2007 Fac PE RVU:** NA **2013 Fac PE RVU:** **Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT **CPT Action (if applicable):** October 2010 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

**78591 Deleted from CPT** **Global:** XXX **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** February 2010 **Tab** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2012 Est Medicare Utilization:** **2007 Work RVU:** 0.40 **2013 Work RVU:** **2007 NF PE RVU:** 3.21 **2013 NF PE RVU:** **2007 Fac PE RVU:** NA **2013 Fac PE RVU:** **Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT **CPT Action (if applicable):** October 2010 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

**78593 Deleted from CPT** **Global:** XXX **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** February 2010 **Tab** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2012 Est Medicare Utilization:** **2007 Work RVU:** 0.49 **2013 Work RVU:** **2007 NF PE RVU:** 3.84 **2013 NF PE RVU:** **2007 Fac PE RVU:** NA **2013 Fac PE RVU:** **Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT **CPT Action (if applicable):** October 2010 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

# Status Report: CMS Requests and Relativity Assessment Issues

**78594 Deleted from CPT** **Global:** XXX **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** February 2010 **Tab** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2012 Est Medicare Utilization:** **2007 Work RVU:** 0.53 **2013 Work RVU:** **2007 NF PE RVU:** 5.12 **2013 NF PE RVU:** **2007 Fac PE RVU:** NA **2013 Fac PE RVU:** **Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT **CPT Action (if applicable):** October 2010 **Published in CPT Asst:** ☐

**78596 Deleted from CPT** **Global:** XXX **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** February 2010 **Tab** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2012 Est Medicare Utilization:** **2007 Work RVU:** 1.27 **2013 Work RVU:** **2007 NF PE RVU:** 7.7 **2013 NF PE RVU:** **2007 Fac PE RVU:** NA **2013 Fac PE RVU:** **Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT **CPT Action (if applicable):** October 2010 **Published in CPT Asst:** ☐

**78597 Quantitative differential pulmonary perfusion, including imaging when performed** **Global:** XXX **Issue:** Pulmonary Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** February 2011 **Tab** 13 **Specialty Developing Recommendation:** ACR, SNM **First Identified:** **2012 Est Medicare Utilization:** 2,037 **2007 Work RVU:** **2013 Work RVU:** 0.75 **2007 NF PE RVU:** **2013 NF PE RVU:** 6.38 **2007 Fac PE RVU:** **2013 Fac PE RVU:** NA **Result:** Decrease

**RUC Recommendation:** 0.75 **CPT Action (if applicable):** October 2010 **Published in CPT Asst:** ☐

**78598 Quantitative differential pulmonary perfusion and ventilation (eg, aerosol or gas), including imaging when performed** **Global:** XXX **Issue:** Pulmonary Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** February 2011 **Tab** 13 **Specialty Developing Recommendation:** ACR, SNM **First Identified:** **2012 Est Medicare Utilization:** 6,111 **2007 Work RVU:** **2013 Work RVU:** 0.85 **2007 NF PE RVU:** **2013 NF PE RVU:** 9.79 **2007 Fac PE RVU:** **2013 Fac PE RVU:** NA **Result:** Decrease

**RUC Recommendation:** 0.85 **CPT Action (if applicable):** October 2010 **Published in CPT Asst:** ☐

## Status Report: CMS Requests and Relativity Assessment Issues

---

<b>78815</b>	<b>Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh</b>	<b>Global:</b> XXX	<b>Issue:</b>	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
--------------	---	--------------------	---------------	-------------------------	----------------------

<b>Most Recent RUC Meeting:</b> February 2011	<b>Tab</b> 41	<b>Specialty Developing Recommendation:</b> ACR, SNM	<b>First Identified:</b> October 2010	<b>2012 Est Medicare Utilization:</b> 534,881	<b>2007 Work RVU:</b> 0.00	<b>2013 Work RVU:</b> 0.00
---	---------------	--	---------------------------------------	---	----------------------------	----------------------------

<b>2007 NF PE RVU:</b> 0	<b>2013 NF PE RVU:</b> 0.00
--------------------------	-----------------------------

<b>2007 Fac PE RVU</b> 0	<b>2013 Fac PE RVU:</b> NA
--------------------------	----------------------------

**RUC Recommendation:** Reaffirmed RUC recommendation

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Maintain

---

<b>79101</b>	<b>Radiopharmaceutical therapy, by intravenous administration</b>	<b>Global:</b> XXX	<b>Issue:</b> Radiopharmaceutical Therapy	<b>Screen:</b> Different Performing Specialty from Survey	<b>Complete?</b> Yes
--------------	---	--------------------	---	---	----------------------

<b>Most Recent RUC Meeting:</b> February 2010	<b>Tab</b> 31	<b>Specialty Developing Recommendation:</b> SNM, ACR	<b>First Identified:</b> October 2009	<b>2012 Est Medicare Utilization:</b> 664	<b>2007 Work RVU:</b> 1.96	<b>2013 Work RVU:</b> 1.96
---	---------------	--	---------------------------------------	---	----------------------------	----------------------------

<b>2007 NF PE RVU:</b> 2.98	<b>2013 NF PE RVU:</b> 2.16
-----------------------------	-----------------------------

<b>2007 Fac PE RVU</b> NA	<b>2013 Fac PE RVU:</b> NA
---------------------------	----------------------------

**RUC Recommendation:** Article published Feb 2012

**CPT Action (if applicable):**

**Referred to CPT Asst** ☒

**Published in CPT Asst:** Feb 2012

**Result:** Maintain

---

<b>88104</b>	<b>Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation</b>	<b>Global:</b> XXX	<b>Issue:</b> Cytopathology	<b>Screen:</b> Harvard Valued - Utilization over 100,000	<b>Complete?</b> Yes
--------------	---	--------------------	-----------------------------	--	----------------------

<b>Most Recent RUC Meeting:</b> October 2010	<b>Tab</b> 17	<b>Specialty Developing Recommendation:</b> AUR, ASC, CAP	<b>First Identified:</b> October 2009	<b>2012 Est Medicare Utilization:</b> 104,085	<b>2007 Work RVU:</b> 0.56	<b>2013 Work RVU:</b> 0.56
--	---------------	---	---------------------------------------	---	----------------------------	----------------------------

<b>2007 NF PE RVU:</b> 0.93	<b>2013 NF PE RVU:</b> 1.66
-----------------------------	-----------------------------

<b>2007 Fac PE RVU</b> NA	<b>2013 Fac PE RVU:</b> NA
---------------------------	----------------------------

**RUC Recommendation:** 0.56

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Maintain

# Status Report: CMS Requests and Relativity Assessment Issues

**88106** Cytopathology, fluids, washings or brushings, except cervical or vaginal; simple filter method with interpretation **Global:** XXX **Issue:** Cytopathology **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** October 2010

**Tab 17 Specialty Developing Recommendation:** AUR, ASC, CAP

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 7,479

**2007 Work RVU:** 0.56

**2013 Work RVU:** 0.37

**2007 NF PE RVU:** 1.39

**2013 NF PE RVU:** 2.12

**2007 Fac PE RVU:** NA

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** 0.56

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**88107** Deleted from CPT

**Global:** XXX **Issue:** Cytopathology

**Screen:** Harvard Valued - Utilization over 100,000

**Complete?** Yes

**Most Recent RUC Meeting:** October 2010

**Tab 17 Specialty Developing Recommendation:** AUR, ASC, CAP

**First Identified:** February 2010

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 0.76

**2013 Work RVU:**

**2007 NF PE RVU:** 1.66

**2013 NF PE RVU:**

**2007 Fac PE RVU:** NA

**2013 Fac PE RVU:**

**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):**

October 2010

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**88108** Cytopathology, concentration technique, smears and interpretation (eg, Saccomanno technique)

**Global:** XXX **Issue:** Cytopathology

**Screen:** Harvard Valued - Utilization over 100,000

**Complete?** Yes

**Most Recent RUC Meeting:** October 2010

**Tab 17 Specialty Developing Recommendation:** AUR, ASC, CAP

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 284,934

**2007 Work RVU:** 0.56

**2013 Work RVU:** 0.44

**2007 NF PE RVU:** 1.27

**2013 NF PE RVU:** 1.86

**2007 Fac PE RVU:** NA

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** 0.56

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**88112** Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal

**Global:** XXX **Issue:** Cytopathology

**Screen:** CMS High Expenditure Procedural Codes

**Complete?** Yes

**Most Recent RUC Meeting:** April 2013

**Tab 33 Specialty Developing Recommendation:** CAP

**First Identified:** September 2011

**2012 Est Medicare Utilization:** 1,065,905

**2007 Work RVU:** 1.18

**2013 Work RVU:** 1.18

**2007 NF PE RVU:** 1.85

**2013 NF PE RVU:** 1.99

**2007 Fac PE RVU:** NA

**2013 Fac PE RVU:** NA

**Result:** Decrease

**RUC Recommendation:** 0.56

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

88120	Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual			Global: XXX	Issue: RAW review	Screen: CMS Request Final Rule for 2013	Complete?	No	
Most Recent RUC Meeting:	January 2013	Tab 34	Specialty Developing Recommendation:	First Identified:	November 2012	2012 Est Medicare Utilization:	76,734	2007 Work RVU:	2013 Work RVU: 1.20
								2007 NF PE RVU:	2013 NF PE RVU: 16.99
								2007 Fac PE RVU Result:	2013 Fac PE RVU: NA
RUC Recommendation:	Review utilization to confirm appropriate shift from 88365, 88367 and 88368 are now in 88120 and 88121.			CPT Action (if applicable):					
				Referred to CPT Asst		<input type="checkbox"/>	Published in CPT Asst:		
88121	Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology			Global: XXX	Issue: RAW review	Screen: CMS Request Final Rule for 2013	Complete?	No	
Most Recent RUC Meeting:	January 2013	Tab 34	Specialty Developing Recommendation:	First Identified:	November 2012	2012 Est Medicare Utilization:	60,652	2007 Work RVU:	2013 Work RVU: 1.00
								2007 NF PE RVU:	2013 NF PE RVU: 15.36
								2007 Fac PE RVU Result:	2013 Fac PE RVU: NA
RUC Recommendation:	Review utilization to confirm appropriate shift from 88365, 88367 and 88368 are now in 88120 and 88121.			CPT Action (if applicable):					
				Referred to CPT Asst		<input type="checkbox"/>	Published in CPT Asst:		
88300	Level I - Surgical pathology, gross examination only			Global: XXX	Issue: Pathology Consultations	Screen: Top 9 Harvard / Low Value-Billed in Multiple Units / CMS Request NPRM for 2012	Complete?	Yes	
Most Recent RUC Meeting:	January 2012	Tab 24	Specialty Developing Recommendation:	AAD, AGA, CAP, ASGE	First Identified:	February 2009	2012 Est Medicare Utilization:	218,603	2007 Work RVU: 0.08
									2013 Work RVU: 0.08
								2007 NF PE RVU:	2013 NF PE RVU: 0.33
								2007 Fac PE RVU Result:	2013 Fac PE RVU: NA
RUC Recommendation:	0.08 and new PE inputs			CPT Action (if applicable):					
				Referred to CPT Asst		<input type="checkbox"/>	Published in CPT Asst:		

## Status Report: CMS Requests and Relativity Assessment Issues

**88302** Level II - Surgical pathology, gross and microscopic examination Appendix, incidental Fallopian tube, sterilization Fingers/toes, amputation, traumatic Foreskin, newborn Hernia sac, any location Hydrocele sac Nerve Skin, plastic repair Sympathetic ganglion Testis, castration Vaginal mucosa, incidental Vas deferens, sterilization

**Global:** XXX **Issue:** Pathology Consultations

**Screen:** Top 9 Harvard / CMS Request NPRM for 2012

**Complete?** Yes

**Most Recent RUC Meeting:** January 2012

**Tab** 24

**Specialty Developing Recommendation:** AAD, AGA, CAP, ASGE

**First Identified:** February 2009

**2012 Est Medicare Utilization:** 103,017

**2007 Work RVU:** 0.13

**2013 Work RVU:** 0.13

**2007 NF PE RVU:** 1.1

**2013 NF PE RVU:** 0.76

**2007 Fac PE RVU:** NA

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** 0.13 and new PE inputs

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**88304** Level III - Surgical pathology, gross and microscopic examination Abortion, induced Abscess Aneurysm - arterial/ventricular Anus, tag Appendix, other than incidental Artery, atheromatous plaque Bartholin's gland cyst Bone fragment(s), other than pathologic fracture Bursa/synovial cyst Carpal tunnel tissue Cartilage, shavings Cholesteatoma Colon, colostomy stoma Conjunctiva - biopsy/pterygium Cornea Diverticulum - esophagus/small intestine Dupuytren's contracture tissue Femoral head, other than fracture Fissure/fistula Foreskin, other than newborn Gallbladder Ganglion cyst Hematoma Hemorrhoids Hydatid of Morgagni Intervertebral disc Joint, loose body Meniscus Mucocele, salivary Neuroma - Morton's/traumatic Pilonidal cyst/sinus Polyps, inflammatory - nasal/sinusoidal Skin - cyst/tag/debridement Soft tissue, debridement Soft tissue, lipoma Spermatocoele Tendon/tendon sheath Testicular appendage Thrombus or embolus Tonsil and/or adenoids Varicocele Vas deferens, other than sterilization Vein, varicosity

**Global:** XXX **Issue:** Pathology Consultations

**Screen:** Top 9 Harvard / Low Value-High Volume / CMS Request NPRM for 2012

**Complete?** Yes

**Most Recent RUC Meeting:** January 2012

**Tab** 24

**Specialty Developing Recommendation:** AAD, AGA, CAP, ASGE

**First Identified:** October 2008

**2012 Est Medicare Utilization:** 1,103,235

**2007 Work RVU:** 0.22

**2013 Work RVU:** 0.22

**2007 NF PE RVU:** 1.37

**2013 NF PE RVU:** 1.07

**2007 Fac PE RVU:** NA

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** 0.22 and new PE inputs

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

88305	<b>Level IV - Surgical pathology, gross and microscopic examination</b> Abortion - spontaneous/missed Artery, biopsy Bone marrow, biopsy Bone exostosis Brain/meninges, other than for tumor resection Breast, biopsy, not requiring microscopic evaluation of surgical margins Breast, reduction mammoplasty Bronchus, biopsy Cell block, any source Cervix, biopsy Colon, biopsy Duodenum, biopsy Endocervix, curettings/biopsy Endometrium, curettings/biopsy Esophagus, biopsy Extremity, amputation, traumatic Fallopian tube, biopsy Fallopian tube, ectopic pregnancy Femoral head, fracture Fingers/toes, amputation, non-traumatic Gingiva/oral mucosa, biopsy Heart valve Joint, resection Kidney, biopsy Larynx, biopsy Leiomyoma(s), uterine myomectomy - without uterus Lip, biopsy/wedge resection Lung, transbronchial biopsy Lymph node, biopsy Muscle, biopsy Nasal mucosa, biopsy Nasopharynx/oropharynx, biopsy Nerve, biopsy Odontogenic/dental cyst Omentum, biopsy Ovary with or without tube, non-neoplastic Ovary, biopsy/wedge resection Parathyroid gland Peritoneum, biopsy Pituitary tumor Placenta, other than third trimester Pleura/pericardium - biopsy/tissue Polyp, cervical/endometrial Polyp, colorectal Polyp, stomach/small intestine Prostate, needle biopsy Prostate, TUR Salivary gland, biopsy Sinus, paranasal biopsy Skin, other than cyst/tag/debridement/plastic repair Small intestine, biopsy Soft tissue, other than tumor/mass/lipoma/debridement Spleen Stomach, biopsy Synovium Testis, other than tumor/biopsy/castration Thyroglossal duct/brachial cleft cyst Tongue, biopsy Tonsil, biopsy Trachea, biopsy Ureter, biopsy Urethra, biopsy Urinary bladder, biopsy Uterus, with or without tubes and ovaries, for prolapse Vagina, biopsy Vulva/labia, biopsy			<b>Global:</b> XXX	<b>Issue:</b> Pathology Consultations	<b>Screen:</b> Top 9 Harvard / CMS Request NPRM for 2012	<b>Complete?</b> Yes
<b>Most Recent</b>	<b>Tab</b> 24	<b>Specialty Developing</b>	AAD, AGA,	<b>First</b>	<b>2012 Est</b>	<b>2007 Work RVU:</b>	<b>2013 Work RVU:</b>
<b>RUC Meeting:</b>	January 2012	<b>Recommendation:</b>	CAP, ASGE	<b>Identified:</b> October 2008	<b>Medicare</b>	<b>2007 NF PE RVU:</b>	<b>2013 NF PE RVU:</b>
					<b>Utilization:</b> 17,049,080	<b>2007 Fac PE RVU</b> NA	<b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 0.75 and new PE inputs				<b>CPT Action (if applicable):</b>		<b>Result:</b> Maintain	
				<b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	

## Status Report: CMS Requests and Relativity Assessment Issues

**88307** Level V - Surgical pathology, gross and microscopic examination Adrenal, resection Bone - biopsy/curettings Bone fragment(s), pathologic fracture Brain, biopsy Brain/meninges, tumor resection Breast, excision of lesion, requiring microscopic evaluation of surgical margins Breast, mastectomy - partial/simple Cervix, conization Colon, segmental resection, other than for tumor Extremity, amputation, non-traumatic Eye, enucleation Kidney, partial/total nephrectomy Larynx, partial/total resection Liver, biopsy - needle/wedge Liver, partial resection Lung, wedge biopsy Lymph nodes, regional resection Mediastinum, mass Myocardium, biopsy Odontogenic tumor Ovary with or without tube, neoplastic Pancreas, biopsy Placenta, third trimester Prostate, except radical resection Salivary gland Sentinel lymph node Small intestine, resection, other than for tumor Soft tissue mass (except lipoma) - biopsy/simple excision Stomach - subtotal/total resection, other than for tumor Testis, biopsy Thymus, tumor Thyroid, total/lobe Ureter, resection Urinary bladder, TUR Uterus, with or without tubes and ovaries, other than neoplastic/prolapse

**Global:** XXX **Issue:** Pathology Consultations

**Screen:** Top 9 Harvard / CMS  
Request NPRM for 2012

**Complete?** Yes

**Most Recent**  
**RUC Meeting:** January 2012

**Tab** 24

**Specialty Developing**  
**Recommendation:** AAD, AGA,  
CAP, ASGE

**First**  
**Identified:** February 2009

**2012 Est**  
**Medicare**  
**Utilization:** 893,694

**2007 Work RVU:** 1.59

**2013 Work RVU:** 1.59

**2007 NF PE RVU:** 3.48

**2013 NF PE RVU:** 7.10

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** 1.59 and new PE inputs

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**88309** Level VI - Surgical pathology, gross and microscopic examination Bone resection Breast, mastectomy - with regional lymph nodes Colon, segmental resection for tumor Colon, total resection Esophagus, partial/total resection Extremity, disarticulation Fetus, with dissection Larynx, partial/total resection - with regional lymph nodes Lung - total/lobe/segment resection Pancreas, total/subtotal resection Prostate, radical resection Small intestine, resection for tumor Soft tissue tumor, extensive resection Stomach - subtotal/total resection for tumor Testis, tumor Tongue/tonsil -resection for tumor Urinary bladder, partial/total resection Uterus, with or without tubes and ovaries, neoplastic Vulva, total/subtotal resection

**Global:** XXX **Issue:** Pathology Services

**Screen:** Top 9 Harvard / CMS  
Request NPRM for 2012

**Complete?** Yes

**Most Recent**  
**RUC Meeting:** January 2012

**Tab** 24

**Specialty Developing**  
**Recommendation:** AAD, AGA,  
CAP, ASGE

**First**  
**Identified:** February 2009

**2012 Est**  
**Medicare**  
**Utilization:** 158,685

**2007 Work RVU:** 2.80

**2013 Work RVU:** 2.80

**2007 NF PE RVU:** 4.86

**2013 NF PE RVU:** 10.30

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** 2.80 and new PE inputs

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**



## Status Report: CMS Requests and Relativity Assessment Issues

**88312** Special stain including interpretation and report; Group I for microorganisms (eg, acid fast, methenamine silver) **Global:** XXX **Issue:** Special Stains **Screen:** Top 9 Harvard / CMS High Expenditure Procedural Codes **Complete?** Yes

**Most Recent RUC Meeting:** January 2012

**Tab** 33 **Specialty Developing Recommendation:** CAP

**First Identified:** October 2008

**2012 Est Medicare Utilization:** 1,434,726

**2007 Work RVU:** 0.54

**2013 Work RVU:** 0.54

**2007 NF PE RVU:** 1.76

**2013 NF PE RVU:** 2.31

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** 0.54

**CPT Action (if applicable):** June 2010  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**88313** Special stain including interpretation and report; Group II, all other (eg, iron, trichrome), except stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry

**Global:** XXX **Issue:** Special Stains

**Screen:** Top 9 Harvard / Low Value-High Volume

**Complete?** Yes

**Most Recent RUC Meeting:** February 2011

**Tab** 33 **Specialty Developing Recommendation:** CAP

**First Identified:** October 2008

**2012 Est Medicare Utilization:** 1,483,056

**2007 Work RVU:** 0.24

**2013 Work RVU:** 0.24

**2007 NF PE RVU:** 1.42

**2013 NF PE RVU:** 1.73

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** 0.24

**CPT Action (if applicable):** June 2010  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**88314** Special stain including interpretation and report; histochemical stain on frozen tissue block (List separately in addition to code for primary procedure)

**Global:** XXX **Issue:** Special Stains

**Screen:** Top 9 Harvard

**Complete?** Yes

**Most Recent RUC Meeting:** February 2011

**Tab** 33 **Specialty Developing Recommendation:** CAP

**First Identified:** February 2009

**2012 Est Medicare Utilization:** 18,596

**2007 Work RVU:** 0.45

**2013 Work RVU:** 0.45

**2007 NF PE RVU:** 2.04

**2013 NF PE RVU:** 1.91

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** 0.45

**CPT Action (if applicable):** June 2010  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

# Status Report: CMS Requests and Relativity Assessment Issues

<b>88318</b>	Deleted from CPT			<b>Global:</b> XXX	<b>Issue:</b> Special Stains	<b>Screen:</b> Top 9 Harvard	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b>	February 2010	<b>Tab</b> 22	<b>Specialty Developing Recommendation:</b>	CAP, AAD	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b>	
<b>RUC Recommendation:</b>	Deleted from CPT				<b>CPT Action (if applicable):</b>	June 2010	
				<b>Referred to CPT Asst</b>	<input type="checkbox"/>	<b>Published in CPT Asst:</b>	
						<b>2007 Work RVU:</b> 0.42	<b>2013 Work RVU:</b>
						<b>2007 NF PE RVU:</b> 1.98	<b>2013 NF PE RVU:</b>
						<b>2007 Fac PE RVU</b> NA	<b>2013 Fac PE RVU:</b>
						<b>Result:</b> Deleted from CPT	

<b>88319</b>	Special stain including interpretation and report; Group III, for enzyme constituents			<b>Global:</b> XXX	<b>Issue:</b> Special Stains	<b>Screen:</b> Top 9 Harvard	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b>	February 2011	<b>Tab</b> 33	<b>Specialty Developing Recommendation:</b>	CAP	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b>	
<b>RUC Recommendation:</b>	0.53				<b>CPT Action (if applicable):</b>	June 2010	
				<b>Referred to CPT Asst</b>	<input type="checkbox"/>	<b>Published in CPT Asst:</b>	
						<b>2007 Work RVU:</b> 0.53	<b>2013 Work RVU:</b> 0.53
						<b>2007 NF PE RVU:</b> 3.36	<b>2013 NF PE RVU:</b> 2.00
						<b>2007 Fac PE RVU</b> NA	<b>2013 Fac PE RVU:</b> NA
						<b>Result:</b> Maintain	

<b>88329</b>	Pathology consultation during surgery;			<b>Global:</b> XXX	<b>Issue:</b> Pathology Consultation During Surgery	<b>Screen:</b> Harvard Valued - Utilization over 100,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b>	October 2010	<b>Tab</b> 18	<b>Specialty Developing Recommendation:</b>	CAP	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b>	
<b>RUC Recommendation:</b>	0.67				<b>CPT Action (if applicable):</b>		
				<b>Referred to CPT Asst</b>	<input type="checkbox"/>	<b>Published in CPT Asst:</b>	
						<b>2007 Work RVU:</b> 0.67	<b>2013 Work RVU:</b> 0.67
						<b>2007 NF PE RVU:</b> 0.66	<b>2013 NF PE RVU:</b> 0.98
						<b>2007 Fac PE RVU</b> 0.27	<b>2013 Fac PE RVU:</b> 0.34
						<b>Result:</b> Maintain	

<b>88331</b>	Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen			<b>Global:</b> XXX	<b>Issue:</b> Pathology Consultation During Surgery	<b>Screen:</b> Harvard Valued - Utilization over 100,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b>	October 2010	<b>Tab</b> 18	<b>Specialty Developing Recommendation:</b>	CAP	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b>	
<b>RUC Recommendation:</b>	1.19				<b>CPT Action (if applicable):</b>		
				<b>Referred to CPT Asst</b>	<input type="checkbox"/>	<b>Published in CPT Asst:</b>	
						<b>2007 Work RVU:</b> 1.19	<b>2013 Work RVU:</b> 1.19
						<b>2007 NF PE RVU:</b> 1.14	<b>2013 NF PE RVU:</b> 1.72
						<b>2007 Fac PE RVU</b> NA	<b>2013 Fac PE RVU:</b> NA
						<b>Result:</b> Maintain	

## Status Report: CMS Requests and Relativity Assessment Issues

**88332** Pathology consultation during surgery; each additional tissue block with frozen section(s) (List separately in addition to code for primary procedure) **Global:** XXX **Issue:** Pathology Consultation During Surgery **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** October 2010

**Tab 18** **Specialty Developing Recommendation:** CAP

**First Identified:** October 2009

**2012 Est Medicare Utilization:** 189,604

**2007 Work RVU:** 0.59

**2013 Work RVU:** 0.59

**2007 NF PE RVU:** 0.46

**2013 NF PE RVU:** 0.67

**2007 Fac PE RVU:** NA

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** 0.59

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**88342** Immunohistochemistry (including tissue immunoperoxidase), each antibody **Global:** XXX **Issue:** Immunohistochemistry **Screen:** CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes **Complete?** Yes

**Most Recent RUC Meeting:** October 2012

**Tab 12** **Specialty Developing Recommendation:** CAP

**First Identified:** April 2011

**2012 Est Medicare Utilization:** 3,996,571

**2007 Work RVU:** 0.85

**2013 Work RVU:** 0.85

**2007 NF PE RVU:** 1.6

**2013 NF PE RVU:** 2.50

**2007 Fac PE RVU:** NA

**2013 Fac PE RVU:** NA

**Result:** Decrease

**RUC Recommendation:** 0.60

**CPT Action (if applicable):** May 2012

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**88346** Immunofluorescent study, each antibody; direct method **Global:** XXX **Issue:** RAW **Screen:** CMS-Other - Utilization over 250,000 **Complete?** No

**Most Recent RUC Meeting:**

**Tab** **Specialty Developing Recommendation:**

**First Identified:** April 2013

**2012 Est Medicare Utilization:** 265,191

**2007 Work RVU:** 0.86

**2013 Work RVU:** 0.86

**2007 NF PE RVU:** 1.67

**2013 NF PE RVU:** 2.33

**2007 Fac PE RVU:** NA

**2013 Fac PE RVU:** NA

**Result:**

**RUC Recommendation:** Review Action Plan

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**88348** Electron microscopy; diagnostic

**Global:** XXX **Issue:** RAW

**Screen:** Services with Stand-Alone PE Procedure Time

**Complete?** No

**Most Recent RUC Meeting:** October 2012 **Tab** 27 **Specialty Developing Recommendation:**

**First Identified:** October 2012

**2012 Est Medicare Utilization:** 13,103

**2007 Work RVU:** 1.51

**2013 Work RVU:** 1.51

**2007 NF PE RVU:** 11.48

**2013 NF PE RVU:** 19.69

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** Review PE at October 2013 meeting.

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:**

**88349** Electron microscopy; scanning

**Global:** XXX **Issue:** RAW

**Screen:** Services with Stand-Alone PE Procedure Time

**Complete?** No

**Most Recent RUC Meeting:** October 2012 **Tab** 27 **Specialty Developing Recommendation:**

**First Identified:** October 2012

**2012 Est Medicare Utilization:** 41

**2007 Work RVU:** 0.76

**2013 Work RVU:** 0.76

**2007 NF PE RVU:** 4.88

**2013 NF PE RVU:** 12.03

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** Review PE at October 2013 meeting.

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:**

**8834XX**

**Global:** **Issue:** Immunohistochemistry

**Screen:** CMS High Expenditure Procedural Codes

**Complete?** Yes

**Most Recent RUC Meeting:** October 2012 **Tab** 12 **Specialty Developing Recommendation:** CAP

**First Identified:**

**2012 Est Medicare Utilization:**

**2007 Work RVU:**

**2013 Work RVU:**

**2007 NF PE RVU:**

**2013 NF PE RVU:**

**2007 Fac PE RVU**

**2013 Fac PE RVU:**

**RUC Recommendation:** 0.24

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

# Status Report: CMS Requests and Relativity Assessment Issues

**88356** Morphometric analysis; nerve **Global:** XXX **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** No

**Most Recent RUC Meeting:** **Tab** **Specialty Developing Recommendation:** **First Identified:** April 2013 **2012 Est Medicare Utilization:** 16,029 **2007 Work RVU:** 3.02 **2013 Work RVU:** 3.02 **2007 NF PE RVU:** 4.79 **2013 NF PE RVU:** 4.96 **2007 Fac PE RVU:** NA **2013 Fac PE RVU:** NA **Result:**

**RUC Recommendation:** Review Action Plan **CPT Action (if applicable):** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

**88365** In situ hybridization (eg, FISH), each probe **Global:** XXX **Issue:** In Situ Hybridization **Screen:** CMS Request - NPRM for 2012 / CMS Request Final Rule for 2013 **Complete?** No

**Most Recent RUC Meeting:** April 2013 **Tab** 34 **Specialty Developing Recommendation:** CAP **First Identified:** September 2011 **2012 Est Medicare Utilization:** 48,889 **2007 Work RVU:** 1.20 **2013 Work RVU:** 1.20 **2007 NF PE RVU:** 2.32 **2013 NF PE RVU:** 4.01 **2007 Fac PE RVU:** NA **2013 Fac PE RVU:** NA **Result:**

**RUC Recommendation:** Refer to CPT **CPT Action (if applicable):** **Referred to CPT Asst** ☒ **Published in CPT Asst:** Dec 2011 & May 2

**88367** Morphometric analysis, in situ hybridization (quantitative or semi-quantitative) each probe; using computer-assisted technology **Global:** XXX **Issue:** In Situ Hybridization **Screen:** CMS Request - NPRM for 2012 / CMS Request Final Rule for 2013 **Complete?** No

**Most Recent RUC Meeting:** April 2013 **Tab** 34 **Specialty Developing Recommendation:** CAP **First Identified:** September 2011 **2012 Est Medicare Utilization:** 130,217 **2007 Work RVU:** 1.30 **2013 Work RVU:** 1.30 **2007 NF PE RVU:** 4.31 **2013 NF PE RVU:** 6.23 **2007 Fac PE RVU:** NA **2013 Fac PE RVU:** NA **Result:**

**RUC Recommendation:** Refer to CPT **CPT Action (if applicable):** **Referred to CPT Asst** ☒ **Published in CPT Asst:** Dec 2011 & May 2

## Status Report: CMS Requests and Relativity Assessment Issues

**88368** Morphometric analysis, in situ hybridization (quantitative or semi-quantitative) each probe; manual **Global:** XXX **Issue:** In Situ Hybridization **Screen:** CMS Request - NPRM for 2012 / CMS Request Final Rule for 2013 **Complete?** No

**Most Recent** **Tab** 34 **Specialty Developing** CAP  
**RUC Meeting:** April 2013 **Recommendation:**

**First Identified:** September 2011 **2012 Est Medicare Utilization:** 282,297

**2007 Work RVU:** 1.40 **2013 Work RVU:** 1.40  
**2007 NF PE RVU:** 2.96 **2013 NF PE RVU:** 5.37  
**2007 Fac PE RVU** NA **2013 Fac PE RVU:** NA

**RUC Recommendation:** Refer to CPT

**CPT Action (if applicable):**

**Referred to CPT Asst** ☒

**Published in CPT Asst:** Dec 2011 & May 2

**Result:**

**90465** Deleted from CPT

**Global:** XXX **Issue:** Immunization Administration

**Screen:** CMS Request - Practice Expense Review **Complete?** Yes

**Most Recent** **Tab** R **Specialty Developing** AAP  
**RUC Meeting:** February 2008 **Recommendation:**

**First Identified:** NA **2012 Est Medicare Utilization:**

**2007 Work RVU:** 0.17 **2013 Work RVU:**  
**2007 NF PE RVU:** 0.35 **2013 NF PE RVU:**  
**2007 Fac PE RVU** NA **2013 Fac PE RVU:**

**RUC Recommendation:** New PE inputs

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** PE Only

**90467** Deleted from CPT

**Global:** XXX **Issue:** Immunization Administration

**Screen:** CMS Request - Practice Expense Review **Complete?** Yes

**Most Recent** **Tab** R **Specialty Developing** AAP  
**RUC Meeting:** February 2008 **Recommendation:**

**First Identified:** NA **2012 Est Medicare Utilization:**

**2007 Work RVU:** 0.17 **2013 Work RVU:**  
**2007 NF PE RVU:** 0.17 **2013 NF PE RVU:**  
**2007 Fac PE RVU** 0.09 **2013 Fac PE RVU:**

**RUC Recommendation:** New PE inputs

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** PE Only

## Status Report: CMS Requests and Relativity Assessment Issues

**90471** Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid) **Global:** XXX **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review / CMS Fastest Growing **Complete?** Yes

**Most Recent**  
**RUC Meeting:** February 2008

**Tab** R

**Specialty Developing** AAP  
**Recommendation:**

**First**  
**Identified:** February 2008

**2012 Est**  
**Medicare**  
**Utilization:** 631,025

**2007 Work RVU:** 0.17

**2013 Work RVU:** 0.17

**2007 NF PE RVU:** 0.35

**2013 NF PE RVU:** 0.58

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** PE Only

**RUC Recommendation:** New PE inputs

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**90472** Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)

**Global:** ZZZ

**Issue:** Immunization Administration

**Screen:** CMS Request - Practice Expense Review

**Complete?** Yes

**Most Recent**  
**RUC Meeting:** February 2008

**Tab** R

**Specialty Developing** AAP  
**Recommendation:**

**First**  
**Identified:** February 2008

**2012 Est**  
**Medicare**  
**Utilization:** 23,626

**2007 Work RVU:** 0.15

**2013 Work RVU:** 0.15

**2007 NF PE RVU:** 0.13

**2013 NF PE RVU:** 0.21

**2007 Fac PE RVU** 0.11

**2013 Fac PE RVU:** NA

**Result:** PE Only

**RUC Recommendation:** New PE inputs

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**90473** Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)

**Global:** XXX

**Issue:** Immunization Administration

**Screen:** CMS Request - Practice Expense Review

**Complete?** Yes

**Most Recent**  
**RUC Meeting:** February 2008

**Tab** R

**Specialty Developing** AAP  
**Recommendation:**

**First**  
**Identified:** NA

**2012 Est**  
**Medicare**  
**Utilization:** 27

**2007 Work RVU:** 0.17

**2013 Work RVU:** 0.17

**2007 NF PE RVU:** 0.18

**2013 NF PE RVU:** 0.58

**2007 Fac PE RVU** 0.06

**2013 Fac PE RVU:** NA

**Result:** PE Only

**RUC Recommendation:** New PE inputs

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**90474** Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

**Most Recent RUC Meeting:** February 2008

**Tab** R

**Specialty Developing Recommendation:** AAP

**First Identified:** NA

**2012 Est Medicare Utilization:** 4

**2007 Work RVU:** 0.15

**2013 Work RVU:** 0.15

**2007 NF PE RVU:** 0.09

**2013 NF PE RVU:** 0.21

**2007 Fac PE RVU** 0.05

**2013 Fac PE RVU:** NA

**Result:** PE Only

**RUC Recommendation:** New PE inputs

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**90785** Interactive complexity (List separately in addition to the code for primary procedure)

**Global:** XXX

**Issue:** Psychotherapy for Crisis and Interactive Complexity

**Screen:** CMS High Expenditure Procedural Codes

**Complete?** Yes

**Most Recent RUC Meeting:** April 2013

**Tab** 35

**Specialty Developing Recommendation:** APA, APA (HCPAC), NASW

**First Identified:**

**2012 Est Medicare Utilization:**

**2007 Work RVU:**

**2013 Work RVU:** 0.11

**2007 NF PE RVU:**

**2013 NF PE RVU:** 0.02

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 0.02

**Result:** Increase

**RUC Recommendation:** 0.33

**CPT Action (if applicable):**

February 2012

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**90791** Psychiatric diagnostic evaluation

**Global:** XXX

**Issue:** Psychotherapy

**Screen:** CMS High Expenditure Procedural Codes

**Complete?** Yes

**Most Recent RUC Meeting:** April 2012

**Tab** 26

**Specialty Developing Recommendation:** APA, APA (HCPAC), NASW

**First Identified:**

**2012 Est Medicare Utilization:**

**2007 Work RVU:**

**2013 Work RVU:** 2.80

**2007 NF PE RVU:**

**2013 NF PE RVU:** 1.52

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 0.53

**Result:** Increase

**RUC Recommendation:** 3.00

**CPT Action (if applicable):**

February 2012

**Referred to CPT Asst** ☐

**Published in CPT Asst:**



# Status Report: CMS Requests and Relativity Assessment Issues

**90792** Psychiatric diagnostic evaluation with medical services

**Global:** XXX

**Issue:** Psychotherapy

**Screen:** CMS High Expenditure  
Procedural Codes

**Complete?** Yes

**Most Recent  
RUC Meeting:** April 2012

**Tab** 26

**Specialty Developing  
Recommendation:** APA, APA  
(HCPAC),  
NASW

**First  
Identified:**

**2012 Est  
Medicare  
Utilization:**

**2007 Work RVU:**

**2013 Work RVU:** 2.96

**2007 NF PE RVU:**

**2013 NF PE RVU:** 0.58

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 0.48

**RUC Recommendation:** 3.25

**CPT Action (if applicable):** February 2012

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Increase

**90801** Psychiatric diagnostic interview examination

**Global:** 000

**Issue:** RAW review

**Screen:** CMS High Expenditure  
Procedural Codes

**Complete?** Yes

**Most Recent  
RUC Meeting:** January 2012

**Tab** 30

**Specialty Developing  
Recommendation:**

**First  
Identified:** September 2011

**2012 Est  
Medicare  
Utilization:** 1,618,087

**2007 Work RVU:** 2.80

**2013 Work RVU:**

**2007 NF PE RVU:** 1.25

**2013 NF PE RVU:**

**2007 Fac PE RVU** 0.85

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** February 2012

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Deleted from CPT

**90805** Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services

**Global:** 000

**Issue:** RAW review

**Screen:** CMS High Expenditure  
Procedural Codes

**Complete?** Yes

**Most Recent  
RUC Meeting:** January 2012

**Tab** 30

**Specialty Developing  
Recommendation:**

**First  
Identified:** September 2011

**2012 Est  
Medicare  
Utilization:** 1,594,273

**2007 Work RVU:** 1.37

**2013 Work RVU:**

**2007 NF PE RVU:** 0.53

**2013 NF PE RVU:**

**2007 Fac PE RVU** 0.38

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** February 2012

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Deleted from CPT

## Status Report: CMS Requests and Relativity Assessment Issues

---

<b>90806</b> Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;	<b>Global:</b> 000	<b>Issue:</b> RAW review	<b>Screen:</b> CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
---	--------------------	--------------------------	--	----------------------

<b>Most Recent RUC Meeting:</b> January 2012	<b>Tab</b> 30	<b>Specialty Developing Recommendation:</b>
--	---------------	---

<b>First Identified:</b> September 2011
---

<b>2012 Est Medicare Utilization:</b> 6,945,367
---

<b>2007 Work RVU:</b> 1.86
----------------------------

<b>2013 Work RVU:</b>
-----------------------

<b>2007 NF PE RVU:</b> 0.66
-----------------------------

<b>2013 NF PE RVU:</b>
------------------------

<b>2007 Fac PE RVU</b> 0.53
-----------------------------

<b>2013 Fac PE RVU:</b>
-------------------------

<b>RUC Recommendation:</b> Deleted from CPT
---

<b>CPT Action (if applicable):</b> February 2012	<b>Published in CPT Asst:</b>
<b>Referred to CPT Asst</b> <input type="checkbox"/>	

<b>Result:</b> Deleted from CPT
---------------------------------

---

<b>90808</b> Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;	<b>Global:</b> XXX	<b>Issue:</b> RAW review	<b>Screen:</b> CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
---	--------------------	--------------------------	--	----------------------

<b>Most Recent RUC Meeting:</b> January 2012	<b>Tab</b> 30	<b>Specialty Developing Recommendation:</b>
--	---------------	---

<b>First Identified:</b> September 2011
---

<b>2012 Est Medicare Utilization:</b> 397,417
---

<b>2007 Work RVU:</b> 2.79
----------------------------

<b>2013 Work RVU:</b>
-----------------------

<b>2007 NF PE RVU:</b> 0.94
-----------------------------

<b>2013 NF PE RVU:</b>
------------------------

<b>2007 Fac PE RVU</b> 0.8
----------------------------

<b>2013 Fac PE RVU:</b>
-------------------------

<b>RUC Recommendation:</b> Deleted from CPT
---

<b>CPT Action (if applicable):</b> February 2012	<b>Published in CPT Asst:</b>
<b>Referred to CPT Asst</b> <input type="checkbox"/>	

<b>Result:</b> Deleted from CPT
---------------------------------

---

<b>90818</b> Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;	<b>Global:</b> XXX	<b>Issue:</b> RAW review	<b>Screen:</b> CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
--	--------------------	--------------------------	--	----------------------

<b>Most Recent RUC Meeting:</b> January 2012	<b>Tab</b> 30	<b>Specialty Developing Recommendation:</b>
--	---------------	---

<b>First Identified:</b> September 2011
---

<b>2012 Est Medicare Utilization:</b> 1,463,941
---

<b>2007 Work RVU:</b> 1.89
----------------------------

<b>2013 Work RVU:</b>
-----------------------

<b>2007 NF PE RVU:</b> NA
---------------------------

<b>2013 NF PE RVU:</b>
------------------------

<b>2007 Fac PE RVU</b> 0.63
-----------------------------

<b>2013 Fac PE RVU:</b>
-------------------------

<b>RUC Recommendation:</b> Deleted from CPT
---

<b>CPT Action (if applicable):</b> February 2012	<b>Published in CPT Asst:</b>
<b>Referred to CPT Asst</b> <input type="checkbox"/>	

<b>Result:</b> Deleted from CPT
---------------------------------

## Status Report: CMS Requests and Relativity Assessment Issues

**90832** Psychotherapy, 30 minutes with patient and/or family member

**Global:** XXX

**Issue:** Psychotherapy

**Screen:** CMS High Expenditure  
Procedural Codes

**Complete?** Yes

**Most Recent  
RUC Meeting:** April 2012

**Tab** 26

**Specialty Developing  
Recommendation:** APA, APA  
(HCPAC),  
NASW

**First  
Identified:**

**2012 Est  
Medicare  
Utilization:**

**2007 Work RVU:**

**2013 Work RVU:** 1.25

**2007 NF PE RVU:**

**2013 NF PE RVU:** 0.54

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 0.14

**RUC Recommendation:** 1.50

**CPT Action (if applicable):** February 2012

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**90833** Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)

**Global:** ZZZ

**Issue:** Psychotherapy

**Screen:** CMS High Expenditure  
Procedural Codes

**Complete?** Yes

**Most Recent  
RUC Meeting:** April 2012

**Tab** 26

**Specialty Developing  
Recommendation:** APA, APA  
(HCPAC),  
NASW

**First  
Identified:**

**2012 Est  
Medicare  
Utilization:**

**2007 Work RVU:**

**2013 Work RVU:** 0.98

**2007 NF PE RVU:**

**2013 NF PE RVU:** 0.20

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 0.19

**RUC Recommendation:** 1.50

**CPT Action (if applicable):** February 2012

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**90834** Psychotherapy, 45 minutes with patient and/or family member

**Global:** XXX

**Issue:** Psychotherapy

**Screen:** CMS High Expenditure  
Procedural Codes

**Complete?** Yes

**Most Recent  
RUC Meeting:** April 2012

**Tab** 26

**Specialty Developing  
Recommendation:** APA, APA  
(HCPAC),  
NASW

**First  
Identified:**

**2012 Est  
Medicare  
Utilization:**

**2007 Work RVU:**

**2013 Work RVU:** 1.89

**2007 NF PE RVU:**

**2013 NF PE RVU:** 0.41

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 0.20

**RUC Recommendation:** 2.00

**CPT Action (if applicable):** February 2012

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

---

<b>90836</b>	<b>Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)</b>	<b>Global:</b> ZZZ	<b>Issue:</b> Psychotherapy	<b>Screen:</b> CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
--------------	---	--------------------	-----------------------------	--	----------------------

**Most Recent RUC Meeting:** April 2012

**Tab** 26

**Specialty Developing Recommendation:** APA, APA (HCPAC), NASW

**First Identified:**

**2012 Est Medicare Utilization:**

**2007 Work RVU:**

**2013 Work RVU:** 1.60

**2007 NF PE RVU:**

**2013 NF PE RVU:** 0.32

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 0.32

**RUC Recommendation:** 1.90

**CPT Action (if applicable):** February 2012  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Increase

---

<b>90837</b>	<b>Psychotherapy, 60 minutes with patient and/or family member</b>	<b>Global:</b> XXX	<b>Issue:</b> Psychotherapy	<b>Screen:</b> CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
--------------	--	--------------------	-----------------------------	--	----------------------

**Most Recent RUC Meeting:** April 2012

**Tab** 26

**Specialty Developing Recommendation:** APA, APA (HCPAC), NASW

**First Identified:**

**2012 Est Medicare Utilization:**

**2007 Work RVU:**

**2013 Work RVU:** 2.83

**2007 NF PE RVU:**

**2013 NF PE RVU:** 0.53

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 0.32

**RUC Recommendation:** 3.00

**CPT Action (if applicable):** February 2012  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Increase

---

<b>90838</b>	<b>Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)</b>	<b>Global:</b> ZZZ	<b>Issue:</b> Psychotherapy	<b>Screen:</b> CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
--------------	---	--------------------	-----------------------------	--	----------------------

**Most Recent RUC Meeting:** April 2012

**Tab** 26

**Specialty Developing Recommendation:** APA, APA (HCPAC), NASW

**First Identified:**

**2012 Est Medicare Utilization:**

**2007 Work RVU:**

**2013 Work RVU:** 2.56

**2007 NF PE RVU:**

**2013 NF PE RVU:** 0.54

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 0.52

**RUC Recommendation:** 2.50

**CPT Action (if applicable):** February 2012  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Increase

# Status Report: CMS Requests and Relativity Assessment Issues

## 90839 Psychotherapy for crisis; first 60 minutes

Global: XXX

Issue: Psychotherapy for Crisis and Interactive Complexity

Screen: CMS High Expenditure Procedural Codes

Complete? Yes

Most Recent  
RUC Meeting: April 2013

Tab 35

Specialty Developing  
Recommendation: APA, APA  
(HCPAC),  
NASW

First  
Identified:

2012 Est  
Medicare  
Utilization:

2007 Work RVU:

2013 Work RVU: 0.00

2007 NF PE RVU:

2013 NF PE RVU: 0.00

2007 Fac PE RVU

2013 Fac PE RVU: 0.00

RUC Recommendation: 3.13

CPT Action (if applicable): February 2012

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Increase

## 90840 Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)

Global: XXX

Issue: Psychotherapy for Crisis and Interactive Complexity

Screen: CMS High Expenditure Procedural Codes

Complete? Yes

Most Recent  
RUC Meeting: April 2013

Tab 35

Specialty Developing  
Recommendation: APA, APA  
(HCPAC),  
NASW

First  
Identified:

2012 Est  
Medicare  
Utilization:

2007 Work RVU:

2013 Work RVU: 0.00

2007 NF PE RVU:

2013 NF PE RVU: 0.00

2007 Fac PE RVU

2013 Fac PE RVU: 0.00

RUC Recommendation: 1.50

CPT Action (if applicable): February 2012

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Increase

## 90845 Psychoanalysis

Global: XXX

Issue: Psychotherapy

Screen: CMS High Expenditure Procedural Codes

Complete? Yes

Most Recent  
RUC Meeting: October 2011

Tab

Specialty Developing  
Recommendation:

First  
Identified:

2012 Est  
Medicare  
Utilization: 4,371

2007 Work RVU: 1.79

2013 Work RVU: 1.79

2007 NF PE RVU: 0.53

2013 NF PE RVU: 0.35

2007 Fac PE RVU 0.49

2013 Fac PE RVU: 0.33

RUC Recommendation: 2.10

CPT Action (if applicable):

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Increase

## 90846 Family psychotherapy (without the patient present)

Global: XXX

Issue: Psychotherapy

Screen: CMS High Expenditure Procedural Codes

Complete? Yes

Most Recent  
RUC Meeting: April 2012

Tab 26

Specialty Developing  
Recommendation: APA, APA  
(HCPAC),  
NASW

First  
Identified:

2012 Est  
Medicare  
Utilization: 21,547

2007 Work RVU: 1.83

2013 Work RVU: 1.83

2007 NF PE RVU: 0.62

2013 NF PE RVU: 0.27

2007 Fac PE RVU 0.60

2013 Fac PE RVU: 0.40

RUC Recommendation: 2.40

CPT Action (if applicable): February 2012

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Increase

## Status Report: CMS Requests and Relativity Assessment Issues

---

**90847** Family psychotherapy (conjoint psychotherapy) (with patient present)      **Global:** XXX    **Issue:** Psychotherapy      **Screen:** CMS High Expenditure Procedural Codes      **Complete?** Yes

**Most Recent RUC Meeting:** April 2012      **Tab** 26    **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW      **First Identified:**      **2012 Est Medicare Utilization:** 272,667      **2007 Work RVU:** 2.21      **2013 Work RVU:** 2.21  
**2007 NF PE RVU:** 0.8      **2013 NF PE RVU:** 0.31  
**2007 Fac PE RVU:** 0.69      **2013 Fac PE RVU:** 0.42  
**Result:** Increase

**RUC Recommendation:** 2.50      **CPT Action (if applicable):** February 2012  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

---

**90853** Group psychotherapy (other than of a multiple-family group)      **Global:** XXX    **Issue:** Psychotherapy      **Screen:** CMS High Expenditure Procedural Codes      **Complete?** Yes

**Most Recent RUC Meeting:** April 2012      **Tab** 26    **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW      **First Identified:**      **2012 Est Medicare Utilization:** 1,209,375      **2007 Work RVU:** 0.59      **2013 Work RVU:** 0.59  
**2007 NF PE RVU:** 0.26      **2013 NF PE RVU:** 0.10  
**2007 Fac PE RVU:** 0.22      **2013 Fac PE RVU:** 0.10  
**Result:** Maintain

**RUC Recommendation:** 0.59      **CPT Action (if applicable):** February 2012  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

---

**90862** Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy      **Global:** XXX    **Issue:** RAW review      **Screen:** CMS High Expenditure Procedural Codes      **Complete?** Yes

**Most Recent RUC Meeting:** January 2012      **Tab** 30    **Specialty Developing Recommendation:**      **First Identified:** September 2011      **2012 Est Medicare Utilization:** 5,325,913      **2007 Work RVU:** 0.95      **2013 Work RVU:**      **2007 NF PE RVU:** 0.46      **2013 NF PE RVU:**      **2007 Fac PE RVU:** 0.31      **2013 Fac PE RVU:**      **Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT      **CPT Action (if applicable):** February 2012  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

---

## Status Report: CMS Requests and Relativity Assessment Issues

**90863** Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure) **Global:** XXX **Issue:** Pharmacologic Management with Psychotherapy **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

**Most Recent RUC Meeting:** April 2013

**Tab** 40 **Specialty Developing Recommendation:** APA (HCPAC)

**First Identified:**

**2012 Est Medicare Utilization:**

**2007 Work RVU:**

**2013 Work RVU:** 0.00

**2007 NF PE RVU:**

**2013 NF PE RVU:** 0.00

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 0.00

**Result:** Increase

**RUC Recommendation:** 0.48

**CPT Action (if applicable):** February 2012  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**90870** Electroconvulsive therapy (includes necessary monitoring)

**Global:** 000

**Issue:** Electroconvulsive Therapy

**Screen:** Harvard Valued - Utilization over 100,000

**Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab** 41 **Specialty Developing Recommendation:** APA

**First Identified:** October 2009

**2012 Est Medicare Utilization:** 144,555

**2007 Work RVU:** 1.88

**2013 Work RVU:** 2.50

**2007 NF PE RVU:** 1.93

**2013 NF PE RVU:** 2.65

**2007 Fac PE RVU** 0.54

**2013 Fac PE RVU:** 0.57

**Result:** Increase

**RUC Recommendation:** 2.50

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**90935** Hemodialysis procedure with single evaluation by a physician or other qualified health care professional

**Global:** 000

**Issue:** Hemodialysis-Dialysis Services

**Screen:** Top 9 Harvard

**Complete?** Yes

**Most Recent RUC Meeting:** October 2009

**Tab** 30 **Specialty Developing Recommendation:** RPA

**First Identified:** October 2008

**2012 Est Medicare Utilization:** 1,343,209

**2007 Work RVU:** 1.22

**2013 Work RVU:** 1.48

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 0.64

**2013 Fac PE RVU:** 0.53

**Result:** Increase

**RUC Recommendation:** 1.48

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**90937** Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription

**Global:** 000

**Issue:** Hemodialysis-Dialysis Services

**Screen:** Top 9 Harvard

**Complete?** Yes

**Most Recent RUC Meeting:** October 2009

**Tab** 30 **Specialty Developing Recommendation:** RPA

**First Identified:** February 2009

**2012 Est Medicare Utilization:** 80,888

**2007 Work RVU:** 2.11

**2013 Work RVU:** 2.11

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 0.93

**2013 Fac PE RVU:** 0.77

**Result:** Maintain

**RUC Recommendation:** 2.11

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**90945** Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), with single evaluation by a physician or other qualified health care professional **Global:** 000 **Issue:** Hemodialysis-Dialysis Services **Screen:** Top 9 Harvard **Complete?** Yes

**Most Recent RUC Meeting:** October 2009

**Tab** 30 **Specialty Developing Recommendation:** RPA

**First Identified:** February 2009

**2012 Est Medicare Utilization:** 141,836

**2007 Work RVU:** 1.28

**2013 Work RVU:** 1.56

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 0.66

**2013 Fac PE RVU:** 0.85

**Result:** Increase

**RUC Recommendation:** 1.56

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**90947** Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies) requiring repeated evaluation by a physician or other qualified health care professional, with or without substantial revision of dialysis prescription **Global:** 000 **Issue:** Hemodialysis-Dialysis Services **Screen:** Top 9 Harvard **Complete?** Yes

**Most Recent RUC Meeting:** October 2009

**Tab** 30 **Specialty Developing Recommendation:** RPA

**First Identified:** February 2009

**2012 Est Medicare Utilization:** 14,902

**2007 Work RVU:** 2.16

**2013 Work RVU:** 2.52

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 0.94

**2013 Fac PE RVU:** 0.91

**Result:** Increase

**RUC Recommendation:** 2.52

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**90951** End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

**Most Recent RUC Meeting:** April 2009

**Tab** 29 **Specialty Developing Recommendation:** RPA

**First Identified:** February 2009

**2012 Est Medicare Utilization:** 38

**2007 Work RVU:**

**2013 Work RVU:** 18.46

**2007 NF PE RVU:**

**2013 NF PE RVU:** 7.39

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 7.39

**Result:** PE Only

**RUC Recommendation:** RUC Recommended revised clinical staff time

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**



## Status Report: CMS Requests and Relativity Assessment Issues

**90952** End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

**Most Recent**  
**RUC Meeting:** April 2009

**Tab 29** **Specialty Developing** RPA  
**Recommendation:**

**First**  
**Identified:** February 2009

**2012 Est**  
**Medicare**  
**Utilization:**

**2007 Work RVU:** **2013 Work RVU:** 0.00

**2007 NF PE RVU:** **2013 NF PE RVU:** 0.00

**2007 Fac PE RVU** **2013 Fac PE RVU:** 0.00

**Result:** PE Only

**RUC Recommendation:** RUC Recommended revised clinical staff time

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**90953** End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

**Most Recent**  
**RUC Meeting:** April 2009

**Tab 29** **Specialty Developing** RPA  
**Recommendation:**

**First**  
**Identified:** February 2009

**2012 Est**  
**Medicare**  
**Utilization:** 12

**2007 Work RVU:** **2013 Work RVU:** 0.00

**2007 NF PE RVU:** **2013 NF PE RVU:** 0.00

**2007 Fac PE RVU** **2013 Fac PE RVU:** 0.00

**Result:** PE Only

**RUC Recommendation:** RUC Recommended revised clinical staff time

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**90954** End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

**Most Recent**  
**RUC Meeting:** April 2009

**Tab 29** **Specialty Developing** RPA  
**Recommendation:**

**First**  
**Identified:** February 2009

**2012 Est**  
**Medicare**  
**Utilization:** 573

**2007 Work RVU:** **2013 Work RVU:** 15.98

**2007 NF PE RVU:** **2013 NF PE RVU:** 6.49

**2007 Fac PE RVU** **2013 Fac PE RVU:** 6.49

**Result:** PE Only

**RUC Recommendation:** RUC Recommended revised clinical staff time

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**90955** End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

**Most Recent** **Tab** 29 **Specialty Developing** RPA **First** **2012 Est** **2007 Work RVU:** **2013 Work RVU:** 8.79  
**RUC Meeting:** April 2009 **Recommendation:** **Identified:** February 2009 **Medicare** **2007 NF PE RVU:** **2013 NF PE RVU:** 3.91  
**Utilization:** 148 **2007 Fac PE RVU** **2013 Fac PE RVU:** 3.91  
**Result:** PE Only

**RUC Recommendation:** RUC Recommended revised clinical staff time

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**90956** End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

**Most Recent** **Tab** 29 **Specialty Developing** RPA **First** **2012 Est** **2007 Work RVU:** **2013 Work RVU:** 5.95  
**RUC Meeting:** April 2009 **Recommendation:** **Identified:** February 2009 **Medicare** **2007 NF PE RVU:** **2013 NF PE RVU:** 2.89  
**Utilization:** 139 **2007 Fac PE RVU** **2013 Fac PE RVU:** 2.89  
**Result:** PE Only

**RUC Recommendation:** RUC Recommended revised clinical staff time

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**90957** End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

**Most Recent** **Tab** 29 **Specialty Developing** RPA **First** **2012 Est** **2007 Work RVU:** **2013 Work RVU:** 12.52  
**RUC Meeting:** April 2009 **Recommendation:** **Identified:** February 2009 **Medicare** **2007 NF PE RVU:** **2013 NF PE RVU:** 5.38  
**Utilization:** 2,703 **2007 Fac PE RVU** **2013 Fac PE RVU:** 5.38  
**Result:** PE Only

**RUC Recommendation:** RUC Recommended revised clinical staff time

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

<b>90958</b>	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month	<b>Global:</b> XXX	<b>Issue:</b> End-Stage Renal Disease	<b>Screen:</b> CMS Request - Practice Expense Review	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2009	<b>Tab 29 Specialty Developing Recommendation:</b> RPA	<b>First Identified:</b> February 2009	<b>2012 Est Medicare Utilization:</b> 893	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> PE Only	<b>2013 Work RVU:</b> 8.34 <b>2013 NF PE RVU:</b> 3.84 <b>2013 Fac PE RVU:</b> 3.84
<b>RUC Recommendation:</b> RUC Recommended revised clinical staff time		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	
<b>90959</b>	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month	<b>Global:</b> XXX	<b>Issue:</b> End-Stage Renal Disease	<b>Screen:</b> CMS Request - Practice Expense Review	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2009	<b>Tab 29 Specialty Developing Recommendation:</b> RPA	<b>First Identified:</b> February 2009	<b>2012 Est Medicare Utilization:</b> 560	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> PE Only	<b>2013 Work RVU:</b> 5.50 <b>2013 NF PE RVU:</b> 2.78 <b>2013 Fac PE RVU:</b> 2.78
<b>RUC Recommendation:</b> RUC Recommended revised clinical staff time		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	
<b>90960</b>	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face visits by a physician or other qualified health care professional per month	<b>Global:</b> XXX	<b>Issue:</b> End-Stage Renal Disease	<b>Screen:</b> CMS Request - Practice Expense Review	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2009	<b>Tab 29 Specialty Developing Recommendation:</b> RPA	<b>First Identified:</b> February 2009	<b>2012 Est Medicare Utilization:</b> 2,221,153	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> PE Only	<b>2013 Work RVU:</b> 5.18 <b>2013 NF PE RVU:</b> 2.79 <b>2013 Fac PE RVU:</b> 2.79
<b>RUC Recommendation:</b> RUC Recommended revised physician and clinical staff time		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	

## Status Report: CMS Requests and Relativity Assessment Issues

**90961** End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 2-3 face-to-face visits by a physician or other qualified health care professional per month **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

**Most Recent**  
**RUC Meeting:** April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA

**First Identified:** February 2009

**2012 Est Medicare Utilization:** 639,838

**2007 Work RVU:**  
**2007 NF PE RVU:**  
**2007 Fac PE RVU Result:** PE Only  
**2013 Work RVU:** 4.26  
**2013 NF PE RVU:** 2.46  
**2013 Fac PE RVU:** 2.46

**RUC Recommendation:** RUC Recommended revised physician and clinical staff time

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**90962** End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

**Most Recent**  
**RUC Meeting:** April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA

**First Identified:** February 2009

**2012 Est Medicare Utilization:** 185,238

**2007 Work RVU:**  
**2007 NF PE RVU:**  
**2007 Fac PE RVU Result:** PE Only  
**2013 Work RVU:** 3.15  
**2013 NF PE RVU:** 2.06  
**2013 Fac PE RVU:** 2.06

**RUC Recommendation:** RUC Recommended revised clinical staff time

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**90963** End-stage renal disease (ESRD) related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

**Most Recent**  
**RUC Meeting:** April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA

**First Identified:** February 2009

**2012 Est Medicare Utilization:** 270

**2007 Work RVU:**  
**2007 NF PE RVU:**  
**2007 Fac PE RVU Result:** PE Only  
**2013 Work RVU:** 10.56  
**2013 NF PE RVU:** 4.63  
**2013 Fac PE RVU:** 4.63

**RUC Recommendation:** RUC Recommended revised clinical staff time

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**90964** End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

**Most Recent RUC Meeting:** April 2009

**Tab 29 Specialty Developing Recommendation:** RPA

**First Identified:** February 2009

**2012 Est Medicare Utilization:** 1,024

**2007 Work RVU:**

**2013 Work RVU:** 9.14

**2007 NF PE RVU:**

**2013 NF PE RVU:** 4.11

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 4.11

**Result:** PE Only

**RUC Recommendation:** RUC Recommended revised clinical staff time

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**90965** End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

**Most Recent RUC Meeting:** April 2009

**Tab 29 Specialty Developing Recommendation:** RPA

**First Identified:** February 2009

**2012 Est Medicare Utilization:** 1,722

**2007 Work RVU:**

**2013 Work RVU:** 8.69

**2007 NF PE RVU:**

**2013 NF PE RVU:** 3.91

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 3.91

**Result:** PE Only

**RUC Recommendation:** RUC Recommended revised clinical staff time

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**90966** End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

**Most Recent RUC Meeting:** April 2009

**Tab 29 Specialty Developing Recommendation:** RPA

**First Identified:** February 2009

**2012 Est Medicare Utilization:** 261,419

**2007 Work RVU:**

**2013 Work RVU:** 4.26

**2007 NF PE RVU:**

**2013 NF PE RVU:** 2.45

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 2.45

**Result:** PE Only

**RUC Recommendation:** RUC Recommended revised clinical staff time

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

---

<b>91038</b>	<b>Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)</b>	<b>Global:</b> 000	<b>Issue:</b> Gastroenterological Tests	<b>Screen:</b> CMS Request - Practice Expense Review	<b>Complete?</b> Yes
--------------	--	--------------------	---	--	----------------------

**Most Recent RUC Meeting:** February 2010

**Tab** 23

**Specialty Developing Recommendation:** AGA, ASGE

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 2,696

**2007 Work RVU:** 1.10

**2013 Work RVU:** 1.10

**2007 NF PE RVU:** 2.36

**2013 NF PE RVU:** 13.34

**2007 Fac PE RVU** 2.36

**2013 Fac PE RVU:** NA

**Result:** PE Only

**RUC Recommendation:** New PE Inputs

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

---

**91132** **Electrogastrography, diagnostic, transcutaneous;**

**Global:** XXX

**Issue:** Electrogastrography

**Screen:** CMS Request - Practice Expense Review

**Complete?** Yes

**Most Recent RUC Meeting:** February 2010

**Tab** 24

**Specialty Developing Recommendation:** AGA, ACG, ASGE

**First Identified:**

**2012 Est Medicare Utilization:** 15

**2007 Work RVU:** 0.00

**2013 Work RVU:** 0.52

**2007 NF PE RVU:** 0

**2013 NF PE RVU:** 4.41

**2007 Fac PE RVU** 0

**2013 Fac PE RVU:** NA

**Result:** PE Only

**RUC Recommendation:** New PE Inputs

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

---

**91133** **Electrogastrography, diagnostic, transcutaneous; with provocative testing**

**Global:** XXX

**Issue:** Electrogastrography

**Screen:** CMS Request - Practice Expense Review

**Complete?** Yes

**Most Recent RUC Meeting:** February 2010

**Tab** 24

**Specialty Developing Recommendation:** AGA, ACG, ASGE

**First Identified:**

**2012 Est Medicare Utilization:** 113

**2007 Work RVU:** 0.00

**2013 Work RVU:** 0.66

**2007 NF PE RVU:** 0

**2013 NF PE RVU:** 5.02

**2007 Fac PE RVU** 0

**2013 Fac PE RVU:** NA

**Result:** PE Only

**RUC Recommendation:** New PE Inputs

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

# Status Report: CMS Requests and Relativity Assessment Issues

**92081** Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent) **Global:** XXX **Issue:** Visual Field Examination **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab 42 Specialty Developing Recommendation:** AAO, AOA (optometric)

**First Identified:** October 2009

**2012 Est Medicare Utilization:** 110,606

**2007 Work RVU:** 0.36

**2013 Work RVU:** 0.30

**2007 NF PE RVU:** 0.95

**2013 NF PE RVU:** 0.69

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Decrease

**RUC Recommendation:** 0.30

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**92082** Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33) **Global:** XXX **Issue:** Visual Field Examination **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab 42 Specialty Developing Recommendation:** AAO, AOA (optometric)

**First Identified:** October 2009

**2012 Est Medicare Utilization:** 174,852

**2007 Work RVU:** 0.44

**2013 Work RVU:** 0.40

**2007 NF PE RVU:** 1.26

**2013 NF PE RVU:** 1.03

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Decrease

**RUC Recommendation:** 0.40

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**92083** Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2) **Global:** XXX **Issue:** Visual Field Examination **Screen:** MPC List / CMS High Expenditure Procedural Codes **Complete?** Yes

**Most Recent RUC Meeting:** April 2012

**Tab 46 Specialty Developing Recommendation:** AAO, AOA (optometric)

**First Identified:** October 2010

**2012 Est Medicare Utilization:** 2,735,403

**2007 Work RVU:** 0.50

**2013 Work RVU:** 0.50

**2007 NF PE RVU:** 1.46

**2013 NF PE RVU:** 1.42

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** 0.50

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**92100** Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (eg, diurnal curve or medical treatment of acute elevation of intraocular pressure) **Global:** XXX **Issue:** Serial Tonometry **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

**Most Recent RUC Meeting:** September 2011 **Tab** 36 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** April 2011 **2012 Est Medicare Utilization:** 41,903 **2007 Work RVU:** 0.92 **2013 Work RVU:** 0.61 **2007 NF PE RVU:** 1.33 **2013 NF PE RVU:** 1.77 **2007 Fac PE RVU:** 0.35 **2013 Fac PE RVU:** 0.35 **RUC Recommendation:** 0.61 **CPT Action (if applicable):** Referred to CPT Asst ☐ **Published in CPT Asst:**

**92133** Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve **Global:** XXX **Issue:** Computerized Scanning Ophthalmology Diagnostic Imaging **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent RUC Meeting:** April 2010 **Tab** 23 **Specialty Developing Recommendation:** AAO, AOA (eye) **First Identified:** **2012 Est Medicare Utilization:** 2,213,023 **2007 Work RVU:** **2013 Work RVU:** 0.50 **2007 NF PE RVU:** **2013 NF PE RVU:** 0.79 **2007 Fac PE RVU:** **2013 Fac PE RVU:** NA **RUC Recommendation:** 0.50 **CPT Action (if applicable):** October 2009 **Published in CPT Asst:**

**92134** Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina **Global:** XXX **Issue:** Computerized Scanning Ophthalmology Diagnostic Imaging **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent RUC Meeting:** April 2010 **Tab** 23 **Specialty Developing Recommendation:** AAO, AOA (eye) **First Identified:** **2012 Est Medicare Utilization:** 4,486,433 **2007 Work RVU:** **2013 Work RVU:** 0.50 **2007 NF PE RVU:** **2013 NF PE RVU:** 0.82 **2007 Fac PE RVU:** **2013 Fac PE RVU:** NA **RUC Recommendation:** 0.50 **CPT Action (if applicable):** October 2009 **Published in CPT Asst:**



## Status Report: CMS Requests and Relativity Assessment Issues

**92135 Deleted from CPT** **Global:** XXX **Issue:** Ophthalmic Diagnostic Imaging **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent RUC Meeting:** October 2009 **Tab** 31 **Specialty Developing Recommendation:** AAO, AOA **First Identified:** October 2008 **2012 Est Medicare Utilization:** **2007 Work RVU:** 0.35 **2013 Work RVU:** **2007 NF PE RVU:** 0.79 **2013 NF PE RVU:** **2007 Fac PE RVU:** NA **2013 Fac PE RVU:** **RUC Recommendation:** Deleted from CPT **CPT Action (if applicable):** October 2009 **Result:** Deleted from CPT **Referred to CPT Asst** ☐ **Published in CPT Asst:**

**92136 Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation** **Global:** XXX **Issue:** Ophthalmologic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent RUC Meeting:** February 2009 **Tab** 38 **Specialty Developing Recommendation:** AAO, AOA, ASCRS **First Identified:** October 2008 **2012 Est Medicare Utilization:** 1,372,760 **2007 Work RVU:** 0.54 **2013 Work RVU:** 0.54 **2007 NF PE RVU:** 1.6 **2013 NF PE RVU:** 2.18 **2007 Fac PE RVU:** NA **2013 Fac PE RVU:** NA **RUC Recommendation:** Remove from screen **CPT Action (if applicable):** **Result:** Remove from Screen **Referred to CPT Asst** ☐ **Published in CPT Asst:**

**92235 Fluorescein angiography (includes multiframe imaging) with interpretation and report** **Global:** XXX **Issue:** Fluorescein Angiography **Screen:** Harvard Valued - Utilization over 30,000 / CMS High Expenditure Procedural Codes **Complete?** Yes

**Most Recent RUC Meeting:** January 2012 **Tab** 26 **Specialty Developing Recommendation:** AAO **First Identified:** April 2011 **2012 Est Medicare Utilization:** 1,436,415 **2007 Work RVU:** 0.81 **2013 Work RVU:** 0.81 **2007 NF PE RVU:** 2.54 **2013 NF PE RVU:** 2.48 **2007 Fac PE RVU:** NA **2013 Fac PE RVU:** NA **RUC Recommendation:** 0.81 **CPT Action (if applicable):** **Result:** Maintain **Referred to CPT Asst** ☐ **Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

### 92250 Fundus photography with interpretation and report

Global: XXX

Issue:

Screen: MPC List

Complete? Yes

Most Recent Tab 41 Specialty Developing

RUC Meeting: February 2011

Recommendation:

First Identified: October 2010

2012 Est  
Medicare  
Utilization: 2,655,796

2007 Work RVU: 0.44

2013 Work RVU: 0.44

2007 NF PE RVU: 1.48

2013 NF PE RVU: 1.93

2007 Fac PE RVU NA

2013 Fac PE RVU: NA

RUC Recommendation: Reaffirmed RUC recommendation

CPT Action (if applicable):

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Maintain

### 92270 Electro-oculography with interpretation and report

Global: XXX

Issue: Electro-oculography

Screen: High Volume Growth1

Complete? No

Most Recent Tab 51 Specialty Developing AAO-HNS

RUC Meeting: September 2011

Recommendation:

First Identified: February 2008

2012 Est  
Medicare  
Utilization: 20,725

2007 Work RVU: 0.81

2013 Work RVU: 0.81

2007 NF PE RVU: 1.5

2013 NF PE RVU: 1.91

2007 Fac PE RVU NA

2013 Fac PE RVU: NA

RUC Recommendation: Review September 2013. CPT Assistant article published.

CPT Action (if applicable):

Referred to CPT Asst ☒

Published in CPT Asst: Aug 2008 and Q&A

Result:

### 92285 External ocular photography with interpretation and report for documentation of medical progress (eg, close-up photography, slit lamp photography, goniphotography, stereo-photography)

Global: XXX

Issue: Ocular Photography

Screen: CMS Fastest Growing, Harvard Valued - Utilization over 100,000

Complete? Yes

Most Recent Tab 32 Specialty Developing AAO, AOA

RUC Meeting: October 2009

Recommendation:

First Identified: October 2008

2012 Est  
Medicare  
Utilization: 314,658

2007 Work RVU: 0.20

2013 Work RVU: 0.05

2007 NF PE RVU: 0.95

2013 NF PE RVU: 0.56

2007 Fac PE RVU NA

2013 Fac PE RVU: NA

RUC Recommendation: 0.05 and new PE inputs

CPT Action (if applicable):

Referred to CPT Asst ☐

February 2010

Published in CPT Asst:

Result: Decrease

## Status Report: CMS Requests and Relativity Assessment Issues

**92286** Anterior segment imaging with interpretation and report; with specular microscopy and endothelial cell analysis **Global:** XXX **Issue:** Anterior Segment Imaging **Screen:** Harvard Valued - Utilization over 30,000 / Harvard-Valued Annual Allowed Charges Greater than \$10 million **Complete?** Yes

**Most Recent RUC Meeting:** April 2012 **Tab** 28 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** April 2011 **2012 Est Medicare Utilization:** 150,343 **2007 Work RVU:** 0.66 **2013 Work RVU:** 0.40 **2007 NF PE RVU:** 2.83 **2013 NF PE RVU:** 0.72 **2007 Fac PE RVU:** NA **2013 Fac PE RVU:** NA **Result:** Decrease

**RUC Recommendation:** 0.40 **CPT Action (if applicable):** October 2011 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

**92287** Anterior segment imaging with interpretation and report; with fluorescein angiography **Global:** XXX **Issue:** Anterior Segment Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

**Most Recent RUC Meeting:** April 2012 **Tab** 28 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** **2012 Est Medicare Utilization:** 2,890 **2007 Work RVU:** 0.81 **2013 Work RVU:** 0.81 **2007 NF PE RVU:** 2.28 **2013 NF PE RVU:** 3.36 **2007 Fac PE RVU:** 0.31 **2013 Fac PE RVU:** NA **Result:** Maintain

**RUC Recommendation:** CPT Assistant article published **CPT Action (if applicable):** October 2011 **Referred to CPT Asst** ☒ **Published in CPT Asst:** Mar 2013

**92504** Binocular microscopy (separate diagnostic procedure) **Global:** XXX **Issue:** Binocular Microscopy **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** April 2010 **Tab** 43 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** October 2009 **2012 Est Medicare Utilization:** 200,855 **2007 Work RVU:** 0.18 **2013 Work RVU:** 0.18 **2007 NF PE RVU:** 0.51 **2013 NF PE RVU:** 0.74 **2007 Fac PE RVU:** 0.08 **2013 Fac PE RVU:** 0.09 **Result:** Maintain

**RUC Recommendation:** 0.18 **CPT Action (if applicable):** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

---

<b>92506</b>	<b>Evaluation of speech, language, voice, communication, and/or auditory processing</b>	<b>Global:</b> XXX	<b>Issue:</b> Speech Language Pathology Services	<b>Screen:</b> CMS Request/Speech Language Pathology Request	<b>Complete?</b> Yes
--------------	---	--------------------	--	--	----------------------

**Most Recent RUC Meeting:** February 2010

**Tab** 28

**Specialty Developing Recommendation:** ASHA

**First Identified:**

**2012 Est Medicare Utilization:** 22,112

**2007 Work RVU:** 0.86

**2013 Work RVU:** 0.86

**2007 NF PE RVU:** 2.76

**2013 NF PE RVU:** 5.48

**2007 Fac PE RVU** 0.36

**2013 Fac PE RVU:** NA

**RUC Recommendation:** Deleted from CPT.

**CPT Action (if applicable):** October 2012

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Deleted from CPT

---

<b>92507</b>	<b>Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual</b>	<b>Global:</b> XXX	<b>Issue:</b> Speech Language Pathology Services	<b>Screen:</b> CMS Request/Speech Language Pathology Request	<b>Complete?</b> Yes
--------------	---	--------------------	--	--	----------------------

**Most Recent RUC Meeting:** February 2010

**Tab** 28

**Specialty Developing Recommendation:** ASHA

**First Identified:**

**2012 Est Medicare Utilization:** 140,687

**2007 Work RVU:** 0.52

**2013 Work RVU:** 1.30

**2007 NF PE RVU:** 1.13

**2013 NF PE RVU:** 0.72

**2007 Fac PE RVU** 0.21

**2013 Fac PE RVU:** NA

**RUC Recommendation:** 1.30 work RVU and clinical staff time removed

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

---

<b>92508</b>	<b>Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals</b>	<b>Global:</b> XXX	<b>Issue:</b> Speech Language Pathology Services	<b>Screen:</b> CMS Request/Speech Language Pathology Request	<b>Complete?</b> Yes
--------------	---	--------------------	--	--	----------------------

**Most Recent RUC Meeting:** February 2010

**Tab** 28

**Specialty Developing Recommendation:** ASHA

**First Identified:**

**2012 Est Medicare Utilization:** 1,810

**2007 Work RVU:** 0.26

**2013 Work RVU:** 0.33

**2007 NF PE RVU:** 0.51

**2013 NF PE RVU:** 0.27

**2007 Fac PE RVU** 0.11

**2013 Fac PE RVU:** NA

**RUC Recommendation:** 0.43 work RVU and clinical staff time removed

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

# Status Report: CMS Requests and Relativity Assessment Issues

<b>92526</b>	<b>Treatment of swallowing dysfunction and/or oral function for feeding</b>	<b>Global:</b> XXX	<b>Issue:</b> Speech Language Pathology Services (HCPAC)	<b>Screen:</b> CMS Request/Speech Language Pathology Request / High Volume Growth2	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> April 2009	<b>Tab</b> 39	<b>Specialty Developing Recommendation:</b> ASHA, AAO-HNS	<b>First Identified:</b> NA	<b>2012 Est Medicare Utilization:</b> 45,910	<b>2007 Work RVU:</b> 0.55 <b>2007 NF PE RVU:</b> 1.65 <b>2007 Fac PE RVU</b> 0.19 <b>2013 Work RVU:</b> 1.34 <b>2013 NF PE RVU:</b> 0.86 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Review action plan. 1.34 work RVU and clinical staff time removed		<b>CPT Action (if applicable):</b>		<b>Result:</b> Decrease	
		<b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	

<b>92540</b>	<b>Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording</b>	<b>Global:</b> XXX	<b>Issue:</b> Bundled Audiology Tests	<b>Screen:</b> Codes Reported Together 95% or More	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2009	<b>Tab</b> 22	<b>Specialty Developing Recommendation:</b> AAN, ASHA, AAO-HNS, AAA	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 89,673	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU</b> <b>2013 Work RVU:</b> 1.50 <b>2013 NF PE RVU:</b> 1.41 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 1.50		<b>CPT Action (if applicable):</b>		<b>Result:</b> Decrease	
		<b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	

<b>92541</b>	<b>Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording</b>	<b>Global:</b> XXX	<b>Issue:</b> Bundled Audiology Tests	<b>Screen:</b> Codes Reported Together 95% or More / Harvard Valued - Utilization over 100,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2009	<b>Tab</b> 22	<b>Specialty Developing Recommendation:</b> ASHA, AAO-HNS, AAN	<b>First Identified:</b> February 2008	<b>2012 Est Medicare Utilization:</b> 32,721	<b>2007 Work RVU:</b> 0.40 <b>2007 NF PE RVU:</b> 1.05 <b>2007 Fac PE RVU</b> NA <b>2013 Work RVU:</b> 0.40 <b>2013 NF PE RVU:</b> 0.47 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 0.40 work RVU and clinical staff time removed		<b>CPT Action (if applicable):</b>		<b>Result:</b> Maintain	
		<b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	

## Status Report: CMS Requests and Relativity Assessment Issues

<b>92542</b>	<b>Positional nystagmus test, minimum of 4 positions, with recording</b>	<b>Global:</b> XXX	<b>Issue:</b> Bundled Audiology Tests	<b>Screen:</b> Codes Reported Together 95% or More	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2009	<b>Tab 22</b>	<b>Specialty Developing Recommendation:</b> ASHA, AAO-HNS, AAN	<b>First Identified:</b> February 2008	<b>2012 Est Medicare Utilization:</b> 42,243	<b>2007 Work RVU:</b> 0.33 <b>2007 NF PE RVU:</b> 1.16 <b>2007 Fac PE RVU</b> NA <b>2013 Work RVU:</b> 0.33 <b>2013 NF PE RVU:</b> 0.44 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 0.33 work RVU and clinical staff time removed			<b>CPT Action (if applicable):</b> February 2009	<b>Published in CPT Asst:</b>	<b>Result:</b> Maintain
			<b>Referred to CPT Asst</b> <input type="checkbox"/>		
<hr/>					
<b>92543</b>	<b>Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes 4 tests), with recording</b>	<b>Global:</b> XXX	<b>Issue:</b> Bundled Audiology Tests	<b>Screen:</b> Codes Reported Together 95% or More / Low Value-High Volume / CMS-Other - Utilization over 250,000	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> April 2009	<b>Tab 22</b>	<b>Specialty Developing Recommendation:</b> ASHA, AAO-HNS, AAN	<b>First Identified:</b> February 2008	<b>2012 Est Medicare Utilization:</b> 358,544	<b>2007 Work RVU:</b> 0.10 <b>2007 NF PE RVU:</b> 0.59 <b>2007 Fac PE RVU</b> NA <b>2013 Work RVU:</b> 0.10 <b>2013 NF PE RVU:</b> 0.36 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Review action plan. 0.10 work RVU and clinical staff time removed			<b>CPT Action (if applicable):</b> February 2009	<b>Published in CPT Asst:</b>	<b>Result:</b> Decrease
			<b>Referred to CPT Asst</b> <input type="checkbox"/>		
<hr/>					
<b>92544</b>	<b>Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording</b>	<b>Global:</b> XXX	<b>Issue:</b> Bundled Audiology Tests	<b>Screen:</b> Codes Reported Together 95% or More	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2009	<b>Tab 22</b>	<b>Specialty Developing Recommendation:</b> ASHA, AAO-HNS, AAN	<b>First Identified:</b> February 2008	<b>2012 Est Medicare Utilization:</b> 10,499	<b>2007 Work RVU:</b> 0.26 <b>2007 NF PE RVU:</b> 0.93 <b>2007 Fac PE RVU</b> NA <b>2013 Work RVU:</b> 0.26 <b>2013 NF PE RVU:</b> 0.41 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 0.26 work RVU and clinical staff time removed			<b>CPT Action (if applicable):</b> February 2009	<b>Published in CPT Asst:</b>	<b>Result:</b> Maintain
			<b>Referred to CPT Asst</b> <input type="checkbox"/>		

## Status Report: CMS Requests and Relativity Assessment Issues

### 92545 Oscillating tracking test, with recording

Global: XXX

Issue: Bundled Audiology Tests

Screen: Codes Reported  
Together 95% or More

Complete? Yes

Most Recent  
RUC Meeting: April 2009

Tab 22

Specialty Developing  
Recommendation: ASHA, AAO-  
HNS, AAN

First  
Identified: February 2008

2012 Est  
Medicare  
Utilization: 16,374

2007 Work RVU: 0.23

2013 Work RVU: 0.23

2007 NF PE RVU: 0.85

2013 NF PE RVU: 0.37

2007 Fac PE RVU NA

2013 Fac PE RVU: NA

RUC Recommendation: 0.23 work RVU and clinical staff time removed

CPT Action (if applicable): February 2009

Referred to CPT Asst ☐

Published in CPT Asst:

### 92550 Tympanometry and reflex threshold measurements

Global: XXX

Issue: Bundled Audiology Tests

Screen: Codes Reported  
Together 95% or More

Complete? Yes

Most Recent  
RUC Meeting: April 2009

Tab 22

Specialty Developing  
Recommendation: ASHA, AAO-  
HNS, AAA

First  
Identified:

2012 Est  
Medicare  
Utilization: 278,777

2007 Work RVU:

2013 Work RVU: 0.35

2007 NF PE RVU:

2013 NF PE RVU: 0.25

2007 Fac PE RVU

2013 Fac PE RVU: NA

RUC Recommendation: 0.35

CPT Action (if applicable):

Referred to CPT Asst ☐

Published in CPT Asst:

### 92557 Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)

Global: XXX

Issue: Bundled Audiology Tests

Screen: Codes Reported  
Together 95% or More

Complete? Yes

Most Recent  
RUC Meeting: April 2009

Tab 22

Specialty Developing  
Recommendation: ASHA, AAO-  
HNS, AAN

First  
Identified: February 2008

2012 Est  
Medicare  
Utilization: 1,125,775

2007 Work RVU: 0.00

2013 Work RVU: 0.60

2007 NF PE RVU: 1.21

2013 NF PE RVU: 0.47

2007 Fac PE RVU NA

2013 Fac PE RVU: 0.31

RUC Recommendation: 0.60 work RVU and clinical staff time removed

CPT Action (if applicable): February 2009

Referred to CPT Asst ☐

Published in CPT Asst:

## Status Report: CMS Requests and Relativity Assessment Issues

**92558** Evoked otoacoustic emissions, screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis **Global:** XXX **Issue:** Otoacoustic Emissions Measurement **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent RUC Meeting:** April 2011

**Tab** 35 **Specialty Developing Recommendation:** ASHA

**First Identified:**

**2012 Est Medicare Utilization:** 97

**2007 Work RVU:**

**2013 Work RVU:** 0.00

**2007 NF PE RVU:**

**2013 NF PE RVU:** 0.00

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 0.00

**RUC Recommendation:** 0.17

**CPT Action (if applicable):** February 2011  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Increase

**92567** Tympanometry (impedance testing)

**Global:** XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More / Low Value-High Volume **Complete?** Yes

**Most Recent RUC Meeting:** April 2009

**Tab** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAN

**First Identified:** February 2008

**2012 Est Medicare Utilization:** 718,241

**2007 Work RVU:** 0.00

**2013 Work RVU:** 0.20

**2007 NF PE RVU:** 0.51

**2013 NF PE RVU:** 0.21

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** 0.10

**RUC Recommendation:** 0.20 work RVU and clinical staff time removed

**CPT Action (if applicable):** February 2009  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Decrease

**92568** Acoustic reflex testing, threshold

**Global:** XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More **Complete?** Yes

**Most Recent RUC Meeting:** April 2009

**Tab** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAN

**First Identified:** February 2008

**2012 Est Medicare Utilization:** 21,992

**2007 Work RVU:** 0.00

**2013 Work RVU:** 0.29

**2007 NF PE RVU:** 0.32

**2013 NF PE RVU:** 0.15

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** 0.15

**RUC Recommendation:** 0.29 work RVU and clinical staff time removed

**CPT Action (if applicable):** February 2009  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Decrease



## Status Report: CMS Requests and Relativity Assessment Issues

**92569** Deleted from CPT

**Global:** XXX

**Issue:** Bundled Audiology Tests

**Screen:** Codes Reported Together 95% or More

**Complete?** Yes

**Most Recent RUC Meeting:** April 2009

**Tab** 22

**Specialty Developing Recommendation:**

ASHA, AAO-HNS, AAN

**First Identified:** February 2008

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 0.00

**2013 Work RVU:**

**2007 NF PE RVU:** 0.35

**2013 NF PE RVU:**

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:**

**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** February 2009

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**92570** Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing

**Global:** XXX

**Issue:** Bundled Audiology Tests

**Screen:** Codes Reported Together 95% or More

**Complete?** Yes

**Most Recent RUC Meeting:** April 2009

**Tab** 22

**Specialty Developing Recommendation:**

ASHA, AAO-HNS, AAA

**First Identified:**

**2012 Est Medicare Utilization:** 59,606

**2007 Work RVU:**

**2013 Work RVU:** 0.55

**2007 NF PE RVU:**

**2013 NF PE RVU:** 0.36

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 0.29

**Result:** Decrease

**RUC Recommendation:** 0.55

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**92587** Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report

**Global:** XXX

**Issue:** Otoacoustic Emissions Measurement

**Screen:** CMS Fastest Growing

**Complete?** Yes

**Most Recent RUC Meeting:** April 2011

**Tab** 35

**Specialty Developing Recommendation:**

ASHA

**First Identified:** October 2008

**2012 Est Medicare Utilization:** 93,318

**2007 Work RVU:** 0.13

**2013 Work RVU:** 0.35

**2007 NF PE RVU:** 1.19

**2013 NF PE RVU:** 0.25

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Increase

**RUC Recommendation:** 0.45

**CPT Action (if applicable):** October 2010

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**92588** Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report **Global:** XXX **Issue:** Otoacoustic Emissions Measurement **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent RUC Meeting:** April 2011

**Tab** 35 **Specialty Developing Recommendation:** ASHA

**First Identified:**

**2012 Est Medicare Utilization:** 100,148

**2007 Work RVU:** 0.36

**2013 Work RVU:** 0.55

**2007 NF PE RVU:** 1.48

**2013 NF PE RVU:** 0.39

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Increase

**RUC Recommendation:** 0.60

**CPT Action (if applicable):** February 2011

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**92597** Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech **Global:** XXX **Issue:** Speech Language Pathology Services (RUC) **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

**Most Recent RUC Meeting:** February 2009

**Tab** 30 **Specialty Developing Recommendation:** ASHA

**First Identified:** NA

**2012 Est Medicare Utilization:** 3,004

**2007 Work RVU:** 0.86

**2013 Work RVU:** 1.26

**2007 NF PE RVU:** 1.69

**2013 NF PE RVU:** 0.71

**2007 Fac PE RVU** 0.4

**2013 Fac PE RVU:** NA

**Result:** Decrease

**RUC Recommendation:** 1.48 work RVU and clinical staff time removed

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**925XX1** **Global:** **Issue:** Speech Evaluation **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

**Most Recent RUC Meeting:** January 2013

**Tab** 32 **Specialty Developing Recommendation:** ASHA

**First Identified:**

**2012 Est Medicare Utilization:**

**2007 Work RVU:**

**2013 Work RVU:**

**2007 NF PE RVU:**

**2013 NF PE RVU:**

**2007 Fac PE RVU**

**2013 Fac PE RVU:**

**Result:** Increase

**RUC Recommendation:** 1.75

**CPT Action (if applicable):** October 2012

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

925XX2

Global:

Issue: Speech Evaluation

Screen: CMS Request/Speech  
Language Pathology  
Request

Complete? Yes

Most Recent  
RUC Meeting: January 2013

Tab 32

Specialty Developing  
Recommendation: ASHA

First  
Identified:

2012 Est  
Medicare  
Utilization:

2007 Work RVU:

2013 Work RVU:

2007 NF PE RVU:

2013 NF PE RVU:

2007 Fac PE RVU

2013 Fac PE RVU:

RUC Recommendation: 1.50

CPT Action (if applicable):  
Referred to CPT Asst ☐ Published in CPT Asst:

October 2012

Result: Increase

925XX3

Global:

Issue: Speech Evaluation

Screen: CMS Request/Speech  
Language Pathology  
Request

Complete? Yes

Most Recent  
RUC Meeting: January 2013

Tab 32

Specialty Developing  
Recommendation: ASHA

First  
Identified:

2012 Est  
Medicare  
Utilization:

2007 Work RVU:

2013 Work RVU:

2007 NF PE RVU:

2013 NF PE RVU:

2007 Fac PE RVU

2013 Fac PE RVU:

RUC Recommendation: 3.36

CPT Action (if applicable):  
Referred to CPT Asst ☐ Published in CPT Asst:

October 2012

Result: Increase

925XX4

Global:

Issue: Speech Evaluation

Screen: CMS Request/Speech  
Language Pathology  
Request

Complete? Yes

Most Recent  
RUC Meeting: January 2013

Tab 32

Specialty Developing  
Recommendation: ASHA

First  
Identified:

2012 Est  
Medicare  
Utilization:

2007 Work RVU:

2013 Work RVU:

2007 NF PE RVU:

2013 NF PE RVU:

2007 Fac PE RVU

2013 Fac PE RVU:

RUC Recommendation: 1.75

CPT Action (if applicable):  
Referred to CPT Asst ☐ Published in CPT Asst:

October 2012

Result: Increase

## Status Report: CMS Requests and Relativity Assessment Issues

<b>92605</b>	<b>Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour</b>	<b>Global:</b> XXX	<b>Issue:</b> Eval of Rx for Non-Speech Generating Device	<b>Screen:</b> CMS Request/Speech Language Pathology Request	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2011	<b>Tab</b> 35 <b>Specialty Developing Recommendation:</b> ASHA	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> 0.00 <b>2007 NF PE RVU:</b> 0 <b>2007 Fac PE RVU:</b> 0 <b>Result:</b> Increase	<b>2013 Work RVU:</b> 1.75 <b>2013 NF PE RVU:</b> 0.83 <b>2013 Fac PE RVU:</b> 0.71
<b>RUC Recommendation:</b> 1.75	<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	February 2011	<b>Published in CPT Asst:</b>		
<b>92606</b>	<b>Therapeutic service(s) for the use of non-speech-generating device, including programming and modification</b>	<b>Global:</b> XXX	<b>Issue:</b> Speech Language Pathology Services	<b>Screen:</b> CMS Request/Speech Language Pathology Request	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2010	<b>Tab</b> 28 <b>Specialty Developing Recommendation:</b> ASHA	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> 0.00 <b>2007 NF PE RVU:</b> 0 <b>2007 Fac PE RVU:</b> 0 <b>Result:</b> Decrease	<b>2013 Work RVU:</b> 1.40 <b>2013 NF PE RVU:</b> 0.93 <b>2013 Fac PE RVU:</b> 0.57
<b>RUC Recommendation:</b> 1.40 work RVU and clinical staff time removed	<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>		
<b>92607</b>	<b>Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour</b>	<b>Global:</b> XXX	<b>Issue:</b> Speech Language Pathology Services	<b>Screen:</b> CMS Request/Speech Language Pathology Request	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2010	<b>Tab</b> 28 <b>Specialty Developing Recommendation:</b> ASHA	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 249	<b>2007 Work RVU:</b> 0.00 <b>2007 NF PE RVU:</b> 3.38 <b>2007 Fac PE RVU:</b> NA <b>Result:</b> Decrease	<b>2013 Work RVU:</b> 1.85 <b>2013 NF PE RVU:</b> 1.56 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 1.85 work RVU and clinical staff time removed	<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>		

## Status Report: CMS Requests and Relativity Assessment Issues

**92608** Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

**Most Recent RUC Meeting:** February 2010

**Tab 28 Specialty Developing Recommendation:** ASHA

**First Identified:**

**2012 Est Medicare Utilization:** 107

**2007 Work RVU:** 0.00

**2013 Work RVU:** 0.70

**2007 NF PE RVU:** 0.63

**2013 NF PE RVU:** 0.67

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Decrease

**RUC Recommendation:** 0.70 work RVU and clinical staff time removed

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**92609** Therapeutic services for the use of speech-generating device, including programming and modification

**Global:** XXX

**Issue:** Speech Language Pathology Services

**Screen:** CMS Request/Speech Language Pathology Request

**Complete?** Yes

**Most Recent RUC Meeting:** February 2010

**Tab 28 Specialty Developing Recommendation:** ASHA

**First Identified:**

**2012 Est Medicare Utilization:** 3,477

**2007 Work RVU:** 0.00

**2013 Work RVU:** 1.50

**2007 NF PE RVU:** 1.77

**2013 NF PE RVU:** 1.32

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Decrease

**RUC Recommendation:** 1.50 work RVU and clinical staff time removed

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**92610** Evaluation of oral and pharyngeal swallowing function

**Global:** XXX

**Issue:** Speech Language Pathology Services (RUC)

**Screen:** CMS Request/Speech Language Pathology Request / High Volume Growth2

**Complete?** No

**Most Recent RUC Meeting:** February 2009

**Tab 30 Specialty Developing Recommendation:** ASHA, AAO-HNS

**First Identified:** NA

**2012 Est Medicare Utilization:** 9,879

**2007 Work RVU:** 0.00

**2013 Work RVU:** 1.30

**2007 NF PE RVU:** 2.98

**2013 NF PE RVU:** 0.92

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** 0.60

**Result:** Decrease

**RUC Recommendation:** Review action plan. 1.30 work RVU and clinical staff time removed

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording			Global: XXX	Issue: Speech Language Pathology Services (HCPAC)	Screen: CMS Request/Speech Language Pathology Request	Complete?	Yes
Most Recent RUC Meeting:	April 2009	Tab 39	Specialty Developing Recommendation: ASHA	First Identified: NA	2012 Est Medicare Utilization: 8,661	2007 Work RVU: 0.00 2007 NF PE RVU: 3.04 2007 Fac PE RVU: NA Result: Decrease	2013 Work RVU: 1.34 2013 NF PE RVU: 1.15 2013 Fac PE RVU: NA	
RUC Recommendation: 1.34 work RVU and clinical staff time removed				CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:		
92618	Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)			Global: ZZZ	Issue: Eval of Rx for Non-Speech Generating Device	Screen: CMS Request/Speech Language Pathology Request	Complete?	Yes
Most Recent RUC Meeting:	April 2011	Tab 35	Specialty Developing Recommendation: ASHA	First Identified:	2012 Est Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Increase	2013 Work RVU: 0.65 2013 NF PE RVU: 0.28 2013 Fac PE RVU: 0.26	
RUC Recommendation: 0.65				CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:		
92620	Evaluation of central auditory function, with report; initial 60 minutes			Global: XXX	Issue: Audiology Services	Screen: CMS Request - Audiology Services	Complete?	Yes
Most Recent RUC Meeting:	October 2008	Tab 17	Specialty Developing Recommendation: ASHA, AAO-HNS	First Identified: NA	2012 Est Medicare Utilization: 1,077	2007 Work RVU: 0.00 2007 NF PE RVU: 1.32 2007 Fac PE RVU: NA Result: Decrease	2013 Work RVU: 1.50 2013 NF PE RVU: 1.15 2013 Fac PE RVU: 0.85	
RUC Recommendation: 1.50				CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:		

## Status Report: CMS Requests and Relativity Assessment Issues

---

<b>92621</b>	<b>Evaluation of central auditory function, with report; each additional 15 minutes</b> (List separately in addition to code for primary procedure)	<b>Global:</b> ZZZ	<b>Issue:</b> Audiology Services	<b>Screen:</b> CMS Request - Audiology Services	<b>Complete?</b> Yes
--------------	--	--------------------	----------------------------------	---	----------------------

**Most Recent RUC Meeting:** October 2008

**Tab** 17

**Specialty Developing Recommendation:**

ASHA, AAO-HNS

**First Identified:** NA

**2012 Est Medicare Utilization:** 24

**2007 Work RVU:** 0.00

**2013 Work RVU:** 0.35

**2007 NF PE RVU:** 0.29

**2013 NF PE RVU:** 0.29

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** 0.19

**Result:** Decrease

**RUC Recommendation:** 0.35

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

---

<b>92625</b>	<b>Assessment of tinnitus (includes pitch, loudness matching, and masking)</b>	<b>Global:</b> XXX	<b>Issue:</b> Audiology Services	<b>Screen:</b> CMS Request - Audiology Services	<b>Complete?</b> Yes
--------------	--	--------------------	----------------------------------	---	----------------------

**Most Recent RUC Meeting:** October 2008

**Tab** 17

**Specialty Developing Recommendation:**

ASHA, AAO-HNS

**First Identified:** NA

**2012 Est Medicare Utilization:** 5,751

**2007 Work RVU:** 0.00

**2013 Work RVU:** 1.15

**2007 NF PE RVU:** 1.3

**2013 NF PE RVU:** 0.82

**2007 Fac PE RVU** 1.30

**2013 Fac PE RVU:** 0.60

**Result:** Decrease

**RUC Recommendation:** 1.15

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

---

<b>92626</b>	<b>Evaluation of auditory rehabilitation status; first hour</b>	<b>Global:</b> XXX	<b>Issue:</b> Audiology Services	<b>Screen:</b> CMS Request - Audiology Services / High Volume Growth2	<b>Complete?</b> No
--------------	---	--------------------	----------------------------------	---	---------------------

**Most Recent RUC Meeting:** October 2008

**Tab** 17

**Specialty Developing Recommendation:**

ASHA, AAO-HNS

**First Identified:** NA

**2012 Est Medicare Utilization:** 17,394

**2007 Work RVU:** 0.00

**2013 Work RVU:** 1.40

**2007 NF PE RVU:** 2.11

**2013 NF PE RVU:** 1.16

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** 0.75

**Result:** Decrease

**RUC Recommendation:** Review action plan. 1.40

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

# Status Report: CMS Requests and Relativity Assessment Issues

**92627** Evaluation of auditory rehabilitation status; each additional 15 minutes (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services **Complete?** Yes

**Most Recent RUC Meeting:** October 2008

**Tab** 17

**Specialty Developing Recommendation:**

ASHA, AAO-HNS

**First Identified:** NA

**2012 Est Medicare Utilization:** 1,633

**2007 Work RVU:** 0.00

**2013 Work RVU:** 0.33

**2007 NF PE RVU:** 0.52

**2013 NF PE RVU:** 0.29

**2007 Fac PE RVU** 0.52

**2013 Fac PE RVU:** 0.17

**Result:** Decrease

**RUC Recommendation:** 0.33

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**92640** Diagnostic analysis with programming of auditory brainstem implant, per hour **Global:** XXX **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services **Complete?** Yes

**Most Recent RUC Meeting:** October 2008

**Tab** 17

**Specialty Developing Recommendation:**

ASHA, AAO-HNS

**First Identified:** NA

**2012 Est Medicare Utilization:** 39

**2007 Work RVU:** 0.00

**2013 Work RVU:** 1.76

**2007 NF PE RVU:** 1.4

**2013 NF PE RVU:** 1.49

**2007 Fac PE RVU** 1.40

**2013 Fac PE RVU:** 0.95

**Result:** Decrease

**RUC Recommendation:** 1.76

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**92920** Percutaneous transluminal coronary angioplasty; single major coronary artery or branch **Global:** 000 **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

**Most Recent RUC Meeting:** January 2012

**Tab** 10

**Specialty Developing Recommendation:**

ACC

**First Identified:** October 2010

**2012 Est Medicare Utilization:**

**2007 Work RVU:**

**2013 Work RVU:** 10.10

**2007 NF PE RVU:**

**2013 NF PE RVU:** NA

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 3.70

**Result:** Decrease

**RUC Recommendation:** 9.00

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**92921** Percutaneous transluminal coronary angioplasty; each additional branch of a major coronary artery (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

**Most Recent RUC Meeting:** January 2012

**Tab** 10

**Specialty Developing Recommendation:**

ACC

**First Identified:** October 2010

**2012 Est Medicare Utilization:**

**2007 Work RVU:**

**2013 Work RVU:** 0.00

**2007 NF PE RVU:**

**2013 NF PE RVU:** 0.00

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 0.00

**Result:** Decrease

**RUC Recommendation:** 4.00

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**



## Status Report: CMS Requests and Relativity Assessment Issues

---

<b>92924</b>	<b>Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch</b>	<b>Global:</b> 000	<b>Issue:</b> Percutaneous Coronary Intervention	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2012	<b>Tab</b> 10 <b>Specialty Developing Recommendation:</b> ACC	<b>First Identified:</b> October 2010	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease	<b>2013 Work RVU:</b> 11.99 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 4.41
<b>RUC Recommendation:</b> 11.00		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	October 2011 <b>Published in CPT Asst:</b>		

---

<b>92925</b>	<b>Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)</b>	<b>Global:</b> ZZZ	<b>Issue:</b> Percutaneous Coronary Intervention	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2012	<b>Tab</b> 10 <b>Specialty Developing Recommendation:</b> ACC	<b>First Identified:</b> October 2010	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease	<b>2013 Work RVU:</b> 0.00 <b>2013 NF PE RVU:</b> 0.00 <b>2013 Fac PE RVU:</b> 0.00
<b>RUC Recommendation:</b> 5.00		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	October 2011 <b>Published in CPT Asst:</b>		

---

<b>92928</b>	<b>Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch</b>	<b>Global:</b> 000	<b>Issue:</b> Percutaneous Coronary Intervention	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2012	<b>Tab</b> 10 <b>Specialty Developing Recommendation:</b> ACC	<b>First Identified:</b> October 2010	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease	<b>2013 Work RVU:</b> 11.21 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 4.10
<b>RUC Recommendation:</b> 10.49		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	October 2011 <b>Published in CPT Asst:</b>		

---

## Status Report: CMS Requests and Relativity Assessment Issues

**92929** Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

**Most Recent RUC Meeting:** January 2012

**Tab 10 Specialty Developing Recommendation:** ACC

**First Identified:** October 2010

**2012 Est Medicare Utilization:**

**2007 Work RVU:**  
**2007 NF PE RVU:**  
**2007 Fac PE RVU Result:** Decrease

**2013 Work RVU:** 0.00  
**2013 NF PE RVU:** 0.00  
**2013 Fac PE RVU:** 0.00

**RUC Recommendation:** 4.44

**CPT Action (if applicable):** October 2011  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**92933** Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch **Global:** 000 **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

**Most Recent RUC Meeting:** January 2012

**Tab 10 Specialty Developing Recommendation:** ACC

**First Identified:** October 2010

**2012 Est Medicare Utilization:**

**2007 Work RVU:**  
**2007 NF PE RVU:**  
**2007 Fac PE RVU Result:** Decrease

**2013 Work RVU:** 12.54  
**2013 NF PE RVU:** NA  
**2013 Fac PE RVU:** 4.58

**RUC Recommendation:** 12.32

**CPT Action (if applicable):** October 2011  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**92934** Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

**Most Recent RUC Meeting:** January 2012

**Tab 10 Specialty Developing Recommendation:** ACC

**First Identified:** October 2010

**2012 Est Medicare Utilization:**

**2007 Work RVU:**  
**2007 NF PE RVU:**  
**2007 Fac PE RVU Result:** Decrease

**2013 Work RVU:** 0.00  
**2013 NF PE RVU:** 0.00  
**2013 Fac PE RVU:** 0.00

**RUC Recommendation:** 5.50

**CPT Action (if applicable):** October 2011  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

<b>92937</b>	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel	<b>Global:</b> 000	<b>Issue:</b> Percutaneous Coronary Intervention	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2012	<b>Tab</b> 10 <b>Specialty Developing Recommendation:</b> ACC	<b>First Identified:</b> October 2010	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease	<b>2013 Work RVU:</b> 11.20 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 4.09
<b>RUC Recommendation:</b> 10.49		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	October 2011 <b>Published in CPT Asst:</b>		
<b>92938</b>	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft (List separately in addition to code for primary procedure)	<b>Global:</b> ZZZ	<b>Issue:</b> Percutaneous Coronary Intervention	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2012	<b>Tab</b> 10 <b>Specialty Developing Recommendation:</b> ACC	<b>First Identified:</b> October 2010	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease	<b>2013 Work RVU:</b> 0.00 <b>2013 NF PE RVU:</b> 0.00 <b>2013 Fac PE RVU:</b> 0.00
<b>RUC Recommendation:</b> 6.00		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	October 2011 <b>Published in CPT Asst:</b>		
<b>92941</b>	Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel	<b>Global:</b> 000	<b>Issue:</b> Percutaneous Coronary Intervention	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2012	<b>Tab</b> 10 <b>Specialty Developing Recommendation:</b> ACC	<b>First Identified:</b> October 2010	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease	<b>2013 Work RVU:</b> 12.56 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 4.59
<b>RUC Recommendation:</b> 12.32		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	October 2011 <b>Published in CPT Asst:</b>		

## Status Report: CMS Requests and Relativity Assessment Issues

<b>92943</b>	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel	<b>Global:</b> 000	<b>Issue:</b> Percutaneous Coronary Intervention	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2012	<b>Tab</b> 10 <b>Specialty Developing Recommendation:</b> ACC	<b>First Identified:</b> October 2010	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease	<b>2013 Work RVU:</b> 12.56 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 4.59
<b>RUC Recommendation:</b> 12.32		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	October 2011 <b>Published in CPT Asst:</b>		
<hr/>					
<b>92944</b>	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (List separately in addition to code for primary procedure)	<b>Global:</b> ZZZ	<b>Issue:</b> Percutaneous Coronary Intervention	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2012	<b>Tab</b> 10 <b>Specialty Developing Recommendation:</b> ACC	<b>First Identified:</b> October 2010	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease	<b>2013 Work RVU:</b> 0.00 <b>2013 NF PE RVU:</b> 0.00 <b>2013 Fac PE RVU:</b> 0.00
<b>RUC Recommendation:</b> 6.00		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	October 2011 <b>Published in CPT Asst:</b>		
<hr/>					
<b>92960</b>	Cardioversion, elective, electrical conversion of arrhythmia; external	<b>Global:</b> 000	<b>Issue:</b> Cardioversion	<b>Screen:</b> Harvard Valued - Utilization over 100,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2010	<b>Tab</b> 19 <b>Specialty Developing Recommendation:</b> ACC	<b>First Identified:</b> October 2009	<b>2012 Est Medicare Utilization:</b> 144,062	<b>2007 Work RVU:</b> 2.25 <b>2007 NF PE RVU:</b> 5.83 <b>2007 Fac PE RVU Result:</b> Maintain	<b>2013 Work RVU:</b> 2.25 <b>2013 NF PE RVU:</b> 3.65 <b>2013 Fac PE RVU:</b> 1.13
<b>RUC Recommendation:</b> 2.25		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

## Status Report: CMS Requests and Relativity Assessment Issues

**92973** Percutaneous transluminal coronary thrombectomy mechanical (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** No

<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> April 2013	<b>2012 Est Medicare Utilization:</b> 13,472	<b>2007 Work RVU:</b> 3.28 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 1.42 <b>Result:</b>	<b>2013 Work RVU:</b> 3.28 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 1.20
<b>RUC Recommendation:</b> Review Action Plan			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	

**92980** Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel **Global:** 000 **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

<b>Most Recent RUC Meeting:</b> January 2012	<b>Tab</b> 10	<b>Specialty Developing Recommendation:</b> ACC	<b>First Identified:</b> October 2010	<b>2012 Est Medicare Utilization:</b> 296,361	<b>2007 Work RVU:</b> 14.82 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 6.65 <b>Result:</b> Deleted from CPT	<b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>
<b>RUC Recommendation:</b> Deleted from CPT			<b>CPT Action (if applicable):</b> October 2011 <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	

**92981** Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

<b>Most Recent RUC Meeting:</b> January 2012	<b>Tab</b> 10	<b>Specialty Developing Recommendation:</b> ACC	<b>First Identified:</b> October 2010	<b>2012 Est Medicare Utilization:</b> 33,319	<b>2007 Work RVU:</b> 4.16 <b>2007 NF PE RVU:</b> NA <b>2007 Fac PE RVU:</b> 1.80 <b>Result:</b> Deleted from CPT	<b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>
<b>RUC Recommendation:</b> Deleted from CPT			<b>CPT Action (if applicable):</b> October 2011 <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	

## Status Report: CMS Requests and Relativity Assessment Issues

**92982** Percutaneous transluminal coronary balloon angioplasty; single vessel      **Global:** 000      **Issue:** Percutaneous Coronary Intervention      **Screen:** MPC List / Harvard-Valued Annual Allowed Charges Greater than \$10 million      **Complete?** Yes

**Most Recent**      **Tab** 10      **Specialty Developing**      ACC  
**RUC Meeting:** January 2012      **Recommendation:**

**First Identified:** October 2010

**2012 Est Medicare Utilization:** 24,340

**2007 Work RVU:** 10.96

**2013 Work RVU:**

**2007 NF PE RVU:** NA

**2013 NF PE RVU:**

**2007 Fac PE RVU** 4.97

**2013 Fac PE RVU:**

**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2011  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

**92984** Percutaneous transluminal coronary balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)

**Global:** ZZZ

**Issue:** Percutaneous Coronary Intervention

**Screen:** MPC List

**Complete?** Yes

**Most Recent**      **Tab** 10      **Specialty Developing**      ACC  
**RUC Meeting:** January 2012      **Recommendation:**

**First Identified:** October 2010

**2012 Est Medicare Utilization:** 5,967

**2007 Work RVU:** 2.97

**2013 Work RVU:**

**2007 NF PE RVU:** NA

**2013 NF PE RVU:**

**2007 Fac PE RVU** 1.28

**2013 Fac PE RVU:**

**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2011  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

**92986** Percutaneous balloon valvuloplasty; aortic valve

**Global:** 090

**Issue:** Valvuloplasty

**Screen:** CMS Fastest Growing

**Complete?** Yes

**Most Recent**      **Tab** 26      **Specialty Developing**      ACC  
**RUC Meeting:** October 2008      **Recommendation:**

**First Identified:** October 2008

**2012 Est Medicare Utilization:** 3,467

**2007 Work RVU:** 22.70

**2013 Work RVU:** 22.85

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU** 12.84

**2013 Fac PE RVU:** 11.50

**Result:** Remove from Screen

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

---

<b>92995</b>	<b>Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; single vessel</b>	<b>Global:</b> 000	<b>Issue:</b> Percutaneous Coronary Intervention	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
--------------	--	--------------------	--	-------------------------	----------------------

<b>Most Recent RUC Meeting:</b> January 2012	<b>Tab</b> 10	<b>Specialty Developing Recommendation:</b> ACC
--	---------------	---

<b>First Identified:</b> October 2010
---------------------------------------

<b>2012 Est Medicare Utilization:</b> 828
---

<b>2007 Work RVU:</b> 12.07
-----------------------------

<b>2013 Work RVU:</b>
-----------------------

<b>2007 NF PE RVU:</b> NA
---------------------------

<b>2013 NF PE RVU:</b>
------------------------

<b>2007 Fac PE RVU</b> 5.45
-----------------------------

<b>2013 Fac PE RVU:</b>
-------------------------

<b>RUC Recommendation:</b> Deleted from CPT
---

<b>CPT Action (if applicable):</b> October 2011	
<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>

<b>Result:</b> Deleted from CPT
---------------------------------

---

<b>92996</b>	<b>Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)</b>	<b>Global:</b> ZZZ	<b>Issue:</b> Percutaneous Coronary Intervention	<b>Screen:</b> MPC List	<b>Complete?</b> Yes
--------------	---	--------------------	--	-------------------------	----------------------

<b>Most Recent RUC Meeting:</b> January 2012	<b>Tab</b> 10	<b>Specialty Developing Recommendation:</b> ACC
--	---------------	---

<b>First Identified:</b> October 2010
---------------------------------------

<b>2012 Est Medicare Utilization:</b> 209
---

<b>2007 Work RVU:</b> 3.26
----------------------------

<b>2013 Work RVU:</b>
-----------------------

<b>2007 NF PE RVU:</b> NA
---------------------------

<b>2013 NF PE RVU:</b>
------------------------

<b>2007 Fac PE RVU</b> 1.41
-----------------------------

<b>2013 Fac PE RVU:</b>
-------------------------

<b>RUC Recommendation:</b> Deleted from CPT
---

<b>CPT Action (if applicable):</b> October 2011	
<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>

<b>Result:</b> Deleted from CPT
---------------------------------

---

<b>93000</b>	<b>Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report</b>	<b>Global:</b> XXX	<b>Issue:</b> Electrocardiogram	<b>Screen:</b> CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
--------------	--	--------------------	---------------------------------	--	----------------------

<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b> 20	<b>Specialty Developing Recommendation:</b> AAFP, ACC, ACP
--	---------------	--

<b>First Identified:</b> September 2011
---

<b>2012 Est Medicare Utilization:</b> 12,010,156
--

<b>2007 Work RVU:</b> 0.17
----------------------------

<b>2013 Work RVU:</b> 0.17
----------------------------

<b>2007 NF PE RVU:</b> 0.47
-----------------------------

<b>2013 NF PE RVU:</b> 0.35
-----------------------------

<b>2007 Fac PE RVU</b> NA
---------------------------

<b>2013 Fac PE RVU:</b> NA
----------------------------

<b>RUC Recommendation:</b> 0.17
---------------------------------

<b>CPT Action (if applicable):</b>	
<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>

<b>Result:</b> Maintain
-------------------------

## Status Report: CMS Requests and Relativity Assessment Issues

**93005** Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report      **Global:** XXX      **Issue:** Electrocardiogram      **Screen:** High Volume Growth1 / CMS High Expenditure Procedural Codes      **Complete?** Yes

**Most Recent RUC Meeting:** October 2012

**Tab** 20

**Specialty Developing Recommendation:** AAFP, ACC, ACP

**First Identified:** February 2008

**2012 Est Medicare Utilization:** 574,659

**2007 Work RVU:** 0.00

**2013 Work RVU:** 0.00

**2007 NF PE RVU:** 0.41

**2013 NF PE RVU:** 0.29

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** PE Only

**RUC Recommendation:** 0.00

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**93010** Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only      **Global:** XXX      **Issue:** Electrocardiogram      **Screen:** MPC List / CMS High Expenditure Procedural Codes      **Complete?** Yes

**Most Recent RUC Meeting:** October 2012

**Tab** 20

**Specialty Developing Recommendation:** AAFP, ACC, ACP

**First Identified:** October 2010

**2012 Est Medicare Utilization:** 19,050,227

**2007 Work RVU:** 0.17

**2013 Work RVU:** 0.17

**2007 NF PE RVU:** 0.06

**2013 NF PE RVU:** 0.06

**2007 Fac PE RVU** 0.06

**2013 Fac PE RVU:** 0.06

**Result:** Maintain

**RUC Recommendation:** 0.17

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**93012** Deleted from CPT      **Global:** XXX      **Issue:** External Cardiovascular Device Monitoring      **Screen:** Harvard Valued - Utilization over 100,000      **Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab** 25

**Specialty Developing Recommendation:** ACC

**First Identified:**

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 0.00

**2013 Work RVU:**

**2007 NF PE RVU:** 5.55

**2013 NF PE RVU:**

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:**

**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**



## Status Report: CMS Requests and Relativity Assessment Issues

<b>93014</b>	Deleted from CPT			<b>Global:</b> XXX	<b>Issue:</b> External Cardiovascular Device Monitoring	<b>Screen:</b> Harvard Valued - Utilization over 100,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b>	April 2010	<b>Tab</b> 25	<b>Specialty Developing Recommendation:</b>	ACC	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> 0.52 <b>2007 NF PE RVU:</b> 0.2 <b>2007 Fac PE RVU:</b> 0.20 <b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>
<b>RUC Recommendation:</b>	Deleted from CPT				<b>CPT Action (if applicable):</b> February 2010	<b>Result:</b> Deleted from CPT	
				<b>Referred to CPT Asst</b>	<input type="checkbox"/>	<b>Published in CPT Asst:</b>	
<hr/>							
<b>93015</b>	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report			<b>Global:</b> XXX	<b>Issue:</b> Cardiovascular Stress Tests	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b>	April 2012	<b>Tab</b> 47	<b>Specialty Developing Recommendation:</b>	ACC	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 1,358,474	<b>2007 Work RVU:</b> 0.75 <b>2007 NF PE RVU:</b> 1.95 <b>2007 Fac PE RVU:</b> NA <b>2013 Work RVU:</b> 0.75 <b>2013 NF PE RVU:</b> 1.56 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b>	0.75. CPT Assistant published.				<b>CPT Action (if applicable):</b> October 2010	<b>Result:</b> Maintain	
				<b>Referred to CPT Asst</b>	<input checked="" type="checkbox"/>	<b>Published in CPT Asst:</b>	Jan 2010
<hr/>							
<b>93016</b>	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; supervision only, without interpretation and report			<b>Global:</b> XXX	<b>Issue:</b> Cardiovascular Stress Tests	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b>	April 2012	<b>Tab</b> 47	<b>Specialty Developing Recommendation:</b>	ACC	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 1,182,339	<b>2007 Work RVU:</b> 0.45 <b>2007 NF PE RVU:</b> 0.19 <b>2007 Fac PE RVU:</b> 0.19 <b>2013 Work RVU:</b> 0.45 <b>2013 NF PE RVU:</b> 0.17 <b>2013 Fac PE RVU:</b> 0.17
<b>RUC Recommendation:</b>	0.45				<b>CPT Action (if applicable):</b>	<b>Result:</b> Maintain	
				<b>Referred to CPT Asst</b>	<input type="checkbox"/>	<b>Published in CPT Asst:</b>	

## Status Report: CMS Requests and Relativity Assessment Issues

**93017** Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; tracing only, without interpretation and report **Global:** XXX **Issue:** Cardiovascular Stress Tests **Screen:** High Volume Growth1 / CMS Request - Practice Expense Review / Codes Reported Together 75% or More-Part1 **Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab** 45 **Specialty Developing Recommendation:** ACC

**First Identified:** February 2008

**2012 Est Medicare Utilization:** 128,500

**2007 Work RVU:** 0.00

**2013 Work RVU:** 0.00

**2007 NF PE RVU:** 1.64

**2013 NF PE RVU:** 1.28

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** PE Only

**RUC Recommendation:** New PE inputs

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**93018** Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only **Global:** XXX **Issue:** Cardiovascular Stress Tests and Echocardiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

**Most Recent RUC Meeting:** April 2012

**Tab** 47 **Specialty Developing Recommendation:** ACC

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 1,364,923

**2007 Work RVU:** 0.30

**2013 Work RVU:** 0.30

**2007 NF PE RVU:** 0.12

**2013 NF PE RVU:** 0.11

**2007 Fac PE RVU** 0.12

**2013 Fac PE RVU:** 0.11

**Result:** Maintain

**RUC Recommendation:** 0.30

**CPT Action (if applicable):** October 2010

**Referred to CPT Asst** ☒

**Published in CPT Asst:** Jan 2010

**93025** Microvolt T-wave alternans for assessment of ventricular arrhythmias **Global:** XXX **Issue:** Microvolt T-Wave Assessment **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

**Most Recent RUC Meeting:** October 2008

**Tab** 18 **Specialty Developing Recommendation:** ACC

**First Identified:** NA

**2012 Est Medicare Utilization:** 3,026

**2007 Work RVU:** 0.75

**2013 Work RVU:** 0.75

**2007 NF PE RVU:** 6.67

**2013 NF PE RVU:** 4.24

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** PE Only

**RUC Recommendation:** New PE Inputs

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

# Status Report: CMS Requests and Relativity Assessment Issues

**93040** Rhythm ECG, 1-3 leads; with interpretation and report **Global:** XXX **Issue:** Rhythm EKG **Screen:** Top 9 Harvard **Complete?** Yes

**Most Recent** **Tab** 34 **Specialty Developing** ACC **First** **2012 Est** **2007 Work RVU:** 0.16 **2013 Work RVU:** 0.15  
**RUC Meeting:** October 2009 **Recommendation:** **Identified:** February 2009 **Medicare** **2007 NF PE RVU:** 0.2 **2013 NF PE RVU:** 0.22  
**2007 Fac PE RVU** NA **2013 Fac PE RVU:** NA  
**RUC Recommendation:** 0.15 **CPT Action (if applicable):** **Result:** Decrease  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**93041** Rhythm ECG, 1-3 leads; tracing only without interpretation and report **Global:** XXX **Issue:** Rhythm EKG **Screen:** Top 9 Harvard **Complete?** Yes

**Most Recent** **Tab** 34 **Specialty Developing** ACC **First** **2012 Est** **2007 Work RVU:** 0.00 **2013 Work RVU:** 0.00  
**RUC Meeting:** October 2009 **Recommendation:** **Identified:** February 2009 **Medicare** **2007 NF PE RVU:** 0.15 **2013 NF PE RVU:** 0.17  
**2007 Fac PE RVU** NA **2013 Fac PE RVU:** NA  
**RUC Recommendation:** 0.00 (PE only) **CPT Action (if applicable):** **Result:** Maintain  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**93042** Rhythm ECG, 1-3 leads; interpretation and report only **Global:** XXX **Issue:** Rhythm EKG **Screen:** Top 9 Harvard **Complete?** Yes

**Most Recent** **Tab** 34 **Specialty Developing** ACC, ACEP **First** **2012 Est** **2007 Work RVU:** 0.16 **2013 Work RVU:** 0.15  
**RUC Meeting:** October 2009 **Recommendation:** **Identified:** October 2008 **Medicare** **2007 NF PE RVU:** 0.05 **2013 NF PE RVU:** 0.05  
**2007 Fac PE RVU** 0.05 **2013 Fac PE RVU:** 0.05  
**RUC Recommendation:** 0.15 **CPT Action (if applicable):** **Result:** Decrease  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**93224** External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation by a physician or other qualified health care professional **Global:** XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent** **Tab** 25 **Specialty Developing** ACC **First** **2012 Est** **2007 Work RVU:** 0.52 **2013 Work RVU:** 0.52  
**RUC Meeting:** April 2010 **Recommendation:** **Identified:** October 2009 **Medicare** **2007 NF PE RVU:** 3.29 **2013 NF PE RVU:** 2.21  
**2007 Fac PE RVU** NA **2013 Fac PE RVU:** NA  
**RUC Recommendation:** 0.52 **CPT Action (if applicable):** February 2010 **Result:** Maintain  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**93225** External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; recording (includes connection, recording, and disconnection) **Global:** XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** April 2010 **Tab** 25 **Specialty Developing Recommendation:** ACC **First Identified:** **2012 Est Medicare Utilization:** 129,885 **2007 Work RVU:** 0.00 **2013 Work RVU:** 0.00 **2007 NF PE RVU:** 1.2 **2013 NF PE RVU:** 0.82 **2007 Fac PE RVU:** NA **2013 Fac PE RVU:** NA **RUC Recommendation:** N/A no physician work **CPT Action (if applicable):** February 2010 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Maintain

**93226** External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; scanning analysis with report **Global:** XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** April 2010 **Tab** 25 **Specialty Developing Recommendation:** ACC **First Identified:** **2012 Est Medicare Utilization:** 148,574 **2007 Work RVU:** 0.00 **2013 Work RVU:** 0.00 **2007 NF PE RVU:** 1.88 **2013 NF PE RVU:** 1.16 **2007 Fac PE RVU:** NA **2013 Fac PE RVU:** NA **RUC Recommendation:** N/A no physician work **CPT Action (if applicable):** February 2010 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Maintain

**93227** External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; review and interpretation by a physician or other qualified health care professional **Global:** XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** April 2010 **Tab** 25 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2012 Est Medicare Utilization:** 389,172 **2007 Work RVU:** 0.52 **2013 Work RVU:** 0.52 **2007 NF PE RVU:** 0.21 **2013 NF PE RVU:** 0.23 **2007 Fac PE RVU:** 0.21 **2013 Fac PE RVU:** 0.23 **RUC Recommendation:** 0.52 **CPT Action (if applicable):** February 2010 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Maintain

## Status Report: CMS Requests and Relativity Assessment Issues

**93228** External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional

**Global:** XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab 25 Specialty Developing Recommendation:** ACC

**First Identified:**

**2012 Est Medicare Utilization:** 61,709

**2007 Work RVU:**

**2013 Work RVU:** 0.52

**2007 NF PE RVU:**

**2013 NF PE RVU:** 0.19

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 0.19

**Result:** Maintain

**RUC Recommendation:** 0.52

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**93229** External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional

**Global:** XXX

**Issue:** External Cardiovascular Device Monitoring

**Screen:** Harvard Valued - Utilization over 100,000

**Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab 25 Specialty Developing Recommendation:** ACC

**First Identified:**

**2012 Est Medicare Utilization:** 98,646

**2007 Work RVU:**

**2013 Work RVU:** 0.00

**2007 NF PE RVU:**

**2013 NF PE RVU:** 21.62

**2007 Fac PE RVU**

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** Contractor Priced

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**93230** Deleted from CPT

**Global:** XXX

**Issue:** Cardiac Device Monitoring

**Screen:** CMS Request - 2009 Final Rule, Harvard Valued - Utilization over 100,000

**Complete?** Yes

**Most Recent RUC Meeting:** April 2009

**Tab 31 Specialty Developing Recommendation:** ACC

**First Identified:** NA

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 0.52

**2013 Work RVU:**

**2007 NF PE RVU:** 3.49

**2013 NF PE RVU:**

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:**

**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

February 2010

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**93231 Deleted from CPT**

**Global:** XXX

**Issue:** External Cardiovascular  
Device Monitoring

**Screen:** Harvard Valued -  
Utilization over 100,000

**Complete?** Yes

**Most Recent  
RUC Meeting:** April 2010

**Tab** 25

**Specialty Developing  
Recommendation:**

**First  
Identified:**

**2012 Est  
Medicare  
Utilization:**

**2007 Work RVU:** 0.00

**2013 Work RVU:**

**2007 NF PE RVU:** 1.37

**2013 NF PE RVU:**

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** February 2010

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**93232 Deleted from CPT**

**Global:** XXX

**Issue:** External Cardiovascular  
Device Monitoring

**Screen:** Harvard Valued -  
Utilization over 100,000

**Complete?** Yes

**Most Recent  
RUC Meeting:** April 2010

**Tab** 25

**Specialty Developing  
Recommendation:**

**First  
Identified:**

**2012 Est  
Medicare  
Utilization:**

**2007 Work RVU:** 0.00

**2013 Work RVU:**

**2007 NF PE RVU:** 1.92

**2013 NF PE RVU:**

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** February 2010

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**93233 Deleted from CPT**

**Global:** XXX

**Issue:** Cardiac Device Monitoring

**Screen:** CMS Request - 2009  
Final Rule, Harvard  
Valued - Utilization over  
100,000

**Complete?** Yes

**Most Recent  
RUC Meeting:** April 2009

**Tab** 31

**Specialty Developing  
Recommendation:** ACC

**First  
Identified:** NA

**2012 Est  
Medicare  
Utilization:**

**2007 Work RVU:** 0.52

**2013 Work RVU:**

**2007 NF PE RVU:** 0.2

**2013 NF PE RVU:**

**2007 Fac PE RVU** 0.20

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** February 2010

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**93235 Deleted from CPT**

**Global:** XXX

**Issue:** External Cardiovascular  
Device Monitoring

**Screen:** Harvard Valued -  
Utilization over 100,000

**Complete?** Yes

**Most Recent  
RUC Meeting:** April 2010

**Tab** 25

**Specialty Developing  
Recommendation:**

**First  
Identified:**

**2012 Est  
Medicare  
Utilization:**

**2007 Work RVU:** 0.00

**2013 Work RVU:**

**2007 NF PE RVU:** 0

**2013 NF PE RVU:**

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** February 2010

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**93236 Deleted from CPT**

**Global:** XXX

**Issue:** Cardiovascular Stress Test

**Screen:** Harvard Valued -  
Utilization over 100,000

**Complete?** Yes

**Most Recent  
RUC Meeting:** April 2009

**Tab** 38

**Specialty Developing  
Recommendation:** ACC

**First  
Identified:** February 2008

**2012 Est  
Medicare  
Utilization:**

**2007 Work RVU:** 0.00

**2013 Work RVU:**

**2007 NF PE RVU:** 0

**2013 NF PE RVU:**

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** February 2010

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**93237 Deleted from CPT**

**Global:** XXX

**Issue:** Wearable Cardiac Device  
Monitoring

**Screen:** Harvard Valued -  
Utilization over 100,000

**Complete?** Yes

**Most Recent  
RUC Meeting:** February 2010

**Tab** 31

**Specialty Developing  
Recommendation:** ACC

**First  
Identified:** October 2009

**2012 Est  
Medicare  
Utilization:**

**2007 Work RVU:** 0.45

**2013 Work RVU:**

**2007 NF PE RVU:** 0.18

**2013 NF PE RVU:**

**2007 Fac PE RVU** 0.18

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** February 2010

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**93268** External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; includes transmission, review and interpretation by a physician or other qualified health care professional **Global:** XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent**  
**RUC Meeting:** April 2010

**Tab** 25 **Specialty Developing** ACC  
**Recommendation:**

**First**  
**Identified:**

**2012 Est**  
**Medicare**  
**Utilization:** 21,384

**2007 Work RVU:** 0.52

**2013 Work RVU:** 0.52

**2007 NF PE RVU:** 7.02

**2013 NF PE RVU:** 5.95

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** 0.52

**CPT Action (if applicable):** February 2010

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**93270** External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; recording (includes connection, recording, and disconnection) **Global:** XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent**  
**RUC Meeting:** April 2010

**Tab** 25 **Specialty Developing** ACC  
**Recommendation:**

**First**  
**Identified:**

**2012 Est**  
**Medicare**  
**Utilization:** 52,507

**2007 Work RVU:** 0.00

**2013 Work RVU:** 0.00

**2007 NF PE RVU:** 1

**2013 NF PE RVU:** 0.27

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** PE Only

**RUC Recommendation:** New PE inputs

**CPT Action (if applicable):** February 2010

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**93271** External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; transmission and analysis **Global:** XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent**  
**RUC Meeting:** April 2010

**Tab** 25 **Specialty Developing** ACC  
**Recommendation:**

**First**  
**Identified:**

**2012 Est**  
**Medicare**  
**Utilization:** 75,315

**2007 Work RVU:** 0.00

**2013 Work RVU:** 0.00

**2007 NF PE RVU:** 5.82

**2013 NF PE RVU:** 5.50

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** PE Only

**RUC Recommendation:** New PE inputs

**CPT Action (if applicable):** February 2010

**Referred to CPT Asst** ☐

**Published in CPT Asst:**



## Status Report: CMS Requests and Relativity Assessment Issues

**93272** External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; review and interpretation by a physician or other qualified health care professional

**Global:** XXX

**Issue:** External Cardiovascular Device Monitoring

**Screen:** Harvard Valued - Utilization over 100,000

**Complete?** Yes

**Most Recent**  
**RUC Meeting:** April 2010

**Tab** 25

**Specialty Developing** ACC  
**Recommendation:**

**First Identified:**

**2012 Est Medicare Utilization:** 94,294

**2007 Work RVU:** 0.52

**2013 Work RVU:** 0.52

**2007 NF PE RVU:** 0.2

**2013 NF PE RVU:** 0.18

**2007 Fac PE RVU** 0.20

**2013 Fac PE RVU:** 0.18

**Result:** Maintain

**RUC Recommendation:** 0.52

**CPT Action (if applicable):** February 2010

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**93307** Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography

**Global:** XXX

**Issue:** Cardiology Services

**Screen:** CMS Request - Practice Expense Review

**Complete?** Yes

**Most Recent**  
**RUC Meeting:** February 2009

**Tab** 31

**Specialty Developing** ACC  
**Recommendation:**

**First Identified:** NA

**2012 Est Medicare Utilization:** 61,371

**2007 Work RVU:** 0.92

**2013 Work RVU:** 0.92

**2007 NF PE RVU:** 4.1

**2013 NF PE RVU:** 2.40

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** PE Only

**RUC Recommendation:** New PE inputs

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**93308** Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study

**Global:** XXX

**Issue:** Transthoracic Echocardiography

**Screen:** Harvard Valued - Utilization over 30,000

**Complete?** Yes

**Most Recent**  
**RUC Meeting:** September 2011

**Tab** 39

**Specialty Developing** ACC  
**Recommendation:**

**First Identified:** April 2011

**2012 Est Medicare Utilization:** 176,949

**2007 Work RVU:** 0.53

**2013 Work RVU:** 0.53

**2007 NF PE RVU:** 2.26

**2013 NF PE RVU:** 2.40

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** 0.53

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**93308** Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study **Global:** XXX **Issue:** Echocardiography **Screen:** CMS Fastest Growing, Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** October 2008

**Tab** 26 **Specialty Developing Recommendation:** ACC

**First Identified:** October 2008

**2012 Est Medicare Utilization:** 176,949

**2007 Work RVU:** 0.53

**2013 Work RVU:** 0.53

**2007 NF PE RVU:** 2.26

**2013 NF PE RVU:** 2.40

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** Remove from screen

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Remove from Screen

**93320** Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete

**Global:** ZZZ

**Issue:** Cardiology Services

**Screen:** CMS Request - Practice Expense Review

**Complete?** Yes

**Most Recent RUC Meeting:** February 2009

**Tab** 31 **Specialty Developing Recommendation:** ACC

**First Identified:** NA

**2012 Est Medicare Utilization:** 350,673

**2007 Work RVU:** 0.38

**2013 Work RVU:** 0.38

**2007 NF PE RVU:** 1.82

**2013 NF PE RVU:** 0.92

**2007 Fac PE RVU** 1.82

**2013 Fac PE RVU:** NA

**RUC Recommendation:** New PE inputs

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** PE Only

**93325** Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)

**Global:** ZZZ

**Issue:** Cardiology Services

**Screen:** CMS Request - Practice Expense Review / CMS-Other - Utilization over 250,000

**Complete?** No

**Most Recent RUC Meeting:** February 2009

**Tab** 31 **Specialty Developing Recommendation:** ACC

**First Identified:** NA

**2012 Est Medicare Utilization:** 472,594

**2007 Work RVU:** 0.07

**2013 Work RVU:** 0.07

**2007 NF PE RVU:** 2.36

**2013 NF PE RVU:** 0.50

**2007 Fac PE RVU** 2.36

**2013 Fac PE RVU:** NA

**RUC Recommendation:** Review action plan. New PE inputs

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** PE Only

# Status Report: CMS Requests and Relativity Assessment Issues

<b>93350</b>	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report;	<b>Global:</b> XXX	<b>Issue:</b> Stress Echo with ECG Monitoring	<b>Screen:</b> Other - Identified by RUC / Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab</b> 45 <b>Specialty Developing Recommendation:</b> ACC	<b>First Identified:</b> April 2008	<b>2012 Est Medicare Utilization:</b> 145,564	<b>2007 Work RVU:</b> 1.48 <b>2007 NF PE RVU:</b> 3.03 <b>2007 Fac PE RVU:</b> NA <b>Result:</b> Decrease Jan 2010	<b>2013 Work RVU:</b> 1.46 <b>2013 NF PE RVU:</b> 4.37 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 1.46; CPT Assistant article published		<b>CPT Action (if applicable):</b> Referred to CPT Asst <input checked="" type="checkbox"/>		<b>Published in CPT Asst:</b> October 2010	
<b>93451</b>	Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed	<b>Global:</b> 000	<b>Issue:</b> Diagnostic Cardiac Catheterization	<b>Screen:</b> Codes Reported Together 95% or More	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2011	<b>Tab</b> 28 <b>Specialty Developing Recommendation:</b> ACC	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 29,686	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU:</b> <b>Result:</b> Decrease	<b>2013 Work RVU:</b> 2.72 <b>2013 NF PE RVU:</b> 20.72 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 3.02		<b>CPT Action (if applicable):</b> Referred to CPT Asst <input type="checkbox"/>		<b>Published in CPT Asst:</b> October 2009	
<b>93452</b>	Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed	<b>Global:</b> 000	<b>Issue:</b> Diagnostic Cardiac Catheterization	<b>Screen:</b> Codes Reported Together 95% or More	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2011	<b>Tab</b> 28 <b>Specialty Developing Recommendation:</b> ACC	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 13,068	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU:</b> <b>Result:</b> Decrease	<b>2013 Work RVU:</b> 4.75 <b>2013 NF PE RVU:</b> 20.80 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 4.32		<b>CPT Action (if applicable):</b> Referred to CPT Asst <input type="checkbox"/>		<b>Published in CPT Asst:</b> October 2009	

## Status Report: CMS Requests and Relativity Assessment Issues

<b>93453</b>	Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed	<b>Global:</b> 000	<b>Issue:</b> Diagnostic Cardiac Catheterization	<b>Screen:</b> Codes Reported Together 95% or More	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2011	<b>Tab</b> 28 <b>Specialty Developing Recommendation:</b> ACC	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 5,221	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease	<b>2013 Work RVU:</b> 6.24 <b>2013 NF PE RVU:</b> 27.09 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 5.98		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	October 2009 <b>Published in CPT Asst:</b>		
<b>93454</b>	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation;	<b>Global:</b> 000	<b>Issue:</b> Diagnostic Cardiac Catheterization	<b>Screen:</b> Codes Reported Together 95% or More	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2011	<b>Tab</b> 28 <b>Specialty Developing Recommendation:</b> ACC	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 83,517	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease	<b>2013 Work RVU:</b> 4.79 <b>2013 NF PE RVU:</b> 21.40 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 4.95		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	October 2009 <b>Published in CPT Asst:</b>		
<b>93455</b>	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography	<b>Global:</b> 000	<b>Issue:</b> Diagnostic Cardiac Catheterization	<b>Screen:</b> Codes Reported Together 95% or More	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2011	<b>Tab</b> 28 <b>Specialty Developing Recommendation:</b> ACC	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 24,190	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease	<b>2013 Work RVU:</b> 5.54 <b>2013 NF PE RVU:</b> 24.91 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 6.15		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	October 2009 <b>Published in CPT Asst:</b>		

## Status Report: CMS Requests and Relativity Assessment Issues

93456	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization	Global: 000	Issue: Diagnostic Cardiac Catheterization	Screen: Codes Reported Together 95% or More	Complete? Yes		
Most Recent RUC Meeting:	April 2011	Tab 28	Specialty Developing Recommendation: ACC	First Identified:	2012 Est Medicare Utilization: 10,658	2007 Work RVU:	2013 Work RVU: 6.15
						2007 NF PE RVU:	2013 NF PE RVU: 26.67
						2007 Fac PE RVU	2013 Fac PE RVU: NA
RUC Recommendation:	6.00			CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>	October 2009	Result: Decrease	
					Published in CPT Asst:		
93457	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization	Global: 000	Issue: Diagnostic Cardiac Catheterization	Screen: Codes Reported Together 95% or More	Complete? Yes		
Most Recent RUC Meeting:	April 2011	Tab 28	Specialty Developing Recommendation: ACC	First Identified:	2012 Est Medicare Utilization: 2,665	2007 Work RVU:	2013 Work RVU: 6.89
						2007 NF PE RVU:	2013 NF PE RVU: 30.16
						2007 Fac PE RVU	2013 Fac PE RVU: NA
RUC Recommendation:	7.66			CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>	October 2009	Result: Decrease	
					Published in CPT Asst:		
93458	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed	Global: 000	Issue: Diagnostic Cardiac Catheterization	Screen: Codes Reported Together 95% or More	Complete? Yes		
Most Recent RUC Meeting:	April 2011	Tab 28	Specialty Developing Recommendation: ACC	First Identified:	2012 Est Medicare Utilization: 567,395	2007 Work RVU:	2013 Work RVU: 5.85
						2007 NF PE RVU:	2013 NF PE RVU: 25.49
						2007 Fac PE RVU	2013 Fac PE RVU: NA
RUC Recommendation:	6.51			CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>	October 2009	Result: Decrease	
					Published in CPT Asst:		

## Status Report: CMS Requests and Relativity Assessment Issues

93459	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	Global: 000	Issue: Diagnostic Cardiac Catheterization	Screen: Codes Reported Together 95% or More	Complete? Yes		
Most Recent RUC Meeting:	April 2011	Tab 28	Specialty Developing Recommendation: ACC	First Identified:	2012 Est Medicare Utilization: 130,972	2007 Work RVU:	2013 Work RVU: 6.60
						2007 NF PE RVU:	2013 NF PE RVU: 28.00
						2007 Fac PE RVU	2013 Fac PE RVU: NA
RUC Recommendation:	7.34			CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>	October 2009	Result: Decrease	
					Published in CPT Asst:		
93460	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed	Global: 000	Issue: Diagnostic Cardiac Catheterization	Screen: Codes Reported Together 95% or More	Complete? Yes		
Most Recent RUC Meeting:	April 2011	Tab 28	Specialty Developing Recommendation: ACC	First Identified:	2012 Est Medicare Utilization: 96,670	2007 Work RVU:	2013 Work RVU: 7.35
						2007 NF PE RVU:	2013 NF PE RVU: 29.67
						2007 Fac PE RVU	2013 Fac PE RVU: NA
RUC Recommendation:	7.88			CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>	October 2009	Result: Decrease	
					Published in CPT Asst:		
93461	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	Global: 000	Issue: Diagnostic Cardiac Catheterization	Screen: Codes Reported Together 95% or More	Complete? Yes		
Most Recent RUC Meeting:	April 2011	Tab 28	Specialty Developing Recommendation: ACC	First Identified:	2012 Est Medicare Utilization: 19,498	2007 Work RVU:	2013 Work RVU: 8.10
						2007 NF PE RVU:	2013 NF PE RVU: 34.36
						2007 Fac PE RVU	2013 Fac PE RVU: NA
RUC Recommendation:	9.00			CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>	October 2009	Result: Decrease	
					Published in CPT Asst:		

## Status Report: CMS Requests and Relativity Assessment Issues

**93462** Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

**Most Recent RUC Meeting:** April 2011

**Tab 28 Specialty Developing Recommendation:** ACC

**First Identified:**

**2012 Est Medicare Utilization:** 20,975

**2007 Work RVU:**

**2013 Work RVU:** 3.73

**2007 NF PE RVU:**

**2013 NF PE RVU:** 1.47

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 1.47

**RUC Recommendation:** 3.73

**CPT Action (if applicable):** October 2009

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**93463** Pharmacologic agent administration (eg, inhaled nitric oxide, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent) including assessing hemodynamic measurements before, during, after and repeat pharmacologic agent administration, when performed (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

**Most Recent RUC Meeting:** April 2011

**Tab 28 Specialty Developing Recommendation:** ACC

**First Identified:**

**2012 Est Medicare Utilization:** 8,316

**2007 Work RVU:**

**2013 Work RVU:** 2.00

**2007 NF PE RVU:**

**2013 NF PE RVU:** 0.72

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 0.72

**RUC Recommendation:** 2.00

**CPT Action (if applicable):** October 2009

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**93464** Physiologic exercise study (eg, bicycle or arm ergometry) including assessing hemodynamic measurements before and after (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

**Most Recent RUC Meeting:** April 2011

**Tab 28 Specialty Developing Recommendation:** ACC

**First Identified:**

**2012 Est Medicare Utilization:** 679

**2007 Work RVU:**

**2013 Work RVU:** 1.80

**2007 NF PE RVU:**

**2013 NF PE RVU:** 6.40

**2007 Fac PE RVU**

**2013 Fac PE RVU:** NA

**RUC Recommendation:** 1.80

**CPT Action (if applicable):** October 2009

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

## Status Report: CMS Requests and Relativity Assessment Issues

**93501 Deleted from CPT**

**Global:** 000

**Issue:** Cardiac Catheterization

**Screen:** Codes Reported  
Together 95% or More

**Complete?** Yes

**Most Recent  
RUC Meeting:** April 2010

**Tab** 26

**Specialty Developing  
Recommendation:** ACC

**First  
Identified:** February 2008

**2012 Est  
Medicare  
Utilization:**

**2007 Work RVU:** 0.00

**2013 Work RVU:**

**2007 NF PE RVU:** 0

**2013 NF PE RVU:**

**2007 Fac PE RVU:** 0

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2009

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**93508 Deleted from CPT**

**Global:** 000

**Issue:** Cardiac Catheterization

**Screen:** Codes Reported  
Together 95% or More

**Complete?** Yes

**Most Recent  
RUC Meeting:** April 2010

**Tab** 26

**Specialty Developing  
Recommendation:** ACC

**First  
Identified:** February 2008

**2012 Est  
Medicare  
Utilization:**

**2007 Work RVU:** 0.00

**2013 Work RVU:**

**2007 NF PE RVU:** 0

**2013 NF PE RVU:**

**2007 Fac PE RVU:** 0

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2009

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**93510 Deleted from CPT**

**Global:** 000

**Issue:** Cardiac Catheterization

**Screen:** Codes Reported  
Together 95% or More/  
CMS Request - Practice  
Expense Review,  
Harvard Valued -  
Utilization over 100,000

**Complete?** Yes

**Most Recent  
RUC Meeting:** February 2009

**Tab** 31

**Specialty Developing  
Recommendation:** ACC

**First  
Identified:** February 2008

**2012 Est  
Medicare  
Utilization:**

**2007 Work RVU:** 0.00

**2013 Work RVU:**

**2007 NF PE RVU:** 0

**2013 NF PE RVU:**

**2007 Fac PE RVU:** 0

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2009

**Referred to CPT Asst** ☐

**Published in CPT Asst:**



## Status Report: CMS Requests and Relativity Assessment Issues

**93511 Deleted from CPT**

**Global:** 000

**Issue:** Cardiac Catheterization

**Screen:** Codes Reported  
Together 95% or More

**Complete?** Yes

**Most Recent  
RUC Meeting:** April 2010

**Tab** 26

**Specialty Developing  
Recommendation:** ACC

**First  
Identified:** February 2008

**2012 Est  
Medicare  
Utilization:**

**2007 Work RVU:** 0.00

**2013 Work RVU:**

**2007 NF PE RVU:** NA

**2013 NF PE RVU:**

**2007 Fac PE RVU** 0

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2009

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Deleted from CPT

**93514 Deleted from CPT**

**Global:** 000

**Issue:** Cardiac Catheterization

**Screen:** Codes Reported  
Together 95% or More

**Complete?** Yes

**Most Recent  
RUC Meeting:** April 2010

**Tab** 26

**Specialty Developing  
Recommendation:** ACC

**First  
Identified:** February 2008

**2012 Est  
Medicare  
Utilization:**

**2007 Work RVU:** 0.00

**2013 Work RVU:**

**2007 NF PE RVU:** 0

**2013 NF PE RVU:**

**2007 Fac PE RVU** 0

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2009

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Deleted from CPT

**93524 Deleted from CPT**

**Global:** 000

**Issue:** Cardiac Catheterization

**Screen:** Codes Reported  
Together 95% or More

**Complete?** Yes

**Most Recent  
RUC Meeting:** April 2010

**Tab** 26

**Specialty Developing  
Recommendation:** ACC

**First  
Identified:** February 2008

**2012 Est  
Medicare  
Utilization:**

**2007 Work RVU:** 0.00

**2013 Work RVU:**

**2007 NF PE RVU:** NA

**2013 NF PE RVU:**

**2007 Fac PE RVU** 0

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2009

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Deleted from CPT

## Status Report: CMS Requests and Relativity Assessment Issues

**93526 Deleted from CPT**

**Global:** 000

**Issue:** Cardiac Catheterization

**Screen:** Codes Reported  
Together 95% or More /  
Harvard Valued -  
Utilization over 100,000

**Complete?** Yes

**Most Recent  
RUC Meeting:** February 2008

**Tab** S

**Specialty Developing  
Recommendation:** ACC

**First  
Identified:** February 2008

**2012 Est  
Medicare  
Utilization:**

**2007 Work RVU:** 0.00

**2013 Work RVU:**

**2007 NF PE RVU:** 0

**2013 NF PE RVU:**

**2007 Fac PE RVU** 0

**2013 Fac PE RVU:**

**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2009

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**93527 Deleted from CPT**

**Global:** 000

**Issue:** Cardiac Catheterization

**Screen:** Codes Reported  
Together 95% or More

**Complete?** Yes

**Most Recent  
RUC Meeting:** April 2010

**Tab** 26

**Specialty Developing  
Recommendation:** ACC

**First  
Identified:** February 2008

**2012 Est  
Medicare  
Utilization:**

**2007 Work RVU:** 0.00

**2013 Work RVU:**

**2007 NF PE RVU:** NA

**2013 NF PE RVU:**

**2007 Fac PE RVU** 0

**2013 Fac PE RVU:**

**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2009

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**93528 Deleted from CPT**

**Global:** 000

**Issue:** Cardiac Catheterization

**Screen:** Codes Reported  
Together 95% or More

**Complete?** Yes

**Most Recent  
RUC Meeting:** April 2010

**Tab** 26

**Specialty Developing  
Recommendation:** ACC

**First  
Identified:** February 2008

**2012 Est  
Medicare  
Utilization:**

**2007 Work RVU:** 0.00

**2013 Work RVU:**

**2007 NF PE RVU:** NA

**2013 NF PE RVU:**

**2007 Fac PE RVU** 0

**2013 Fac PE RVU:**

**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2009

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**93529 Deleted from CPT**

**Global:** 000

**Issue:** Cardiac Catheterization

**Screen:** Codes Reported  
Together 95% or More

**Complete?** Yes

**Most Recent  
RUC Meeting:** April 2010

**Tab** 26

**Specialty Developing  
Recommendation:** ACC

**First  
Identified:** February 2008

**2012 Est  
Medicare  
Utilization:**

**2007 Work RVU:** 0.00

**2013 Work RVU:**

**2007 NF PE RVU:** NA

**2013 NF PE RVU:**

**2007 Fac PE RVU** 0

**2013 Fac PE RVU:**

**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2009

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**93539 Deleted from CPT**

**Global:** 000

**Issue:** Cardiac Catheterization

**Screen:** Codes Reported  
Together 95% or More

**Complete?** Yes

**Most Recent  
RUC Meeting:** February 2008

**Tab** S

**Specialty Developing  
Recommendation:** ACC

**First  
Identified:** February 2008

**2012 Est  
Medicare  
Utilization:**

**2007 Work RVU:** 0.00

**2013 Work RVU:**

**2007 NF PE RVU:** NA

**2013 NF PE RVU:**

**2007 Fac PE RVU** 0

**2013 Fac PE RVU:**

**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2009

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**93540 Deleted from CPT**

**Global:** 000

**Issue:** Cardiac Catheterization

**Screen:** Codes Reported  
Together 95% or More

**Complete?** Yes

**Most Recent  
RUC Meeting:** February 2008

**Tab** S

**Specialty Developing  
Recommendation:** ACC

**First  
Identified:** February 2008

**2012 Est  
Medicare  
Utilization:**

**2007 Work RVU:** 0.00

**2013 Work RVU:**

**2007 NF PE RVU:** NA

**2013 NF PE RVU:**

**2007 Fac PE RVU** 0

**2013 Fac PE RVU:**

**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2009

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**93541 Deleted from CPT**

**Global:** 000

**Issue:** Cardiac Catheterization

**Screen:** Codes Reported  
Together 95% or More

**Complete?** Yes

**Most Recent  
RUC Meeting:** April 2010

**Tab** 26

**Specialty Developing  
Recommendation:** ACC

**First  
Identified:** February 2008

**2012 Est  
Medicare  
Utilization:**

**2007 Work RVU:** 0.00

**2013 Work RVU:**

**2007 NF PE RVU:** NA

**2013 NF PE RVU:**

**2007 Fac PE RVU** 0

**2013 Fac PE RVU:**

**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2009

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**93542 Deleted from CPT**

**Global:** 000

**Issue:** Cardiac Catheterization

**Screen:** Codes Reported  
Together 95% or More

**Complete?** Yes

**Most Recent  
RUC Meeting:** April 2010

**Tab** 26

**Specialty Developing  
Recommendation:** ACC

**First  
Identified:** February 2008

**2012 Est  
Medicare  
Utilization:**

**2007 Work RVU:** 0.00

**2013 Work RVU:**

**2007 NF PE RVU:** NA

**2013 NF PE RVU:**

**2007 Fac PE RVU** 0

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2009

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**93543 Deleted from CPT**

**Global:** 000

**Issue:** Cardiac Catheterization

**Screen:** Codes Reported  
Together 95% or More /  
CMS Request - Practice  
Expense Review,  
Harvard Valued -  
Utilization over 100,000

**Complete?** Yes

**Most Recent  
RUC Meeting:** February 2009

**Tab** 31

**Specialty Developing  
Recommendation:** ACC

**First  
Identified:** February 2008

**2012 Est  
Medicare  
Utilization:**

**2007 Work RVU:** 0.00

**2013 Work RVU:**

**2007 NF PE RVU:** NA

**2013 NF PE RVU:**

**2007 Fac PE RVU** 0

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2009

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**93544 Deleted from CPT**

**Global:** 000

**Issue:** Cardiac Catheterization

**Screen:** Codes Reported  
Together 95% or More

**Complete?** Yes

**Most Recent  
RUC Meeting:** February 2008

**Tab** S

**Specialty Developing  
Recommendation:** ACC

**First  
Identified:** February 2008

**2012 Est  
Medicare  
Utilization:**

**2007 Work RVU:** 0.00

**2013 Work RVU:**

**2007 NF PE RVU:** NA

**2013 NF PE RVU:**

**2007 Fac PE RVU** 0

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2009

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**93545 Deleted from CPT**

**Global:** 000

**Issue:** Cardiac Catheterization

**Screen:** Codes Reported  
Together 95% or More /  
CMS Request - Practice  
Expense Review

**Complete?** Yes

**Most Recent  
RUC Meeting:** February 2009

**Tab** 31

**Specialty Developing  
Recommendation:** ACC

**First  
Identified:** February 2008

**2012 Est  
Medicare  
Utilization:**

**2007 Work RVU:** 0.00

**2013 Work RVU:**

**2007 NF PE RVU:** NA

**2013 NF PE RVU:**

**2007 Fac PE RVU** 0

**2013 Fac PE RVU:**

**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2009

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**93555 Deleted from CPT**

**Global:** XXX

**Issue:** Cardiac Catheterization

**Screen:** Codes Reported  
Together 95% or More /  
CMS Request - Practice  
Expense Review

**Complete?** Yes

**Most Recent  
RUC Meeting:** February 2009

**Tab** 31

**Specialty Developing  
Recommendation:** ACC

**First  
Identified:** February 2008

**2012 Est  
Medicare  
Utilization:**

**2007 Work RVU:** 0.00

**2013 Work RVU:**

**2007 NF PE RVU:** 0

**2013 NF PE RVU:**

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:**

**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2009

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**93556 Deleted from CPT**

**Global:** XXX

**Issue:** Cardiac Catheterization

**Screen:** Codes Reported  
Together 95% or More /  
CMS Request - Practice  
Expense Review

**Complete?** Yes

**Most Recent  
RUC Meeting:** February 2009

**Tab** 31

**Specialty Developing  
Recommendation:** ACC

**First  
Identified:** February 2008

**2012 Est  
Medicare  
Utilization:**

**2007 Work RVU:** 0.00

**2013 Work RVU:**

**2007 NF PE RVU:** 0

**2013 NF PE RVU:**

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:**

**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2009

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**93563** Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective coronary angiography during congenital heart catheterization (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

**Most Recent RUC Meeting:** April 2011 **Tab 28** **Specialty Developing Recommendation:** ACC **First Identified:** **2012 Est Medicare Utilization:** 200 **2007 Work RVU:** **2013 Work RVU:** 1.11 **2007 NF PE RVU:** **2013 NF PE RVU:** 0.40 **2007 Fac PE RVU** **2013 Fac PE RVU:** 0.40 **RUC Recommendation:** 2.00 **CPT Action (if applicable):** October 2009 **Published in CPT Asst:** **Referred to CPT Asst** ☐ **Result:** Decrease

**93564** Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective opacification of aortocoronary venous or arterial bypass graft(s) (eg, aortocoronary saphenous vein, free radial artery, or free mammary artery graft) to one or more coronary arteries and in situ arterial conduits (eg, internal mammary), whether native or used for bypass to one or more coronary arteries during congenital heart catheterization, when performed (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

**Most Recent RUC Meeting:** April 2011 **Tab 28** **Specialty Developing Recommendation:** ACC **First Identified:** **2012 Est Medicare Utilization:** 20 **2007 Work RVU:** **2013 Work RVU:** 1.13 **2007 NF PE RVU:** **2013 NF PE RVU:** 0.41 **2007 Fac PE RVU** **2013 Fac PE RVU:** 0.41 **RUC Recommendation:** 2.10 **CPT Action (if applicable):** October 2009 **Published in CPT Asst:** **Referred to CPT Asst** ☐ **Result:** Decrease

**93565** Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective left ventricular or left atrial angiography (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

**Most Recent RUC Meeting:** April 2011 **Tab 28** **Specialty Developing Recommendation:** ACC **First Identified:** **2012 Est Medicare Utilization:** 308 **2007 Work RVU:** **2013 Work RVU:** 0.86 **2007 NF PE RVU:** **2013 NF PE RVU:** 0.31 **2007 Fac PE RVU** **2013 Fac PE RVU:** 0.31 **RUC Recommendation:** 1.90 **CPT Action (if applicable):** October 2009 **Published in CPT Asst:** **Referred to CPT Asst** ☐ **Result:** Decrease

## Status Report: CMS Requests and Relativity Assessment Issues

---

<b>93566</b>	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective right ventricular or right atrial angiography (List separately in addition to code for primary procedure)	<b>Global:</b> ZZZ	<b>Issue:</b> Diagnostic Cardiac Catheterization	<b>Screen:</b> Codes Reported Together 95% or More	<b>Complete?</b> Yes
--------------	---	--------------------	--	--	----------------------

**Most Recent RUC Meeting:** April 2011

**Tab 28 Specialty Developing Recommendation:** ACC

**First Identified:**

**2012 Est Medicare Utilization:** 2,476

**2007 Work RVU:**

**2013 Work RVU:** 0.86

**2007 NF PE RVU:**

**2013 NF PE RVU:** 4.26

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 0.31

**RUC Recommendation:** 0.96

**CPT Action (if applicable):** October 2009  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Decrease

---

<b>93567</b>	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for supra-ventricular aortography (List separately in addition to code for primary procedure)	<b>Global:</b> ZZZ	<b>Issue:</b> Diagnostic Cardiac Catheterization	<b>Screen:</b> Codes Reported Together 95% or More	<b>Complete?</b> Yes
--------------	---	--------------------	--	--	----------------------

**Most Recent RUC Meeting:** April 2011

**Tab 28 Specialty Developing Recommendation:** ACC

**First Identified:**

**2012 Est Medicare Utilization:** 54,387

**2007 Work RVU:**

**2013 Work RVU:** 0.97

**2007 NF PE RVU:**

**2013 NF PE RVU:** 3.21

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 0.36

**RUC Recommendation:** 0.97

**CPT Action (if applicable):** October 2009  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Decrease

---

<b>93568</b>	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for pulmonary angiography (List separately in addition to code for primary procedure)	<b>Global:</b> ZZZ	<b>Issue:</b> Diagnostic Cardiac Catheterization	<b>Screen:</b> Codes Reported Together 95% or More	<b>Complete?</b> Yes
--------------	---	--------------------	--	--	----------------------

**Most Recent RUC Meeting:** April 2011

**Tab 28 Specialty Developing Recommendation:** ACC

**First Identified:**

**2012 Est Medicare Utilization:** 2,372

**2007 Work RVU:**

**2013 Work RVU:** 0.88

**2007 NF PE RVU:**

**2013 NF PE RVU:** 3.69

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 0.32

**RUC Recommendation:** 0.98

**CPT Action (if applicable):** October 2009  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Decrease

## Status Report: CMS Requests and Relativity Assessment Issues

**93613** Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Cardiology Services **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent** **Tab** 26 **Specialty Developing** ACC  
**RUC Meeting:** October 2008 **Recommendation:**

**First Identified:** October 2008

**2012 Est Medicare Utilization:** 39,674

**2007 Work RVU:** 6.99

**2013 Work RVU:** 6.99

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU:** 3.03

**2013 Fac PE RVU:** 2.77

**RUC Recommendation:** Remove from screen

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Remove from Screen

**93613** Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** No

**Most Recent** **Tab** **Specialty Developing**  
**RUC Meeting:** **Recommendation:**

**First Identified:** April 2013

**2012 Est Medicare Utilization:** 39,674

**2007 Work RVU:** 6.99

**2013 Work RVU:** 6.99

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** NA

**2007 Fac PE RVU:** 3.03

**2013 Fac PE RVU:** 2.77

**RUC Recommendation:** Review Action Plan

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:**

**93620** Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording **Global:** 000 **Issue:** Intracardiac Catheter Ablation **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

**Most Recent** **Tab** 45 **Specialty Developing** ACC  
**RUC Meeting:** April 2010 **Recommendation:**

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 62,401

**2007 Work RVU:** 0.00

**2013 Work RVU:** 0.00

**2007 NF PE RVU:** 0

**2013 NF PE RVU:** 0.00

**2007 Fac PE RVU:** 0

**2013 Fac PE RVU:** NA

**RUC Recommendation:** 11.57

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

October 2011

**Published in CPT Asst:**

**Result:** Maintain



# Status Report: CMS Requests and Relativity Assessment Issues

**93641** Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator leads including defibrillation threshold evaluation (induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination) at time of initial implantation or replacement; with testing of single or dual chamber pacing cardioverter-defibrillator pulse generator

**Global:** 000

**Issue:** Insertion/Removal of Pacemaker or Pacing Cardioverter-Defibrillator

**Screen:** Codes Reported Together 75% or More-Part1

**Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab** 45

**Specialty Developing Recommendation:** ACC

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 57,943

**2007 Work RVU:** 0.00

**2013 Work RVU:** 0.00

**2007 NF PE RVU:** NA

**2013 NF PE RVU:** 0.00

**2007 Fac PE RVU:** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** Maintain

**CPT Action (if applicable):** February 2011

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**93651** Intracardiac catheter ablation of arrhythmogenic focus; for treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathways, accessory atrioventricular connections or other atrial foci, singly or in combination

**Global:** 000

**Issue:** Bundling EPS with Transcatheter Ablation

**Screen:** Codes Reported Together 75% or More-Part1

**Complete?** Yes

**Most Recent RUC Meeting:** January 2012

**Tab** 11

**Specialty Developing Recommendation:** ACC, HRS

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 46,701

**2007 Work RVU:** 16.23

**2013 Work RVU:**

**2007 NF PE RVU:** NA

**2013 NF PE RVU:**

**2007 Fac PE RVU:** 6.96

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2011

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**93652** Intracardiac catheter ablation of arrhythmogenic focus; for treatment of ventricular tachycardia

**Global:** 000

**Issue:** Bundling EPS with Transcatheter Ablation

**Screen:** CMS Fastest Growing/Codes Reported Together 75% or More-Part1

**Complete?** Yes

**Most Recent RUC Meeting:** January 2012

**Tab** 11

**Specialty Developing Recommendation:** ACC, HRS

**First Identified:** October 2008

**2012 Est Medicare Utilization:** 4,073

**2007 Work RVU:** 17.65

**2013 Work RVU:**

**2007 NF PE RVU:** NA

**2013 NF PE RVU:**

**2007 Fac PE RVU:** 7.58

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2011

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

<b>93653</b>	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording, His recording with intracardiac catheter ablation of arrhythmogenic focus; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry	<b>Global:</b> 000	<b>Issue:</b> Bundling EPS with Transcatheter Ablation	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2012	<b>Tab 11</b>	<b>Specialty Developing Recommendation:</b> ACC, HRS	<b>First Identified:</b> October 2011	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease
<b>RUC Recommendation:</b> 15.00			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>October 2011</b> <b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 15.00 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 5.91

<b>93654</b>	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording, His recording with intracardiac catheter ablation of arrhythmogenic focus; with treatment of ventricular tachycardia or focus of ventricular ectopy including intracardiac electrophysiologic 3D mapping, when performed, and left ventricular pacing and recording, when performed	<b>Global:</b> 000	<b>Issue:</b> Bundling EPS with Transcatheter Ablation	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2012	<b>Tab 11</b>	<b>Specialty Developing Recommendation:</b> ACC, HRS	<b>First Identified:</b> October 2011	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease
<b>RUC Recommendation:</b> 20.00			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>October 2011</b> <b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 20.00 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 7.91

## Status Report: CMS Requests and Relativity Assessment Issues

<b>93655</b> Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Bundling EPS with Transcatheter Ablation	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes
<b>Most Recent RUC Meeting:</b> January 2012	<b>Tab 11 Specialty Developing Recommendation:</b> ACC, HRS	<b>First Identified:</b> October 2011	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease <b>2013 Work RVU:</b> 7.50 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 2.96
<b>RUC Recommendation:</b> 9.00	<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>October 2011</b> <b>Published in CPT Asst:</b>		
<b>93656</b> Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with atrial recording and pacing, when possible, right ventricular pacing and recording, His bundle recording with intracardiac catheter ablation of arrhythmogenic focus, with treatment of atrial fibrillation by ablation by pulmonary vein isolation	Global: 000	Issue: Bundling EPS with Transcatheter Ablation	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes
<b>Most Recent RUC Meeting:</b> January 2012	<b>Tab 11 Specialty Developing Recommendation:</b> ACC, HRS	<b>First Identified:</b> October 2011	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease <b>2013 Work RVU:</b> 20.02 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 7.90
<b>RUC Recommendation:</b> 20.02	<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>October 2011</b> <b>Published in CPT Asst:</b>		
<b>93657</b> Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Bundling EPS with Transcatheter Ablation	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes
<b>Most Recent RUC Meeting:</b> January 2012	<b>Tab 11 Specialty Developing Recommendation:</b> ACC, HRS	<b>First Identified:</b> October 2011	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease <b>2013 Work RVU:</b> 7.50 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 2.96
<b>RUC Recommendation:</b> 10.00	<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>October 2011</b> <b>Published in CPT Asst:</b>		

# Status Report: CMS Requests and Relativity Assessment Issues

**93662** Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Electrocardiography **Screen:** High Volume Growth1 **Complete?** No

**Most Recent** **Tab** 51 **Specialty Developing** ACC  
**RUC Meeting:** September 2011 **Recommendation:**

**First Identified:** February 2008

**2012 Est Medicare Utilization:** 19,481

**2007 Work RVU:** 0.00 **2013 Work RVU:** 0.00  
**2007 NF PE RVU:** 0 **2013 NF PE RVU:** 0.00  
**2007 Fac PE RVU** 0 **2013 Fac PE RVU:** NA  
**Result:**

**RUC Recommendation:** Review September 2014

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**93701** Bioimpedance-derived physiologic cardiovascular analysis

**Global:** XXX

**Issue:**

**Screen:** Low Value-High Volume

**Complete?** Yes

**Most Recent** **Tab** 41 **Specialty Developing**  
**RUC Meeting:** February 2011 **Recommendation:**

**First Identified:** October 2010

**2012 Est Medicare Utilization:** 200,150

**2007 Work RVU:** 0.17 **2013 Work RVU:** 0.00  
**2007 NF PE RVU:** 0.91 **2013 NF PE RVU:** 0.73  
**2007 Fac PE RVU** NA **2013 Fac PE RVU:** NA  
**Result:** Remove from Screen

**RUC Recommendation:** Remove from screen

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**93731** Deleted from CPT

**Global:** XXX

**Issue:** Cardiology Services

**Screen:** CMS Fastest Growing

**Complete?** Yes

**Most Recent** **Tab** 26 **Specialty Developing** ACC  
**RUC Meeting:** October 2008 **Recommendation:**

**First Identified:** October 2008

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 0.45 **2013 Work RVU:**  
**2007 NF PE RVU:** 0.7 **2013 NF PE RVU:**  
**2007 Fac PE RVU** NA **2013 Fac PE RVU:**  
**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**93732** Deleted from CPT

**Global:** XXX

**Issue:** Cardiology Services

**Screen:** CMS Fastest Growing

**Complete?** Yes

**Most Recent** **Tab** 26 **Specialty Developing** ACC  
**RUC Meeting:** October 2008 **Recommendation:**

**First Identified:** October 2008

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 0.92 **2013 Work RVU:**  
**2007 NF PE RVU:** 0.94 **2013 NF PE RVU:**  
**2007 Fac PE RVU** NA **2013 Fac PE RVU:**  
**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:**

# Status Report: CMS Requests and Relativity Assessment Issues

**93733 Deleted from CPT**

**Global:** XXX

**Issue:** Cardiology Services

**Screen:** CMS Fastest Growing

**Complete?** Yes

**Most Recent RUC Meeting:** October 2008

**Tab** 26

**Specialty Developing Recommendation:** ACC

**First Identified:** October 2008

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 0.17

**2013 Work RVU:**

**2007 NF PE RVU:** 0.83

**2013 NF PE RVU:**

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:**

**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**93743 Deleted from CPT**

**Global:** XXX

**Issue:** Cardiology Services

**Screen:** CMS Fastest Growing

**Complete?** Yes

**Most Recent RUC Meeting:** October 2008

**Tab** 26

**Specialty Developing Recommendation:** ACC

**First Identified:** October 2008

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 1.03

**2013 Work RVU:**

**2007 NF PE RVU:** 1.15

**2013 NF PE RVU:**

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:**

**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**93744 Deleted from CPT**

**Global:** XXX

**Issue:** Cardiology Services

**Screen:** CMS Fastest Growing

**Complete?** Yes

**Most Recent RUC Meeting:** October 2008

**Tab** 26

**Specialty Developing Recommendation:** ACC

**First Identified:** October 2008

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 1.18

**2013 Work RVU:**

**2007 NF PE RVU:** 1.19

**2013 NF PE RVU:**

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:**

**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**93875 Deleted from CPT**

**Global:** XXX

**Issue:** Noninvasive Vascular Diagnostic Studies

**Screen:** Codes Reported Together 75% or More-Part1

**Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab** 45

**Specialty Developing Recommendation:** AAN, ACC, ACR, SIR, SVS

**First Identified:** February 2010

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 0.22

**2013 Work RVU:**

**2007 NF PE RVU:** 2.38

**2013 NF PE RVU:**

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:**

**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2010

**Referred to CPT Asst** ☒

**Published in CPT Asst:**

SS in process of d

# Status Report: CMS Requests and Relativity Assessment Issues

<b>93880</b>	<b>Duplex scan of extracranial arteries; complete bilateral study</b>			<b>Global:</b> XXX	<b>Issue:</b> Extracranial Studies	<b>Screen:</b> Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b> 21	<b>Specialty Developing Recommendation:</b>	ACC, ACR, SVS	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 2,799,093	<b>2007 Work RVU:</b> 0.60 <b>2007 NF PE RVU:</b> 5.67 <b>2007 Fac PE RVU:</b> NA <b>Result:</b> Increase	<b>2013 Work RVU:</b> 0.60 <b>2013 NF PE RVU:</b> 6.53 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 0.80				<b>CPT Action (if applicable):</b> Referred to CPT Asst <input checked="" type="checkbox"/>	October 2010 <b>Published in CPT Asst:</b>	Addressed in CPT	

<b>93882</b>	<b>Duplex scan of extracranial arteries; unilateral or limited study</b>			<b>Global:</b> XXX	<b>Issue:</b> Extracranial Studies	<b>Screen:</b> CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b> 21	<b>Specialty Developing Recommendation:</b>	ACC, ACR, SVS	<b>First Identified:</b> January 2012	<b>2012 Est Medicare Utilization:</b> 46,169	<b>2007 Work RVU:</b> 0.40 <b>2007 NF PE RVU:</b> 3.63 <b>2007 Fac PE RVU:</b> NA <b>Result:</b> Increase	<b>2013 Work RVU:</b> 0.40 <b>2013 NF PE RVU:</b> 4.71 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 0.50				<b>CPT Action (if applicable):</b> Referred to CPT Asst <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

<b>93886</b>	<b>Transcranial Doppler study of the intracranial arteries; complete study</b>			<b>Global:</b> XXX	<b>Issue:</b> Noninvasive Vascular Diagnostic Studies	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab</b> 45	<b>Specialty Developing Recommendation:</b>	AAN, ACC, ACR, SIR, SVS	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 67,612	<b>2007 Work RVU:</b> 0.94 <b>2007 NF PE RVU:</b> 6.77 <b>2007 Fac PE RVU:</b> NA <b>Result:</b> Maintain	<b>2013 Work RVU:</b> 0.94 <b>2013 NF PE RVU:</b> 10.20 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> CCI Edits				<b>CPT Action (if applicable):</b> Referred to CPT Asst <input type="checkbox"/>	October 2010 <b>Published in CPT Asst:</b>		

## Status Report: CMS Requests and Relativity Assessment Issues

<b>93888</b>	Transcranial Doppler study of the intracranial arteries; limited study	<b>Global:</b> XXX	<b>Issue:</b> Noninvasive Vascular Diagnostic Studies	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab</b> 45	<b>Specialty Developing Recommendation:</b> AAN, ACC, ACR, SIR, SVS	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 17,682	<b>2007 Work RVU:</b> 0.62 <b>2007 NF PE RVU:</b> 4.36 <b>2007 Fac PE RVU</b> NA <b>2013 Work RVU:</b> 0.62 <b>2013 NF PE RVU:</b> 5.83 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> CCI Edits		<b>CPT Action (if applicable):</b> Referred to CPT Asst <input type="checkbox"/>	October 2010	<b>Published in CPT Asst:</b>	<b>Result:</b> Maintain

---

<b>93922</b>	Limited bilateral noninvasive physiologic studies of upper or lower extremity arteries, (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus bidirectional, Doppler waveform recording and analysis at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus volume plethysmography at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries with, transcutaneous oxygen tension measurement at 1-2 levels)	<b>Global:</b> XXX	<b>Issue:</b> Extremity Non-Invasive Arterial Physiologic Studies	<b>Screen:</b> CMS Fastest Growing	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab</b> 27	<b>Specialty Developing Recommendation:</b> SVS, ACR, ACC	<b>First Identified:</b> October 2008	<b>2012 Est Medicare Utilization:</b> 627,664	<b>2007 Work RVU:</b> 0.25 <b>2007 NF PE RVU:</b> 2.78 <b>2007 Fac PE RVU</b> NA <b>2013 Work RVU:</b> 0.25 <b>2013 NF PE RVU:</b> 2.50 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 0.25		<b>CPT Action (if applicable):</b> Referred to CPT Asst <input type="checkbox"/>	February 2010	<b>Published in CPT Asst:</b>	<b>Result:</b> Maintain

## Status Report: CMS Requests and Relativity Assessment Issues

**93923** Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure measurements with bidirectional Doppler waveform recording and analysis, at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental volume plethysmography at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental transcutaneous oxygen tension measurements at 3 or more levels), or single level study with provocative functional maneuvers (eg, measurements with postural provocative tests, or measurements with reactive hyperemia)

**Global:** XXX **Issue:** Extremity Non-Invasive Arterial Physiologic Studies **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab 27 Specialty Developing Recommendation:** SVS, ACR, ACC

**First Identified:** February 2009

**2012 Est Medicare Utilization:** 560,809

**2007 Work RVU:** 0.45

**2013 Work RVU:** 0.45

**2007 NF PE RVU:** 4.18

**2013 NF PE RVU:** 3.80

**2007 Fac PE RVU:** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** 0.45

**CPT Action (if applicable):** February 2010

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Maintain

**93924** Noninvasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing, (ie, bidirectional Doppler waveform or volume plethysmography recording and analysis at rest with ankle/brachial indices immediately after and at timed intervals following performance of a standardized protocol on a motorized treadmill plus recording of time of onset of claudication or other symptoms, maximal walking time, and time to recovery) complete bilateral study

**Global:** XXX **Issue:** Extremity Non-Invasive Arterial Physiologic Studies

**Screen:** CMS Fastest Growing

**Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab 27 Specialty Developing Recommendation:** SVS, ACR, ACC

**First Identified:** February 2009

**2012 Est Medicare Utilization:** 103,201

**2007 Work RVU:** 0.50

**2013 Work RVU:** 0.50

**2007 NF PE RVU:** 5.05

**2013 NF PE RVU:** 4.84

**2007 Fac PE RVU:** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** 0.50

**CPT Action (if applicable):** February 2010

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Maintain



## Status Report: CMS Requests and Relativity Assessment Issues

**93925** Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study      **Global:** XXX      **Issue:** Extremity Studies      **Screen:** CMS-Other - Utilization over 500,000      **Complete?** Yes

**Most Recent RUC Meeting:** April 2012

**Tab** 35

**Specialty Developing Recommendation:** ACC, ACR, SVS

**First Identified:** April 2011

**2012 Est Medicare Utilization:** 580,237

**2007 Work RVU:** 0.58

**2013 Work RVU:** 0.80

**2007 NF PE RVU:** 7.05

**2013 NF PE RVU:** 6.66

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Decrease

**RUC Recommendation:** 0.90

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**93926** Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study      **Global:** XXX      **Issue:** Extremity Studies      **Screen:** CMS-Other - Utilization over 500,000      **Complete?** Yes

**Most Recent RUC Meeting:** April 2012

**Tab** 35

**Specialty Developing Recommendation:** ACC, ACR, SVS

**First Identified:** April 2011

**2012 Est Medicare Utilization:** 218,272

**2007 Work RVU:** 0.39

**2013 Work RVU:** 0.50

**2007 NF PE RVU:** 4.31

**2013 NF PE RVU:** 3.77

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Decrease

**RUC Recommendation:** 0.70

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**93931** Duplex scan of upper extremity arteries or arterial bypass grafts; unilateral or limited study      **Global:** XXX      **Issue:** Noninvasive Vascular Diagnostic Studies      **Screen:** Codes Reported Together 75% or More-Part1      **Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab** 45

**Specialty Developing Recommendation:** AAN, ACC, ACR, SIR, SVS

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 39,717

**2007 Work RVU:** 0.31

**2013 Work RVU:** 0.31

**2007 NF PE RVU:** 3.64

**2013 NF PE RVU:** 4.48

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** CCI Edits

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

October 2010

**Published in CPT Asst:**

# Status Report: CMS Requests and Relativity Assessment Issues

**93970** Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study **Global:** XXX **Issue:** Extremity Studies **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

**Most Recent RUC Meeting:** April 2012

**Tab** 35

**Specialty Developing Recommendation:** ACC, ACR, SVS

**First Identified:** April 2011

**2012 Est Medicare Utilization:** 1,639,051

**2007 Work RVU:** 0.68

**2013 Work RVU:** 0.70

**2007 NF PE RVU:** 5.44

**2013 NF PE RVU:** 4.91

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Decrease

**RUC Recommendation:** 0.70

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**93971** Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study **Global:** XXX **Issue:** Extremity Study **Screen:** Low Value-High Volume **Complete?** Yes

**Most Recent RUC Meeting:** April 2011

**Tab** 29

**Specialty Developing Recommendation:** ACR, SVS

**First Identified:** October 2010

**2012 Est Medicare Utilization:** 1,581,323

**2007 Work RVU:** 0.45

**2013 Work RVU:** 0.45

**2007 NF PE RVU:** 3.67

**2013 NF PE RVU:** 2.94

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** 0.45

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**93976** Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study **Global:** XXX **Issue:** Vascular Study **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent RUC Meeting:** October 2012

**Tab** 27

**Specialty Developing Recommendation:** ACR

**First Identified:** October 2008

**2012 Est Medicare Utilization:** 127,912

**2007 Work RVU:** 1.21

**2013 Work RVU:** 1.21

**2007 NF PE RVU:** 4.33

**2013 NF PE RVU:** 5.00

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Remove from Screen

**RUC Recommendation:** Remove from screen.

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**93978** Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study **Global:** XXX **Issue:** RAW **Screen:** CMS-Other - Utilization over 250,000 **Complete?** No

**Most Recent RUC Meeting:**

**Tab**

**Specialty Developing Recommendation:**

**First Identified:** April 2013

**2012 Est Medicare Utilization:** 297,849

**2007 Work RVU:** 0.65

**2013 Work RVU:** 0.65

**2007 NF PE RVU:** 4.85

**2013 NF PE RVU:** 6.24

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:**

**RUC Recommendation:** Review Action Plan

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

---

<b>93990</b>	Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)	<b>Global:</b> XXX	<b>Issue:</b> Echocardiography	<b>Screen:</b> CMS Fastest Growing	<b>Complete?</b> Yes
--------------	---	--------------------	--------------------------------	------------------------------------	----------------------

<b>Most Recent RUC Meeting:</b> October 2008	<b>Tab</b> 26	<b>Specialty Developing Recommendation:</b>	SVS
--	---------------	---	-----

<b>First Identified:</b> October 2008
---------------------------------------

<b>2012 Est Medicare Utilization:</b> 90,696
--

<b>2007 Work RVU:</b> 0.25	<b>2013 Work RVU:</b> 0.25
<b>2007 NF PE RVU:</b> 4.28	<b>2013 NF PE RVU:</b> 5.87
<b>2007 Fac PE RVU</b> NA	<b>2013 Fac PE RVU:</b> NA
<b>Result:</b> Remove from Screen	

**RUC Recommendation:** Remove from screen

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

---

<b>93990</b>	Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)
--------------	---

<b>Global:</b> XXX	<b>Issue:</b> RAW
--------------------	-------------------

<b>Screen:</b> High Volume Growth2	<b>Complete?</b> No
------------------------------------	---------------------

<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>
---------------------------------	------------	---

<b>First Identified:</b> April 2013
-------------------------------------

<b>2012 Est Medicare Utilization:</b> 90,696
--

<b>2007 Work RVU:</b> 0.25	<b>2013 Work RVU:</b> 0.25
<b>2007 NF PE RVU:</b> 4.28	<b>2013 NF PE RVU:</b> 5.87
<b>2007 Fac PE RVU</b> NA	<b>2013 Fac PE RVU:</b> NA
<b>Result:</b>	

**RUC Recommendation:** Review Action Plan

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

---

<b>94010</b>	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation
--------------	--

<b>Global:</b> XXX	<b>Issue:</b>
--------------------	---------------

<b>Screen:</b> Low Value-High Volume	<b>Complete?</b> Yes
--------------------------------------	----------------------

<b>Most Recent RUC Meeting:</b> February 2011	<b>Tab</b> 41	<b>Specialty Developing Recommendation:</b>
---	---------------	---

<b>First Identified:</b> October 2010
---------------------------------------

<b>2012 Est Medicare Utilization:</b> 1,300,252
---

<b>2007 Work RVU:</b> 0.17	<b>2013 Work RVU:</b> 0.17
<b>2007 NF PE RVU:</b> 0.69	<b>2013 NF PE RVU:</b> 0.91
<b>2007 Fac PE RVU</b> NA	<b>2013 Fac PE RVU:</b> NA
<b>Result:</b> Maintain	

**RUC Recommendation:** Reaffirmed RUC recommendation

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

<b>94014</b>	<b>Patient-initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and review and interpretation by a physician or other qualified health care professional</b>	<b>Global:</b> XXX	<b>Issue:</b> Pulmonary Tests	<b>Screen:</b> High Volume Growth1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2009	<b>Tab 38 Specialty Developing Recommendation:</b> ACCP/ATS	<b>First Identified:</b> February 2008	<b>2012 Est Medicare Utilization:</b> 1,225	<b>2007 Work RVU:</b> 0.52 <b>2007 NF PE RVU:</b> 0.77 <b>2007 Fac PE RVU:</b> NA <b>Result:</b> Remove from Screen	<b>2013 Work RVU:</b> 0.52 <b>2013 NF PE RVU:</b> 0.92 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Remove from screen - RUC articulated concerns regarding claims reporting to CMS	<b>CPT Action (if applicable):</b>	<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		
<hr/>					
<b>94015</b>	<b>Patient-initiated spirometric recording per 30-day period of time; recording (includes hook-up, reinforced education, data transmission, data capture, trend analysis, and periodic recalibration)</b>	<b>Global:</b> XXX	<b>Issue:</b> Pulmonary Tests	<b>Screen:</b> High Volume Growth1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2009	<b>Tab 38 Specialty Developing Recommendation:</b> ACCP/ATS	<b>First Identified:</b> February 2008	<b>2012 Est Medicare Utilization:</b> 874	<b>2007 Work RVU:</b> 0.00 <b>2007 NF PE RVU:</b> 0.61 <b>2007 Fac PE RVU:</b> NA <b>Result:</b> Remove from Screen	<b>2013 Work RVU:</b> 0.00 <b>2013 NF PE RVU:</b> 0.74 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Remove from screen - RUC articulated concerns regarding claims reporting to CMS	<b>CPT Action (if applicable):</b>	<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		
<hr/>					
<b>94016</b>	<b>Patient-initiated spirometric recording per 30-day period of time; review and interpretation only by a physician or other qualified health care professional</b>	<b>Global:</b> XXX	<b>Issue:</b> Pulmonary Tests	<b>Screen:</b> High Volume Growth1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2009	<b>Tab 38 Specialty Developing Recommendation:</b> ACCP/ATS	<b>First Identified:</b> April 2008	<b>2012 Est Medicare Utilization:</b> 30,141	<b>2007 Work RVU:</b> 0.52 <b>2007 NF PE RVU:</b> 0.16 <b>2007 Fac PE RVU:</b> 0.16 <b>Result:</b> Remove from Screen	<b>2013 Work RVU:</b> 0.52 <b>2013 NF PE RVU:</b> 0.18 <b>2013 Fac PE RVU:</b> 0.18
<b>RUC Recommendation:</b> Remove from screen - RUC articulated concerns regarding claims reporting to CMS	<b>CPT Action (if applicable):</b>	<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

## Status Report: CMS Requests and Relativity Assessment Issues

**94060** Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration

**Global:** XXX

**Issue:** Evaluation of Wheezing

**Screen:** MPC List

**Complete?** No

**Most Recent RUC Meeting:** October 2012

**Tab** 30

**Specialty Developing Recommendation:** ATS, ACCP

**First Identified:** October 2010

**2012 Est Medicare Utilization:** 1,222,537

**2007 Work RVU:** 0.31

**2013 Work RVU:** 0.27

**2007 NF PE RVU:** 1.13

**2013 NF PE RVU:** 1.60

**2007 Fac PE RVU** 1.13

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** Refer to CPT Assistant. 0.31

**CPT Action (if applicable):**

**Referred to CPT Asst** ☒

**Published in CPT Asst:**

**94240** Deleted from CPT

**Global:** XXX

**Issue:** Pulmonary Tests

**Screen:** Codes Reported Together 75% or More-Part1

**Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab** 45

**Specialty Developing Recommendation:** ACCP, ATS

**First Identified:** February 2010

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 0.26

**2013 Work RVU:**

**2007 NF PE RVU:** 0.7

**2013 NF PE RVU:**

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:**

**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):**

October 2010

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**94260** Deleted from CPT

**Global:** XXX

**Issue:** Pulmonary Tests

**Screen:** Codes Reported Together 75% or More-Part1

**Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab** 45

**Specialty Developing Recommendation:** ACCP, ATS

**First Identified:** February 2010

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 0.13

**2013 Work RVU:**

**2007 NF PE RVU:** 0.63

**2013 NF PE RVU:**

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:**

**Result:** Deleted from CPT

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):**

October 2010

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**94350** Deleted from CPT

**Global:** XXX **Issue:** Pulmonary Tests

**Screen:** Codes Reported Together 75% or More-Part1

**Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab** 45

**Specialty Developing Recommendation:** ACCP, ATS

**First Identified:** February 2010

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 0.26

**2013 Work RVU:**

**2007 NF PE RVU:** 0.73

**2013 NF PE RVU:**

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2010

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Deleted from CPT

**94360** Deleted from CPT

**Global:** XXX **Issue:** Pulmonary Tests

**Screen:** Codes Reported Together 75% or More-Part1

**Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab** 45

**Specialty Developing Recommendation:** ACCP, ATS

**First Identified:** February 2010

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 0.26

**2013 Work RVU:**

**2007 NF PE RVU:** 0.77

**2013 NF PE RVU:**

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2010

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Deleted from CPT

**94370** Determination of airway closing volume, single breath tests

**Global:** XXX **Issue:** Pulmonary Tests

**Screen:** Codes Reported Together 75% or More-Part1

**Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab** 45

**Specialty Developing Recommendation:** ACCP, ATS

**First Identified:** February 2010

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 0.26

**2013 Work RVU:**

**2007 NF PE RVU:** 0.69

**2013 NF PE RVU:**

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2010

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Deleted from CPT

# Status Report: CMS Requests and Relativity Assessment Issues

<b>94400</b>	<b>Breathing response to CO2 (CO2 response curve)</b>			<b>Global:</b> XXX	<b>Issue:</b> Pulmonary Diagnostic Testing	<b>Screen:</b> Codes Reported Together 75% or More-Part2	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	AAFP, ACCP, ATS, ACP, APTA, AOTA	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 2,673	<b>2007 Work RVU:</b> 0.40 <b>2007 NF PE RVU:</b> 0.89 <b>2007 Fac PE RVU:</b> NA	<b>2013 Work RVU:</b> 0.40 <b>2013 NF PE RVU:</b> 1.34 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Refer to CPT Assistant				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input checked="" type="checkbox"/>		<b>Published in CPT Asst:</b>	
						<b>Result:</b>	

<b>94450</b>	<b>Breathing response to hypoxia (hypoxia response curve)</b>			<b>Global:</b> XXX	<b>Issue:</b> Pulmonary Tests	<b>Screen:</b> High Volume Growth1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2009	<b>Tab</b> 38	<b>Specialty Developing Recommendation:</b>	ACCP/ATS	<b>First Identified:</b> February 2008	<b>2012 Est Medicare Utilization:</b> 913	<b>2007 Work RVU:</b> 0.40 <b>2007 NF PE RVU:</b> 0.89 <b>2007 Fac PE RVU:</b> NA	<b>2013 Work RVU:</b> 0.40 <b>2013 NF PE RVU:</b> 1.65 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Remove from screen - RUC articulated concerns regarding claims reporting to CMS				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	
						<b>Result:</b> Remove from Screen	

<b>94640</b>	<b>Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes (eg, with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing [IPPB] device)</b>			<b>Global:</b> XXX	<b>Issue:</b> Pulmonary Diagnostic Testing	<b>Screen:</b> Codes Reported Together 75% or More-Part2	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	AAFP, ACCP, ATS, ACP, APTA, AOTA	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 592,181	<b>2007 Work RVU:</b> 0.00 <b>2007 NF PE RVU:</b> 0.32 <b>2007 Fac PE RVU:</b> NA	<b>2013 Work RVU:</b> 0.00 <b>2013 NF PE RVU:</b> 0.56 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Refer to CPT Assistant				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input checked="" type="checkbox"/>		<b>Published in CPT Asst:</b>	
						<b>Result:</b>	

## Status Report: CMS Requests and Relativity Assessment Issues

<b>94668</b>	Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; subsequent	<b>Global:</b> XXX	<b>Issue:</b> Pulmonary Diagnostic Testing	<b>Screen:</b> Codes Reported Together 75% or More-Part2	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b>	<b>Specialty Developing Recommendation:</b> AAFP, ACCP, ATS, ACP, APTA, AOTA	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 11,301	<b>2007 Work RVU:</b> 0.00 <b>2007 NF PE RVU:</b> 0.46 <b>2007 Fac PE RVU:</b> NA <b>2013 Work RVU:</b> 0.00 <b>2013 NF PE RVU:</b> 0.79 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Refer to CPT Assistant			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input checked="" type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b>
<b>94681</b>	Oxygen uptake, expired gas analysis; including CO2 output, percentage oxygen extracted	<b>Global:</b> XXX	<b>Issue:</b> Pulmonary Tests	<b>Screen:</b> High Volume Growth1 / CMS Fastest Growing	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> September 2011	<b>Tab</b> 51	<b>Specialty Developing Recommendation:</b> AACE, TES, ACCP/ATS	<b>First Identified:</b> February 2008	<b>2012 Est Medicare Utilization:</b> 23,244	<b>2007 Work RVU:</b> 0.20 <b>2007 NF PE RVU:</b> 2.16 <b>2007 Fac PE RVU:</b> NA <b>2013 Work RVU:</b> 0.20 <b>2013 NF PE RVU:</b> 1.40 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Remove from screen			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b> Remove from Screen
<b>94720</b>	Carbon monoxide diffusing capacity (eg, single breath, steady state)	<b>Global:</b> XXX	<b>Issue:</b> Pulmonary Tests	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab</b> 45	<b>Specialty Developing Recommendation:</b> ACCP, ATS	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> 0.26 <b>2007 NF PE RVU:</b> 1.04 <b>2007 Fac PE RVU:</b> NA <b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>
<b>RUC Recommendation:</b> Deleted from CPT			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b> October 2010	<b>Result:</b> Deleted from CPT



## Status Report: CMS Requests and Relativity Assessment Issues

**94725** Membrane diffusion capacity

**Global:** XXX

**Issue:** Pulmonary Tests

**Screen:** Codes Reported Together 75% or More-Part1

**Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab** 45

**Specialty Developing Recommendation:** ACCP, ATS

**First Identified:** February 2010

**2012 Est Medicare Utilization:**

**2007 Work RVU:** 0.26

**2013 Work RVU:**

**2007 NF PE RVU:** 2.43

**2013 NF PE RVU:**

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2010

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**94726** Plethysmography for determination of lung volumes and, when performed, airway resistance

**Global:** XXX

**Issue:** Pulmonary Function Testing

**Screen:** Codes Reported Together 75% or More-Part1

**Complete?** Yes

**Most Recent RUC Meeting:** April 2011

**Tab** 19

**Specialty Developing Recommendation:** ACCP, ATS

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 562,881

**2007 Work RVU:**

**2013 Work RVU:** 0.26

**2007 NF PE RVU:**

**2013 NF PE RVU:** 1.50

**2007 Fac PE RVU**

**2013 Fac PE RVU:** NA

**RUC Recommendation:** 0.31

**CPT Action (if applicable):** February 2011

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**94727** Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes

**Global:** XXX

**Issue:** Pulmonary Function Testing

**Screen:** Codes Reported Together 75% or More-Part1

**Complete?** Yes

**Most Recent RUC Meeting:** April 2011

**Tab** 19

**Specialty Developing Recommendation:** ACCP, ATS

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 342,393

**2007 Work RVU:**

**2013 Work RVU:** 0.26

**2007 NF PE RVU:**

**2013 NF PE RVU:** 1.12

**2007 Fac PE RVU**

**2013 Fac PE RVU:** NA

**RUC Recommendation:** 0.31

**CPT Action (if applicable):** February 2011

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

<b>94728</b>	<b>Airway resistance by impulse oscillometry</b>			<b>Global:</b> XXX	<b>Issue:</b> Pulmonary Function Testing	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2011	<b>Tab</b> 19	<b>Specialty Developing Recommendation:</b>	ACCP, ATS	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 12,341	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease	<b>2013 Work RVU:</b> 0.26 <b>2013 NF PE RVU:</b> 1.07 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 0.31				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	February 2011 <b>Published in CPT Asst:</b>		
<hr/>							
<b>94729</b>	<b>Diffusing capacity (eg, carbon monoxide, membrane) (List separately in addition to code for primary procedure)</b>			<b>Global:</b> ZZZ	<b>Issue:</b> Pulmonary Function Testing	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2011	<b>Tab</b> 19	<b>Specialty Developing Recommendation:</b>	ACCP, ATS	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 940,345	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease	<b>2013 Work RVU:</b> 0.19 <b>2013 NF PE RVU:</b> 1.63 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 0.19				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	February 2011 <b>Published in CPT Asst:</b>		
<hr/>							
<b>94760</b>	<b>Noninvasive ear or pulse oximetry for oxygen saturation; single determination</b>			<b>Global:</b> XXX	<b>Issue:</b> Measure Blood Oxygen Level	<b>Screen:</b> CMS Request - Practice Expense Review	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2009	<b>Tab</b> 32	<b>Specialty Developing Recommendation:</b>	ACCP, ATS	<b>First Identified:</b> NA	<b>2012 Est Medicare Utilization:</b> 75,649	<b>2007 Work RVU:</b> 0.00 <b>2007 NF PE RVU:</b> 0.05 <b>2007 Fac PE RVU Result:</b> PE Only	<b>2013 Work RVU:</b> 0.00 <b>2013 NF PE RVU:</b> 0.09 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> New PE inputs				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

## Status Report: CMS Requests and Relativity Assessment Issues

<b>94761</b>	<b>Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations (eg, during exercise)</b>		<b>Global:</b> XXX	<b>Issue:</b> Measure Blood Oxygen Level	<b>Screen:</b> CMS Request - Practice Expense Review	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2009	<b>Tab</b> 32	<b>Specialty Developing Recommendation:</b> ACCP, ATS	<b>First Identified:</b> NA	<b>2012 Est Medicare Utilization:</b> 16,713	<b>2007 Work RVU:</b> 0.00 <b>2007 NF PE RVU:</b> 0.08 <b>2007 Fac PE RVU</b> NA <b>Result:</b> PE Only	<b>2013 Work RVU:</b> 0.00 <b>2013 NF PE RVU:</b> 0.14 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> New PE inputs			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		
<hr/>						
<b>94762</b>	<b>Noninvasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring (separate procedure)</b>		<b>Global:</b> XXX	<b>Issue:</b> Measure Blood Oxygen Level	<b>Screen:</b> CMS Fastest Growing, CMS Request - Practice Expense Review	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2009	<b>Tab</b> 32	<b>Specialty Developing Recommendation:</b> ACCP, ATS	<b>First Identified:</b> October 2008	<b>2012 Est Medicare Utilization:</b> 375,112	<b>2007 Work RVU:</b> 0.00 <b>2007 NF PE RVU:</b> 0.56 <b>2007 Fac PE RVU</b> NA <b>Result:</b> PE Only	<b>2013 Work RVU:</b> 0.00 <b>2013 NF PE RVU:</b> 0.73 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> New PE inputs			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		
<hr/>						
<b>94770</b>	<b>Carbon dioxide, expired gas determination by infrared analyzer</b>		<b>Global:</b> XXX	<b>Issue:</b> Pulmonary Tests	<b>Screen:</b> High Volume Growth1 / Codes Reported Together 75% or More-Part2	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b> 57	<b>Specialty Developing Recommendation:</b> ACCP/ATS	<b>First Identified:</b> February 2008	<b>2012 Est Medicare Utilization:</b> 10,665	<b>2007 Work RVU:</b> 0.15 <b>2007 NF PE RVU:</b> 0.76 <b>2007 Fac PE RVU</b> NA <b>Result:</b> PE Only	<b>2013 Work RVU:</b> 0.15 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 0.06
<b>RUC Recommendation:</b> Refer to CPT Assistant. Remove office-based PE inputs			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input checked="" type="checkbox"/>	<b>Published in CPT Asst:</b>		

# Status Report: CMS Requests and Relativity Assessment Issues

**95004** Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests **Global:** XXX **Issue:** Percutaneous Allergy Tests **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

**Most Recent RUC Meeting:** February 2011 **Tab** 41 **Specialty Developing Recommendation:** JCAAI, ACAAI, AAAAI **First Identified:** October 2010 **2012 Est Medicare Utilization:** 7,897,545 **2007 Work RVU:** 0.00 **2013 Work RVU:** 0.01 **2007 NF PE RVU:** 0.12 **2013 NF PE RVU:** 0.18 **2007 Fac PE RVU:** NA **2013 Fac PE RVU:** NA **RUC Recommendation:** 0.01 **CPT Action (if applicable):** Referred to CPT Asst ☐ **Published in CPT Asst:**

**95010** Percutaneous tests (scratch, puncture, prick) sequential and incremental, with drugs, biologicals or venoms, immediate type reaction, including test interpretation and report by a physician, specify number of tests **Global:** XXX **Issue:** Percutaneous Allergy Tests **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

**Most Recent RUC Meeting:** April 2011 **Tab** 31 **Specialty Developing Recommendation:** JCAAI, ACAAI, AAAAI **First Identified:** October 2010 **2012 Est Medicare Utilization:** 57,154 **2007 Work RVU:** 0.15 **2013 Work RVU:** **2007 NF PE RVU:** 0.31 **2013 NF PE RVU:** **2007 Fac PE RVU:** 0.06 **2013 Fac PE RVU:** **RUC Recommendation:** Deleted from CPT **CPT Action (if applicable):** February 2012 **Published in CPT Asst:**

**95015** Intracutaneous (intradermal) tests, sequential and incremental, with drugs, biologicals, or venoms, immediate type reaction, including test interpretation and report by a physician, specify number of tests **Global:** XXX **Issue:** Intracutaneous Allergy Tests **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

**Most Recent RUC Meeting:** April 2011 **Tab** 31 **Specialty Developing Recommendation:** JCAAI, ACAAI, AAAAI **First Identified:** October 2010 **2012 Est Medicare Utilization:** 71,402 **2007 Work RVU:** 0.15 **2013 Work RVU:** **2007 NF PE RVU:** 0.16 **2013 NF PE RVU:** **2007 Fac PE RVU:** 0.06 **2013 Fac PE RVU:** **RUC Recommendation:** Deleted from CPT **CPT Action (if applicable):** February 2012 **Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**95017** Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with venoms, immediate type reaction, including test interpretation and report, specify number of tests **Global:** XXX **Issue:** Percutaneous Allergy Testing **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

**Most Recent** **Tab** 29 **Specialty Developing Recommendation:** JCAAI

**RUC Meeting:** April 2012

**First Identified:** October 2010

**2012 Est Medicare Utilization:**

**2007 Work RVU:**

**2013 Work RVU:** 0.07

**2007 NF PE RVU:**

**2013 NF PE RVU:** 0.18

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 0.03

**RUC Recommendation:** 0.07

**CPT Action (if applicable):** February 2012  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Decrease

**95018** Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with drugs or biologicals, immediate type reaction, including test interpretation and report, specify number of tests **Global:** XXX **Issue:** Percutaneous Allergy Testing **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

**Most Recent** **Tab** 29 **Specialty Developing Recommendation:** JCAAI

**RUC Meeting:** April 2012

**First Identified:** October 2010

**2012 Est Medicare Utilization:**

**2007 Work RVU:**

**2013 Work RVU:** 0.14

**2007 NF PE RVU:**

**2013 NF PE RVU:** 0.49

**2007 Fac PE RVU**

**2013 Fac PE RVU:** 0.06

**RUC Recommendation:** 0.14

**CPT Action (if applicable):** February 2012  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Decrease

**95024** Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests **Global:** XXX **Issue:** Intracutaneous Allergy Tests **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

**Most Recent** **Tab** 31 **Specialty Developing Recommendation:** JCAAI, ACAAI, AAAAI, AAOA

**RUC Meeting:** April 2011

**First Identified:** October 2010

**2012 Est Medicare Utilization:** 1,976,447

**2007 Work RVU:** 0.00

**2013 Work RVU:** 0.01

**2007 NF PE RVU:** 0.17

**2013 NF PE RVU:** 0.22

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** 0.01

**RUC Recommendation:** New PE Inputs

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** PE Only

## Status Report: CMS Requests and Relativity Assessment Issues

---

<b>95027</b>	<b>Intracutaneous (intradermal) tests, sequential and incremental, with allergenic extracts for airborne allergens, immediate type reaction, including test interpretation and report, specify number of tests</b>	<b>Global:</b> XXX	<b>Issue:</b> Intracutaneous Allergy Tests	<b>Screen:</b> Low Value-Billed in Multiple Units	<b>Complete?</b> Yes
--------------	--	--------------------	--	---	----------------------

**Most Recent RUC Meeting:** February 2011

**Tab** 41

**Specialty Developing Recommendation:** JCAAI, ACAAI, AAAAI

**First Identified:** October 2010

**2012 Est Medicare Utilization:** 233,214

**2007 Work RVU:** 0.00

**2013 Work RVU:** 0.01

**2007 NF PE RVU:** 0.17

**2013 NF PE RVU:** 0.13

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** 0.01

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

---

<b>95115</b>	<b>Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection</b>	<b>Global:</b> XXX	<b>Issue:</b> Immunotherapy Injections	<b>Screen:</b> CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
--------------	--	--------------------	--	--	----------------------

**Most Recent RUC Meeting:** April 2012

**Tab** 48

**Specialty Developing Recommendation:** JCAAI, AAOA

**First Identified:** January 2012

**2012 Est Medicare Utilization:** 1,182,670

**2007 Work RVU:** 0.00

**2013 Work RVU:** 0.00

**2007 NF PE RVU:** 0.35

**2013 NF PE RVU:** 0.27

**2007 Fac PE RVU** 0.29

**2013 Fac PE RVU:** NA

**Result:** PE Only

**RUC Recommendation:** New PE Inputs

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

---

<b>95117</b>	<b>Professional services for allergen immunotherapy not including provision of allergenic extracts; 2 or more injections</b>	<b>Global:</b> XXX	<b>Issue:</b> Immunotherapy Injections	<b>Screen:</b> CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
--------------	--	--------------------	--	--	----------------------

**Most Recent RUC Meeting:** April 2012

**Tab** 48

**Specialty Developing Recommendation:** JCAAI, AAOA

**First Identified:** September 2011

**2012 Est Medicare Utilization:** 2,243,579

**2007 Work RVU:** 0.00

**2013 Work RVU:** 0.00

**2007 NF PE RVU:** 0.44

**2013 NF PE RVU:** 0.31

**2007 Fac PE RVU** 0.38

**2013 Fac PE RVU:** NA

**Result:** PE Only

**RUC Recommendation:** New PE Inputs

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

# Status Report: CMS Requests and Relativity Assessment Issues

**95144** Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy, single dose vial(s) (specify number of vials) **Global:** XXX **Issue:** Antigen Therapy Services **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

**Most Recent RUC Meeting:** February 2011 **Tab** 41 **Specialty Developing Recommendation:** JCAAI, ACAAI, AAAAI **First Identified:** October 2010 **2012 Est Medicare Utilization:** 189,301 **2007 Work RVU:** 0.06 **2013 Work RVU:** 0.06 **2007 NF PE RVU:** 0.21 **2013 NF PE RVU:** 0.31 **2007 Fac PE RVU:** 0.02 **2013 Fac PE RVU:** 0.02 **RUC Recommendation:** 0.06 **CPT Action (if applicable):** Referred to CPT Asst ☐ **Published in CPT Asst:**

**95148** Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 4 single stinging insect venoms **Global:** XXX **Issue:** **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

**Most Recent RUC Meeting:** October 2010 **Tab** 73 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2012 Est Medicare Utilization:** 14,211 **2007 Work RVU:** 0.06 **2013 Work RVU:** 0.06 **2007 NF PE RVU:** 0.67 **2013 NF PE RVU:** 1.54 **2007 Fac PE RVU:** 0.03 **2013 Fac PE RVU:** 0.02 **RUC Recommendation:** 0.06 **CPT Action (if applicable):** Referred to CPT Asst ☐ **Published in CPT Asst:**

**95165** Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses) **Global:** XXX **Issue:** **Screen:** MPC List **Complete?** Yes

**Most Recent RUC Meeting:** February 2011 **Tab** 41 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2012 Est Medicare Utilization:** 5,830,250 **2007 Work RVU:** 0.06 **2013 Work RVU:** 0.06 **2007 NF PE RVU:** 0.21 **2013 NF PE RVU:** 0.32 **2007 Fac PE RVU:** 0.02 **2013 Fac PE RVU:** 0.03 **RUC Recommendation:** Reaffirmed RUC recommendation **CPT Action (if applicable):** Referred to CPT Asst ☐ **Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**95251** Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; interpretation and report **Global:** XXX **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** No

<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> April 2013	<b>2012 Est Medicare Utilization:</b> 29,201	<b>2007 Work RVU:</b> 0.85	<b>2013 Work RVU:</b> 0.85
					<b>2007 NF PE RVU:</b> 0.21	<b>2013 NF PE RVU:</b> 0.36
					<b>2007 Fac PE RVU</b> 0.21	<b>2013 Fac PE RVU:</b> 0.36

**RUC Recommendation:** Review Action Plan **CPT Action (if applicable):**  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**95800** Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time **Global:** XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab</b> 28	<b>Specialty Developing Recommendation:</b> ACNS, AAN, ACCP/ATS, AASM	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 5,280	<b>2007 Work RVU:</b>	<b>2013 Work RVU:</b> 1.05
					<b>2007 NF PE RVU:</b>	<b>2013 NF PE RVU:</b> 4.26
					<b>2007 Fac PE RVU</b>	<b>2013 Fac PE RVU:</b> NA

**RUC Recommendation:** 1.05 **CPT Action (if applicable):** October 2009  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**95801** Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (eg, by airflow or peripheral arterial tone) **Global:** XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab</b> 28	<b>Specialty Developing Recommendation:</b> ACNS, AAN, ACCP/ATS, AASM	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 256	<b>2007 Work RVU:</b>	<b>2013 Work RVU:</b> 1.00
					<b>2007 NF PE RVU:</b>	<b>2013 NF PE RVU:</b> 1.75
					<b>2007 Fac PE RVU</b>	<b>2013 Fac PE RVU:</b> NA

**RUC Recommendation:** 1.00 **CPT Action (if applicable):** October 2009  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**



## Status Report: CMS Requests and Relativity Assessment Issues

---

<b>95803</b>	<b>Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)</b>	<b>Global:</b> XXX	<b>Issue:</b> Sleep Testing	<b>Screen:</b> CMS Request - Practice Expense Review	<b>Complete?</b> Yes
--------------	--	--------------------	-----------------------------	--	----------------------

**Most Recent RUC Meeting:** April 2010

**Tab** 28

**Specialty Developing Recommendation:**

ACNS, AAN, ACCP/ATS, AASM

**First Identified:** NA

**2012 Est Medicare Utilization:** 446

**2007 Work RVU:**

**2013 Work RVU:** 0.90

**2007 NF PE RVU:**

**2013 NF PE RVU:** 3.53

**2007 Fac PE RVU**

**2013 Fac PE RVU:** NA

**RUC Recommendation:** 0.90 and New PE inputs

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

---

<b>95805</b>	<b>Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness</b>	<b>Global:</b> XXX	<b>Issue:</b> Sleep Testing	<b>Screen:</b> CMS Fastest Growing	<b>Complete?</b> Yes
--------------	--	--------------------	-----------------------------	------------------------------------	----------------------

**Most Recent RUC Meeting:** April 2010

**Tab** 28

**Specialty Developing Recommendation:**

ACNS, AAN, ACCP/ATS, AASM

**First Identified:**

**2012 Est Medicare Utilization:** 5,050

**2007 Work RVU:** 1.88

**2013 Work RVU:** 1.20

**2007 NF PE RVU:** 14.7

**2013 NF PE RVU:** 11.34

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** 1.20

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

October 2009

**Published in CPT Asst:**

**Result:** Decrease

---

<b>95806</b>	<b>Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow, and respiratory effort (eg, thoracoabdominal movement)</b>	<b>Global:</b> XXX	<b>Issue:</b> Sleep Testing	<b>Screen:</b> CMS Fastest Growing	<b>Complete?</b> Yes
--------------	---	--------------------	-----------------------------	------------------------------------	----------------------

**Most Recent RUC Meeting:** April 2010

**Tab** 28

**Specialty Developing Recommendation:**

ACNS, AAN, ACCP/ATS, AASM

**First Identified:**

**2012 Est Medicare Utilization:** 10,572

**2007 Work RVU:** 1.66

**2013 Work RVU:** 1.25

**2007 NF PE RVU:** 3.46

**2013 NF PE RVU:** 4.06

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** 1.28

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

October 2009

**Published in CPT Asst:**

**Result:** Decrease

# Status Report: CMS Requests and Relativity Assessment Issues

**95807** Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist **Global:** XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent RUC Meeting:** April 2010 **Tab** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** **2012 Est Medicare Utilization:** 3,623 **2007 Work RVU:** 1.66 **2013 Work RVU:** 1.28 **2007 NF PE RVU:** 11.82 **2013 NF PE RVU:** 13.26 **2007 Fac PE RVU:** NA **2013 Fac PE RVU:** NA **Result:** Decrease

**RUC Recommendation:** 1.25 **CPT Action (if applicable):** October 2009 **Published in CPT Asst:**

**Referred to CPT Asst** ☐

**95808** Polysomnography; any age, sleep staging with 1-3 additional parameters of sleep, attended by a technologist **Global:** XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent RUC Meeting:** April 2010 **Tab** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** **2012 Est Medicare Utilization:** 1,119 **2007 Work RVU:** 2.65 **2013 Work RVU:** 1.74 **2007 NF PE RVU:** 13.79 **2013 NF PE RVU:** 17.33 **2007 Fac PE RVU:** NA **2013 Fac PE RVU:** NA **Result:** Decrease

**RUC Recommendation:** 1.74 **CPT Action (if applicable):** October 2009 **Published in CPT Asst:**

**Referred to CPT Asst** ☐

**95810** Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist **Global:** XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing / MPC List **Complete?** Yes

**Most Recent RUC Meeting:** April 2010 **Tab** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** **2012 Est Medicare Utilization:** 313,830 **2007 Work RVU:** 3.52 **2013 Work RVU:** 2.50 **2007 NF PE RVU:** 17.54 **2013 NF PE RVU:** 16.27 **2007 Fac PE RVU:** NA **2013 Fac PE RVU:** NA **Result:** Decrease

**RUC Recommendation:** 2.50 **CPT Action (if applicable):** October 2009 **Published in CPT Asst:**

**Referred to CPT Asst** ☐

**95811** Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist **Global:** XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent RUC Meeting:** April 2010 **Tab** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** **2012 Est Medicare Utilization:** 357,506 **2007 Work RVU:** 3.79 **2013 Work RVU:** 2.60 **2007 NF PE RVU:** 19.32 **2013 NF PE RVU:** 17.08 **2007 Fac PE RVU:** NA **2013 Fac PE RVU:** NA **Result:** Decrease

**RUC Recommendation:** 2.60 **CPT Action (if applicable):** October 2009 **Published in CPT Asst:**

**Referred to CPT Asst** ☐

## Status Report: CMS Requests and Relativity Assessment Issues

---

<b>95816</b>	<b>Electroencephalogram (EEG); including recording awake and drowsy</b>	<b>Global:</b> XXX	<b>Issue:</b> Electroencephalogram	<b>Screen:</b> CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b> 22	<b>Specialty Developing Recommendation:</b> AAN, ACNS	<b>First Identified:</b> January 2012	<b>2012 Est Medicare Utilization:</b> 284,837	<b>2007 Work RVU:</b> 1.08 <b>2007 NF PE RVU:</b> 4.1 <b>2007 Fac PE RVU</b> NA <b>2013 Work RVU:</b> 1.08 <b>2013 NF PE RVU:</b> 11.06 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 1.08			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b> Maintain

---

<b>95819</b>	<b>Electroencephalogram (EEG); including recording awake and asleep</b>	<b>Global:</b> XXX	<b>Issue:</b> Electroencephalogram	<b>Screen:</b> CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b> 22	<b>Specialty Developing Recommendation:</b> AAN, ACNS	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 273,513	<b>2007 Work RVU:</b> 1.08 <b>2007 NF PE RVU:</b> 3.76 <b>2007 Fac PE RVU</b> NA <b>2013 Work RVU:</b> 1.08 <b>2013 NF PE RVU:</b> 12.89 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 1.08			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b> Maintain

---

<b>95822</b>	<b>Electroencephalogram (EEG); recording in coma or sleep only</b>	<b>Global:</b> XXX	<b>Issue:</b> Electroencephalogram	<b>Screen:</b> CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b> 22	<b>Specialty Developing Recommendation:</b> AAN, ACNS	<b>First Identified:</b> January 2012	<b>2012 Est Medicare Utilization:</b> 22,129	<b>2007 Work RVU:</b> 1.08 <b>2007 NF PE RVU:</b> 4.82 <b>2007 Fac PE RVU</b> NA <b>2013 Work RVU:</b> 1.08 <b>2013 NF PE RVU:</b> 11.40 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 1.08			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b> Maintain

---

## Status Report: CMS Requests and Relativity Assessment Issues

<b>95860</b>	<b>Needle electromyography; 1 extremity with or without related paraspinal areas</b>	<b>Global:</b> XXX	<b>Issue:</b> EMG in Conjunction with Nerve Testing	<b>Screen:</b> Harvard Valued - Utilization over 100,000 / Codes Reported Together 75% or More-Part1 / Harvard-Valued Annual Allowed Charges over \$10 million	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2012	<b>Tab</b> 32	<b>Specialty Developing Recommendation:</b> AAN, AAPMR, AANEM, APTA	<b>First Identified:</b> October 2009	<b>2012 Est Medicare Utilization:</b> 51,483	<b>2007 Work RVU:</b> 0.96 <b>2007 NF PE RVU:</b> 1.36 <b>2007 Fac PE RVU:</b> NA <b>2013 Work RVU:</b> 0.96 <b>2013 NF PE RVU:</b> 2.74 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 0.96			<b>CPT Action (if applicable):</b> February 2011 & October 2011	<b>Result:</b> Maintain	
			<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	

<b>95861</b>	<b>Needle electromyography; 2 extremities with or without related paraspinal areas</b>	<b>Global:</b> XXX	<b>Issue:</b> EMG in Conjunction with Nerve Testing	<b>Screen:</b> Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2012	<b>Tab</b> 32	<b>Specialty Developing Recommendation:</b> AAN, AAPMR, AANEM, APTA	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 109,810	<b>2007 Work RVU:</b> 1.54 <b>2007 NF PE RVU:</b> 1.48 <b>2007 Fac PE RVU:</b> NA <b>2013 Work RVU:</b> 1.54 <b>2013 NF PE RVU:</b> 3.53 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 1.54			<b>CPT Action (if applicable):</b> February 2011 & October 2011 & February 2012	<b>Result:</b> Maintain	
			<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	

## Status Report: CMS Requests and Relativity Assessment Issues

**95863** Needle electromyography; 3 extremities with or without related paraspinal areas **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

**Most Recent RUC Meeting:** April 2012

**Tab** 32

**Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 3,359

**2007 Work RVU:** 1.87  
**2007 NF PE RVU:** 1.79  
**2007 Fac PE RVU:** NA

**2013 Work RVU:** 1.87  
**2013 NF PE RVU:** 4.32  
**2013 Fac PE RVU:** NA

**RUC Recommendation:** 1.87

**CPT Action (if applicable):** February 2011 & October 2011

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Maintain

**95864** Needle electromyography; 4 extremities with or without related paraspinal areas **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

**Most Recent RUC Meeting:** April 2012

**Tab** 32

**Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 6,362

**2007 Work RVU:** 1.99  
**2007 NF PE RVU:** 2.53  
**2007 Fac PE RVU:** NA

**2013 Work RVU:** 1.99  
**2013 NF PE RVU:** 5.12  
**2013 Fac PE RVU:** NA

**RUC Recommendation:** 1.99

**CPT Action (if applicable):** February 2011 & October 2011

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Maintain

**95867** Needle electromyography; cranial nerve supplied muscle(s), unilateral **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

**Most Recent RUC Meeting:** April 2012

**Tab** 32

**Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA

**First Identified:**

**2012 Est Medicare Utilization:** 2,903

**2007 Work RVU:** 0.79  
**2007 NF PE RVU:** 0.98  
**2007 Fac PE RVU:** NA

**2013 Work RVU:** 0.79  
**2013 NF PE RVU:** 2.56  
**2013 Fac PE RVU:** NA

**RUC Recommendation:** 0.79

**CPT Action (if applicable):** October 2011

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Maintain

## Status Report: CMS Requests and Relativity Assessment Issues

<b>95868</b>	<b>Needle electromyography; cranial nerve supplied muscles, bilateral</b>	<b>Global:</b> XXX	<b>Issue:</b> EMG in Conjunction with Nerve Testing	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2012	<b>Tab</b> 32	<b>Specialty Developing Recommendation:</b> AAN, AAPMR, AANEM, APTA	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 2,351	<b>2007 Work RVU:</b> 1.18 <b>2007 NF PE RVU:</b> 1.26 <b>2007 Fac PE RVU:</b> NA <b>2013 Work RVU:</b> 1.18 <b>2013 NF PE RVU:</b> 3.02 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 1.18			<b>CPT Action (if applicable):</b> Referred to CPT Asst <input type="checkbox"/>	October 2011 <b>Published in CPT Asst:</b>	<b>Result:</b> Maintain
<b>95869</b>	<b>Needle electromyography; thoracic paraspinal muscles (excluding T1 or T12)</b>	<b>Global:</b> XXX	<b>Issue:</b> EMG in Conjunction with Nerve Testing	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2012	<b>Tab</b> 32	<b>Specialty Developing Recommendation:</b> AAN, AAPMR, AANEM, APTA	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 2,402	<b>2007 Work RVU:</b> 0.37 <b>2007 NF PE RVU:</b> 0.53 <b>2007 Fac PE RVU:</b> NA <b>2013 Work RVU:</b> 0.37 <b>2013 NF PE RVU:</b> 2.17 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 0.37			<b>CPT Action (if applicable):</b> Referred to CPT Asst <input type="checkbox"/>	October 2011 <b>Published in CPT Asst:</b>	<b>Result:</b> Maintain
<b>95870</b>	<b>Needle electromyography; limited study of muscles in 1 extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters</b>	<b>Global:</b> XXX	<b>Issue:</b> EMG in Conjunction with Nerve Testing	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2012	<b>Tab</b> 32	<b>Specialty Developing Recommendation:</b> AAN, AAPMR, AANEM, APTA	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 39,035	<b>2007 Work RVU:</b> 0.37 <b>2007 NF PE RVU:</b> 0.53 <b>2007 Fac PE RVU:</b> NA <b>2013 Work RVU:</b> 0.37 <b>2013 NF PE RVU:</b> 2.30 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 0.37			<b>CPT Action (if applicable):</b> Referred to CPT Asst <input type="checkbox"/>	October 2011 <b>Published in CPT Asst:</b>	<b>Result:</b> Maintain

## Status Report: CMS Requests and Relativity Assessment Issues

**95885** Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; limited (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

**Most Recent RUC Meeting:** April 2011

**Tab** 20

**Specialty Developing Recommendation:** AAN, AAPMR, AANEM, ACNS, APTA

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 134,489

**2007 Work RVU:**  
**2007 NF PE RVU:**  
**2007 Fac PE RVU**

**2013 Work RVU:** 0.35  
**2013 NF PE RVU:** 1.43  
**2013 Fac PE RVU:** NA

**RUC Recommendation:** 0.35

**CPT Action (if applicable):** February 2011 and October 2011

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**95886** Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels (List separately in addition to code for primary procedure)

**Global:** ZZZ

**Issue:** EMG in Conjunction with Nerve Testing

**Screen:** Codes Reported Together 75% or More-Part1

**Complete?** Yes

**Most Recent RUC Meeting:** April 2011

**Tab** 20

**Specialty Developing Recommendation:** AAN, AAPMR, AANEM, ACNS, APTA

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 720,554

**2007 Work RVU:**  
**2007 NF PE RVU:**  
**2007 Fac PE RVU**

**2013 Work RVU:** 0.70  
**2013 NF PE RVU:** 1.76  
**2013 Fac PE RVU:** NA

**RUC Recommendation:** 0.92

**CPT Action (if applicable):** February 2011 and October 2011

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**95887** Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study (List separately in addition to code for primary procedure)

**Global:** ZZZ

**Issue:** EMG in Conjunction with Nerve Testing

**Screen:** Codes Reported Together 75% or More-Part1

**Complete?** Yes

**Most Recent RUC Meeting:** April 2011

**Tab** 20

**Specialty Developing Recommendation:** AAN, AAPMR, AANEM, ACNS, APTA

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 5,199

**2007 Work RVU:**  
**2007 NF PE RVU:**  
**2007 Fac PE RVU**

**2013 Work RVU:** 0.47  
**2013 NF PE RVU:** 1.61  
**2013 Fac PE RVU:** NA

**RUC Recommendation:** 0.73

**CPT Action (if applicable):** February 2011 and October 2011

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

## Status Report: CMS Requests and Relativity Assessment Issues

**95900** Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** MPC List / Codes Reported Together 75% or More-Part1 **Complete?** Yes

**Most Recent RUC Meeting:** April 2012

**Tab** 32

**Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA

**First Identified:** October 2010

**2012 Est Medicare Utilization:** 1,281,901

**2007 Work RVU:** 0.42  
**2007 NF PE RVU:** 1.18  
**2007 Fac PE RVU** NA

**2013 Work RVU:**  
**2013 NF PE RVU:**  
**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2011& February 2012

**Result:** Deleted from CPT

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**95903** Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** CMS High Expenditure Procedural Codes / Codes Reported Together 75% or More-Part1 **Complete?** Yes

**Most Recent RUC Meeting:** April 2012

**Tab** 32

**Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA

**First Identified:** September 2011

**2012 Est Medicare Utilization:** 2,077,053

**2007 Work RVU:** 0.60  
**2007 NF PE RVU:** 1.15  
**2007 Fac PE RVU** NA

**2013 Work RVU:**  
**2013 NF PE RVU:**  
**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** October 2011 and February 2012 & February 2012

**Result:** Deleted from CPT

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**95904** Nerve conduction, amplitude and latency/velocity study, each nerve; sensory **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 / Low Value-Billed in Multiple Units **Complete?** Yes

**Most Recent RUC Meeting:** April 2012

**Tab** 32

**Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 3,608,158

**2007 Work RVU:** 0.34  
**2007 NF PE RVU:** 1.03  
**2007 Fac PE RVU** NA

**2013 Work RVU:**  
**2013 NF PE RVU:**  
**2013 Fac PE RVU:**

**RUC Recommendation:** Deleted from CPT

**CPT Action (if applicable):** February 2011 & October 2011 & February 2012

**Result:** Deleted from CPT

**Referred to CPT Asst** ☐

**Published in CPT Asst:**



# Status Report: CMS Requests and Relativity Assessment Issues

## 95907 Nerve conduction studies; 1-2 studies

Global: XXX

Issue: EMG in Conjunction with Nerve Testing

Screen: Codes Reported Together 75% or More-Part1

Complete? Yes

Most Recent RUC Meeting: April 2012

Tab 32

Specialty Developing Recommendation:

AAN, AAPMR, AANEM, APTA

First Identified:

2012 Est Medicare Utilization:

2007 Work RVU:

2013 Work RVU: 1.00

2007 NF PE RVU:

2013 NF PE RVU: 1.72

2007 Fac PE RVU

2013 Fac PE RVU: NA

RUC Recommendation: 1.00

CPT Action (if applicable): February 2012

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Decrease

## 95908 Nerve conduction studies; 3-4 studies

Global: XXX

Issue: EMG in Conjunction with Nerve Testing

Screen: Codes Reported Together 75% or More-Part1

Complete? Yes

Most Recent RUC Meeting: April 2012

Tab 32

Specialty Developing Recommendation:

AAN, AAPMR, AANEM, APTA

First Identified:

2012 Est Medicare Utilization:

2007 Work RVU:

2013 Work RVU: 1.25

2007 NF PE RVU:

2013 NF PE RVU: 2.11

2007 Fac PE RVU

2013 Fac PE RVU: NA

RUC Recommendation: 1.37

CPT Action (if applicable): February 2012

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Decrease

## 95909 Nerve conduction studies; 5-6 studies

Global: XXX

Issue: EMG in Conjunction with Nerve Testing

Screen: Codes Reported Together 75% or More-Part1

Complete? Yes

Most Recent RUC Meeting: April 2012

Tab 32

Specialty Developing Recommendation:

AAN, AAPMR, AANEM, APTA

First Identified:

2012 Est Medicare Utilization:

2007 Work RVU:

2013 Work RVU: 1.50

2007 NF PE RVU:

2013 NF PE RVU: 2.52

2007 Fac PE RVU

2013 Fac PE RVU: NA

RUC Recommendation: 1.77

CPT Action (if applicable): February 2012

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Decrease

## Status Report: CMS Requests and Relativity Assessment Issues

### 95910 Nerve conduction studies; 7-8 studies

Global: XXX

Issue: EMG in Conjunction with Nerve Testing

Screen: Codes Reported Together 75% or More-Part1

Complete? Yes

Most Recent RUC Meeting: April 2012

Tab 32

Specialty Developing Recommendation:

AAN, AAPMR, AANEM, APTA

First Identified:

2012 Est Medicare Utilization:

2007 Work RVU:

2013 Work RVU: 2.00

2007 NF PE RVU:

2013 NF PE RVU: 3.29

2007 Fac PE RVU

2013 Fac PE RVU: NA

RUC Recommendation: 2.80

CPT Action (if applicable): February 2012

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Decrease

### 95911 Nerve conduction studies; 9-10 studies

Global: XXX

Issue: EMG in Conjunction with Nerve Testing

Screen: Codes Reported Together 75% or More-Part1

Complete? Yes

Most Recent RUC Meeting: April 2012

Tab 32

Specialty Developing Recommendation:

AAN, AAPMR, AANEM, APTA

First Identified:

2012 Est Medicare Utilization:

2007 Work RVU:

2013 Work RVU: 2.50

2007 NF PE RVU:

2013 NF PE RVU: 3.90

2007 Fac PE RVU

2013 Fac PE RVU: NA

RUC Recommendation: 3.34

CPT Action (if applicable): February 2012

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Decrease

### 95912 Nerve conduction studies; 11-12 studies

Global: XXX

Issue: EMG in Conjunction with Nerve Testing

Screen: Codes Reported Together 75% or More-Part1

Complete? Yes

Most Recent RUC Meeting: April 2012

Tab 32

Specialty Developing Recommendation:

AAN, AAPMR, AANEM, APTA

First Identified:

2012 Est Medicare Utilization:

2007 Work RVU:

2013 Work RVU: 3.00

2007 NF PE RVU:

2013 NF PE RVU: 4.49

2007 Fac PE RVU

2013 Fac PE RVU: NA

RUC Recommendation: 4.00

CPT Action (if applicable): February 2012

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Decrease

# Status Report: CMS Requests and Relativity Assessment Issues

<b>95913</b>	Nerve conduction studies; 13 or more studies			<b>Global:</b> XXX	<b>Issue:</b> EMG in Conjunction with Nerve Testing	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2012	<b>Tab</b> 32	<b>Specialty Developing Recommendation:</b>	AAN, AAPMR, AANEM, APTA	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU</b>	<b>2013 Work RVU:</b> 3.56 <b>2013 NF PE RVU:</b> 5.12 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 4.20				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	February 2012 <b>Published in CPT Asst:</b>	<b>Result:</b> Decrease	
<b>95921</b>	Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including 2 or more of the following: heart rate response to deep breathing with recorded R-R interval, Valsalva ratio, and 30:15 ratio			<b>Global:</b> XXX	<b>Issue:</b> Autonomic Function Testing	<b>Screen:</b> Different Performing Specialty from Survey / Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2012	<b>Tab</b> 33	<b>Specialty Developing Recommendation:</b>	AAN, AANEM	<b>First Identified:</b> October 2009	<b>2012 Est Medicare Utilization:</b> 100,052	<b>2007 Work RVU:</b> 0.90 <b>2007 NF PE RVU:</b> 0.82 <b>2007 Fac PE RVU</b> NA	<b>2013 Work RVU:</b> 0.90 <b>2013 NF PE RVU:</b> 1.71 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 0.90				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	February 2012 <b>Published in CPT Asst:</b>	<b>Result:</b> Maintain	
<b>95922</b>	Testing of autonomic nervous system function; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least 5 minutes of passive tilt			<b>Global:</b> XXX	<b>Issue:</b> Autonomic Function Testing	<b>Screen:</b> High Volume Growth1 / CMS Fastest Growing / Different Performing Specialty from Survey / Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2012	<b>Tab</b> 33	<b>Specialty Developing Recommendation:</b>	AAN, AANEM	<b>First Identified:</b> February 2008	<b>2012 Est Medicare Utilization:</b> 93,970	<b>2007 Work RVU:</b> 0.96 <b>2007 NF PE RVU:</b> 1 <b>2007 Fac PE RVU</b> NA	<b>2013 Work RVU:</b> 0.96 <b>2013 NF PE RVU:</b> 2.19 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 0.96				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input checked="" type="checkbox"/>	February 2012 <b>Published in CPT Asst:</b>	<b>Result:</b> Maintain Dec 2008	

## Status Report: CMS Requests and Relativity Assessment Issues

<b>95923</b>	Testing of autonomic nervous system function; sudomotor, including 1 or more of the following: quantitative sudomotor axon reflex test (QSART), silastic sweat imprint, thermoregulatory sweat test, and changes in sympathetic skin potential	<b>Global:</b> XXX	<b>Issue:</b> Autonomic Function Testing	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2012	<b>Tab</b> 33 <b>Specialty Developing Recommendation:</b> AAN, AANEM	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 12,592	<b>2007 Work RVU:</b> 0.90 <b>2007 NF PE RVU:</b> 1.99 <b>2007 Fac PE RVU Result:</b> Maintain	<b>2013 Work RVU:</b> 0.90 <b>2013 NF PE RVU:</b> 6.78 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 0.90		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		
<b>95924</b>	Testing of autonomic nervous system function; combined parasympathetic and sympathetic adrenergic function testing with at least 5 minutes of passive tilt	<b>Global:</b> XXX	<b>Issue:</b> Autonomic Function Testing	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b> 06 <b>Specialty Developing Recommendation:</b> AAN, AANEM	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU Result:</b> Decrease	<b>2013 Work RVU:</b> 1.73 <b>2013 NF PE RVU:</b> 2.52 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 1.73		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		
<b>95925</b>	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs	<b>Global:</b> XXX	<b>Issue:</b> Evoked Potentials and Reflex Studies	<b>Screen:</b> Codes Reported Together 75% or More-Part1 / CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request Final Rule 2013	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2013	<b>Tab</b> 34 <b>Specialty Developing Recommendation:</b> AAN, AANEM, ACNS, AAPMR	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 13,272	<b>2007 Work RVU:</b> 0.54 <b>2007 NF PE RVU:</b> 1.63 <b>2007 Fac PE RVU</b> NA	<b>2013 Work RVU:</b> 0.54 <b>2013 NF PE RVU:</b> 5.23 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 0.54 and New PE Inputs		<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b> Maintain	

## Status Report: CMS Requests and Relativity Assessment Issues

**95926** Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs

**Global:** XXX

**Issue:** Evoked Potentials and Reflex Studies

**Screen:** Codes Reported Together 75% or More-Part1/ CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request Final Rule 2013

**Complete?** Yes

**Most Recent RUC Meeting:** January 2013

**Tab** 34

**Specialty Developing Recommendation:**

AAN,  
AANEM,  
ACNS,  
AAPMR

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 11,711

**2007 Work RVU:** 0.54

**2013 Work RVU:** 0.54

**2007 NF PE RVU:** 1.59

**2013 NF PE RVU:** 5.02

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** 0.54 and New PE Inputs

**CPT Action (if applicable):** October 2010

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Maintain

**95928** Central motor evoked potential study (transcranial motor stimulation); upper limbs

**Global:** XXX

**Issue:** Evoked Potentials and Reflex Studies

**Screen:** Codes Reported Together 75% or More-Part1 / CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request Final Rule 2013

**Complete?** Yes

**Most Recent RUC Meeting:** April 2013

**Tab** 36

**Specialty Developing Recommendation:**

AAN,  
AANEM,  
AAPMR,  
ACNS

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 1,797

**2007 Work RVU:** 1.50

**2013 Work RVU:** 1.50

**2007 NF PE RVU:** 3.25

**2013 NF PE RVU:** 7.11

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** 1.50

**CPT Action (if applicable):** October 2010

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Maintain

## Status Report: CMS Requests and Relativity Assessment Issues

<b>95929</b>	Central motor evoked potential study (transcranial motor stimulation); lower limbs	<b>Global:</b> XXX	<b>Issue:</b> Evoked Potentials and Reflex Studies	<b>Screen:</b> Codes Reported Together 75% or More-Part1 / CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request Final Rule 2013	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab</b> 36	<b>Specialty Developing Recommendation:</b> AAN, AANEM, AAPMR, ACNS	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 1,440	<b>2007 Work RVU:</b> 1.50 <b>2007 NF PE RVU:</b> 3.48 <b>2007 Fac PE RVU:</b> NA <b>2013 Work RVU:</b> 1.50 <b>2013 NF PE RVU:</b> 7.16 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 1.50			<b>CPT Action (if applicable):</b> October 2010 <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b> Maintain

<b>95934</b>	H-reflex, amplitude and latency study; record gastrocnemius/soleus muscle	<b>Global:</b> XXX	<b>Issue:</b>	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 414,024	<b>2007 Work RVU:</b> 0.51 <b>2007 NF PE RVU:</b> 0.55 <b>2007 Fac PE RVU:</b> NA <b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>
<b>RUC Recommendation:</b> Deleted from CPT			<b>CPT Action (if applicable):</b> October 2011 & February 2012 <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b> Deleted from CPT

<b>95936</b>	H-reflex, amplitude and latency study; record muscle other than gastrocnemius/soleus muscle	<b>Global:</b> XXX	<b>Issue:</b>	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 22,582	<b>2007 Work RVU:</b> 0.55 <b>2007 NF PE RVU:</b> 0.49 <b>2007 Fac PE RVU:</b> NA <b>2013 Work RVU:</b> <b>2013 NF PE RVU:</b> <b>2013 Fac PE RVU:</b>
<b>RUC Recommendation:</b> Deleted from CPT			<b>CPT Action (if applicable):</b> October 2011 & February 2012 <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>Result:</b> Deleted from CPT

## Status Report: CMS Requests and Relativity Assessment Issues

<b>95938</b>	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs			<b>Global:</b> XXX	<b>Issue:</b> Evoked Potentials and Reflex Studies	<b>Screen:</b> Codes Reported Together 75% or More-Part1 / CMS Request Final Rule 2013	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2013	<b>Tab</b> 34	<b>Specialty Developing Recommendation:</b>	AAN, AANEM, AAPMR, ACNS	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 41,292	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU</b>	<b>2013 Work RVU:</b> 0.86 <b>2013 NF PE RVU:</b> 8.88 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 0.86 and new PE inputs				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	October 2010 <b>Published in CPT Asst:</b>	<b>Result:</b> Decrease	
<b>95939</b>	Central motor evoked potential study (transcranial motor stimulation); in upper and lower limbs			<b>Global:</b> XXX	<b>Issue:</b> Evoked Potentials and Reflex Studies	<b>Screen:</b> Codes Reported Together 75% or More-Part1 / CMS Request Final Rule 2013	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2013	<b>Tab</b> 34	<b>Specialty Developing Recommendation:</b>	AAN, AANEM, AAPMR, ACNS	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 16,569	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU</b>	<b>2013 Work RVU:</b> 2.25 <b>2013 NF PE RVU:</b> 12.59 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> 2.25 and new PE inputs				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	October 2010 <b>Published in CPT Asst:</b>	<b>Result:</b> Decrease	
<b>95940</b>	Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure)			<b>Global:</b> XXX	<b>Issue:</b> Intraoperative Neurophysiology Monitoring	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2012	<b>Tab</b> 12	<b>Specialty Developing Recommendation:</b>		<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU</b>	<b>2013 Work RVU:</b> 0.60 <b>2013 NF PE RVU:</b> NA <b>2013 Fac PE RVU:</b> 0.31
<b>RUC Recommendation:</b> 0.60				<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	February 2012 <b>Published in CPT Asst:</b>	<b>Result:</b> Decrease	

# Status Report: CMS Requests and Relativity Assessment Issues

**95941** Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code for primary procedure) **Global:** XXX **Issue:** Intraoperative Neurophysiology Monitoring **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

**Most Recent RUC Meeting:** January 2012 **Tab 12** **Specialty Developing Recommendation:** **First Identified:** **2012 Est Medicare Utilization:** **2007 Work RVU:** **2013 Work RVU:** 0.00  
**2007 NF PE RVU:** **2013 NF PE RVU:** 0.00  
**2007 Fac PE RVU** **2013 Fac PE RVU:** 0.00  
**RUC Recommendation:** 2.00 **CPT Action (if applicable):** February 2012 **Published in CPT Asst:**  
**Referred to CPT Asst** ☐

**95943** Simultaneous, independent, quantitative measures of both parasympathetic function and sympathetic function, based on time-frequency analysis of heart rate variability concurrent with time-frequency analysis of continuous respiratory activity, with mean heart rate and blood pressure measures, during rest, paced (deep) breathing, Valsalva maneuvers, and head-up postural change **Global:** XXX **Issue:** Autonomic Function Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

**Most Recent RUC Meeting:** October 2012 **Tab 06** **Specialty Developing Recommendation:** AAN, AANEM **First Identified:** **2012 Est Medicare Utilization:** **2007 Work RVU:** **2013 Work RVU:** 0.00  
**2007 NF PE RVU:** **2013 NF PE RVU:** 0.00  
**2007 Fac PE RVU** **2013 Fac PE RVU:** 0.00  
**RUC Recommendation:** Carrier Price **CPT Action (if applicable):** February 2012 **Published in CPT Asst:**  
**Referred to CPT Asst** ☐

**95950** Monitoring for identification and lateralization of cerebral seizure focus, electroencephalographic (eg, 8 channel EEG) recording and interpretation, each 24 hours **Global:** XXX **Issue:** EEG Monitoring **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent RUC Meeting:** February 2010 **Tab 26** **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** February 2009 **2012 Est Medicare Utilization:** 1,208 **2007 Work RVU:** 1.51 **2013 Work RVU:** 1.51  
**2007 NF PE RVU:** 4.18 **2013 NF PE RVU:** 8.67  
**2007 Fac PE RVU** NA **2013 Fac PE RVU:** NA  
**RUC Recommendation:** 1.51 and new PE inputs **CPT Action (if applicable):** **Published in CPT Asst:**  
**Referred to CPT Asst** ☐



## Status Report: CMS Requests and Relativity Assessment Issues

**95953** Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours, unattended **Global:** XXX **Issue:** EEG Monitoring **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent RUC Meeting:** February 2010

**Tab** 26 **Specialty Developing Recommendation:** AAN, ACNS

**First Identified:** February 2009

**2012 Est Medicare Utilization:** 24,091

**2007 Work RVU:** 3.30

**2013 Work RVU:** 3.08

**2007 NF PE RVU:** 7.52

**2013 NF PE RVU:** 9.77

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** PE Only

**RUC Recommendation:** 3.08

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**95954** Pharmacological or physical activation requiring physician or other qualified health care professional attendance during EEG recording of activation phase (eg, thiopental activation test) **Global:** XXX **Issue:** EEG Monitoring **Screen:** High Volume Growth1 **Complete?** Yes

**Most Recent RUC Meeting:** February 2008

**Tab** S **Specialty Developing Recommendation:** AAN, ACNS

**First Identified:** February 2008

**2012 Est Medicare Utilization:** 2,544

**2007 Work RVU:** 2.45

**2013 Work RVU:** 2.45

**2007 NF PE RVU:** 4.38

**2013 NF PE RVU:** 11.48

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Remove from Screen

**RUC Recommendation:** Remove from screen

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**95956** Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, electroencephalographic (EEG) recording and interpretation, each 24 hours, attended by a technologist or nurse **Global:** XXX **Issue:** EEG Monitoring **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent RUC Meeting:** February 2010

**Tab** 26 **Specialty Developing Recommendation:** AAN, ACNS

**First Identified:** October 2008

**2012 Est Medicare Utilization:** 5,953

**2007 Work RVU:** 3.08

**2013 Work RVU:** 3.61

**2007 NF PE RVU:** 15.47

**2013 NF PE RVU:** 47.24

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** PE Only

**RUC Recommendation:** 3.61. CPT Assistant article published

**CPT Action (if applicable):**

**Referred to CPT Asst** ☒

**Published in CPT Asst:** Dec 2009

## Status Report: CMS Requests and Relativity Assessment Issues

<b>95970</b>	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (ie, cranial nerve, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming	<b>Global:</b> XXX	<b>Issue:</b> Implanted Neurostimulator Electronic Analysis	<b>Screen:</b> Harvard Valued - Utilization over 100,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab</b> 45 <b>Specialty Developing Recommendation:</b> AAN, AAPM, NASS, ACO, ACNS, ISIS, AAPMR	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 22,351	<b>2007 Work RVU:</b> 0.45 <b>2007 NF PE RVU:</b> 0.86 <b>2007 Fac PE RVU:</b> 0.14	<b>2013 Work RVU:</b> 0.45 <b>2013 NF PE RVU:</b> 1.62 <b>2013 Fac PE RVU:</b> 0.21
<b>RUC Recommendation:</b> 0.45	<b>CPT Action (if applicable):</b> Referred to CPT Asst <input type="checkbox"/>	February 2011	<b>Published in CPT Asst:</b>	<b>Result:</b> Maintain	

---

<b>95971</b>	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming	<b>Global:</b> XXX	<b>Issue:</b> Implanted Neurostimulator Electronic Analysis	<b>Screen:</b> Harvard Valued - Utilization over 100,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2010	<b>Tab</b> 45 <b>Specialty Developing Recommendation:</b> AAN, AAPM, NASS, ACO, ACNS, ISIS, AAPMR	<b>First Identified:</b> October 2009	<b>2012 Est Medicare Utilization:</b> 10,320	<b>2007 Work RVU:</b> 0.78 <b>2007 NF PE RVU:</b> 0.66 <b>2007 Fac PE RVU:</b> 0.22	<b>2013 Work RVU:</b> 0.78 <b>2013 NF PE RVU:</b> 0.92 <b>2013 Fac PE RVU:</b> 0.32
<b>RUC Recommendation:</b> 0.78	<b>CPT Action (if applicable):</b> Referred to CPT Asst <input type="checkbox"/>	February 2011	<b>Published in CPT Asst:</b>	<b>Result:</b> Maintain	

## Status Report: CMS Requests and Relativity Assessment Issues

95971	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming			Global: XXX	Issue: RAW	Screen: High Volume Growth2	Complete? No
Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:	First Identified: April 2013	2012 Est Medicare Utilization:	10,320	2007 Work RVU: 0.78 2007 NF PE RVU: 0.66 2007 Fac PE RVU 0.22	2013 Work RVU: 0.78 2013 NF PE RVU: 0.92 2013 Fac PE RVU: 0.32
RUC Recommendation: Review Action Plan			CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:	Result:	

95972	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, first hour			Global: XXX	Issue: RAW	Screen: High Volume Growth2	Complete? No
Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:	First Identified: April 2013	2012 Est Medicare Utilization: 63,743	2007 Work RVU: 1.50 2007 NF PE RVU: 1.21 2007 Fac PE RVU 0.48	2013 Work RVU: 1.50 2013 NF PE RVU: 1.59 2013 Fac PE RVU: 0.64	
RUC Recommendation: Review Action Plan			CPT Action (if applicable): Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:	Result:	

## Status Report: CMS Requests and Relativity Assessment Issues

**95972** Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, first hour

**Global:** XXX **Issue:** Implanted Neurostimulator Electronic Analysis **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab** 45

**Specialty Developing Recommendation:**

AAN, AAPM, NASS, ACO, ACNS, ISIS, AAPMR

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 63,743

**2007 Work RVU:** 1.50

**2013 Work RVU:** 1.50

**2007 NF PE RVU:** 1.21

**2013 NF PE RVU:** 1.59

**2007 Fac PE RVU:** 0.48

**2013 Fac PE RVU:** 0.64

**RUC Recommendation:** 1.50

**CPT Action (if applicable):** February 2011  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Maintain

**95973** Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)

**Global:** ZZZ

**Issue:** Implanted Neurostimulator Electronic Analysis

**Screen:** Harvard Valued - Utilization over 100,000

**Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab** 45

**Specialty Developing Recommendation:**

AAN, AAPM, NASS, ACO, ACNS, ISIS, AAPMR

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 1,898

**2007 Work RVU:** 0.92

**2013 Work RVU:** 0.92

**2007 NF PE RVU:** 0.61

**2013 NF PE RVU:** 0.86

**2007 Fac PE RVU:** 0.32

**2013 Fac PE RVU:** 0.41

**RUC Recommendation:** 0.92

**CPT Action (if applicable):** February 2011  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Maintain

## Status Report: CMS Requests and Relativity Assessment Issues

**95990** Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed; **Global:** XXX **Issue:** Electronic Analysis Implanted Pump **Screen:** Different Performing Specialty from Survey / Codes Reported Together 75% or More-Part1 **Complete?** Yes

**Most Recent RUC Meeting:** February 2011 **Tab** 07 **Specialty Developing Recommendation:** ASA, AAPM, NASS, AAMP&R, AANS/CNS, ISIS **First Identified:** April 2010 **2012 Est Medicare Utilization:** 10,364 **2007 Work RVU:** 0.00 **2013 Work RVU:** 0.00 **2007 NF PE RVU:** 1.53 **2013 NF PE RVU:** 2.81 **2007 Fac PE RVU** NA **2013 Fac PE RVU:** NA

**RUC Recommendation:** 0.00

**CPT Action (if applicable):** October 2010  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Maintain

**95991** Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed; requiring skill of a physician or other qualified health care professional **Global:** XXX **Issue:** Electronic Analysis Implanted Pump **Screen:** High Volume Growth1 / Codes Reported Together 75% or More-Part1 **Complete?** Yes

**Most Recent RUC Meeting:** February 2011 **Tab** 07 **Specialty Developing Recommendation:** ASA, AAPM **First Identified:** February 2008 **2012 Est Medicare Utilization:** 23,563 **2007 Work RVU:** 0.77 **2013 Work RVU:** 0.77 **2007 NF PE RVU:** 1.53 **2013 NF PE RVU:** 2.95 **2007 Fac PE RVU** NA **2013 Fac PE RVU:** 0.34

**RUC Recommendation:** 0.77

**CPT Action (if applicable):** October 2010  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:** Maintain

**96103** Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI), administered by a computer, with qualified health care professional interpretation and report **Global:** XXX **Issue:** RAW **Screen:** High Volume Growth2 / Different Performing Specialty from Survey2 **Complete?** No

**Most Recent RUC Meeting:** **Tab** **Specialty Developing Recommendation:** **First Identified:** April 2013 **2012 Est Medicare Utilization:** 51,913 **2007 Work RVU:** 0.51 **2013 Work RVU:** 0.51 **2007 NF PE RVU:** 0.49 **2013 NF PE RVU:** 1.52 **2007 Fac PE RVU** 0.15 **2013 Fac PE RVU:** 0.21

**RUC Recommendation:** Review Action Plan

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**Result:**

## Status Report: CMS Requests and Relativity Assessment Issues

**96105** Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour **Global:** XXX **Issue:** Assessment of Aphasia **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

**Most Recent RUC Meeting:** October 2009 **Tab** 33 **Specialty Developing Recommendation:** ASHA, AAN **First Identified:** **2012 Est Medicare Utilization:** 285 **2007 Work RVU:** 0.00 **2013 Work RVU:** 1.75 **2007 NF PE RVU:** 1.83 **2013 NF PE RVU:** 0.98 **2007 Fac PE RVU** NA **2013 Fac PE RVU:** NA **RUC Recommendation:** 1.75 **CPT Action (if applicable):** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Increase

**96120** Neuropsychological testing (eg, Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report **Global:** XXX **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** No

**Most Recent RUC Meeting:** **Tab** **Specialty Developing Recommendation:** **First Identified:** April 2013 **2012 Est Medicare Utilization:** 23,946 **2007 Work RVU:** 0.51 **2013 Work RVU:** 0.51 **2007 NF PE RVU:** 1.04 **2013 NF PE RVU:** 2.48 **2007 Fac PE RVU** 0.15 **2013 Fac PE RVU:** 0.19 **RUC Recommendation:** Review Action Plan **CPT Action (if applicable):** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:**

**96365** Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour **Global:** XXX **Issue:** Intravenous Infusion Therapy **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

**Most Recent RUC Meeting:** January 2013 **Tab** 28 **Specialty Developing Recommendation:** ACRh, ASCO, ASH, ISDA **First Identified:** September 2011 **2012 Est Medicare Utilization:** 1,349,768 **2007 Work RVU:** **2013 Work RVU:** 0.21 **2007 NF PE RVU:** **2013 NF PE RVU:** 1.98 **2007 Fac PE RVU** **2013 Fac PE RVU:** NA **RUC Recommendation:** 0.21 **CPT Action (if applicable):** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Maintain

# Status Report: CMS Requests and Relativity Assessment Issues

**96366** Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Intravenous Infusion Therapy **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

**Most Recent RUC Meeting:** January 2013

**Tab** 28

**Specialty Developing Recommendation:**

ACRh, ASCO, ASH, ISDA

**First Identified:**

**2012 Est Medicare Utilization:** 661,246

**2007 Work RVU:**

**2013 Work RVU:** 0.18

**2007 NF PE RVU:**

**2013 NF PE RVU:** 0.45

**2007 Fac PE RVU**

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** 0.18

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**96367** Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Intravenous Infusion Therapy **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

**Most Recent RUC Meeting:** January 2013

**Tab** 28

**Specialty Developing Recommendation:**

ACRh, ASCO, ASH, ISDA

**First Identified:** September 2011

**2012 Est Medicare Utilization:** 2,045,039

**2007 Work RVU:**

**2013 Work RVU:** 0.19

**2007 NF PE RVU:**

**2013 NF PE RVU:** 0.74

**2007 Fac PE RVU**

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** 0.19

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**96368** Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Intravenous Infusion Therapy **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

**Most Recent RUC Meeting:** January 2013

**Tab** 28

**Specialty Developing Recommendation:**

ACRh, ASCO, ASH, ISDA

**First Identified:**

**2012 Est Medicare Utilization:** 182,737

**2007 Work RVU:**

**2013 Work RVU:** 0.17

**2007 NF PE RVU:**

**2013 NF PE RVU:** 0.37

**2007 Fac PE RVU**

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** 0.17

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**96372** Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular      **Global:** XXX      **Issue:**      **Screen:** Different Performing Specialty from Survey2      **Complete?** No

<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> April 2013	<b>2012 Est Medicare Utilization:</b> 9,407,555	<b>2007 Work RVU:</b>	<b>2013 Work RVU:</b> 0.17
					<b>2007 NF PE RVU:</b>	<b>2013 NF PE RVU:</b> 0.58
					<b>2007 Fac PE RVU Result:</b>	<b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b>	Review Action Plan		<b>CPT Action (if applicable):</b>	<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	

**96405** Chemotherapy administration; intralesional, up to and including 7 lesions      **Global:** 000      **Issue:** Chemotherapy Administration      **Screen:** CMS Request - Practice Expense Review      **Complete?** Yes

<b>Most Recent RUC Meeting:</b> April 2008	<b>Tab</b> 55	<b>Specialty Developing Recommendation:</b> ASCO	<b>First Identified:</b> NA	<b>2012 Est Medicare Utilization:</b> 1,929	<b>2007 Work RVU:</b> 0.52	<b>2013 Work RVU:</b> 0.52
					<b>2007 NF PE RVU:</b> 2.71	<b>2013 NF PE RVU:</b> 1.92
					<b>2007 Fac PE RVU Result:</b> PE Only	<b>2013 Fac PE RVU:</b> 0.33
<b>RUC Recommendation:</b>	New PE inputs		<b>CPT Action (if applicable):</b>	<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	

**96406** Chemotherapy administration; intralesional, more than 7 lesions      **Global:** 000      **Issue:** Chemotherapy Administration      **Screen:** CMS Request - Practice Expense Review      **Complete?** Yes

<b>Most Recent RUC Meeting:</b> April 2008	<b>Tab</b> 55	<b>Specialty Developing Recommendation:</b> ASCO	<b>First Identified:</b> NA	<b>2012 Est Medicare Utilization:</b> 247	<b>2007 Work RVU:</b> 0.80	<b>2013 Work RVU:</b> 0.80
					<b>2007 NF PE RVU:</b> 3.08	<b>2013 NF PE RVU:</b> 2.64
					<b>2007 Fac PE RVU Result:</b> PE Only	<b>2013 Fac PE RVU:</b> 0.49
<b>RUC Recommendation:</b>	New PE inputs		<b>CPT Action (if applicable):</b>	<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	



# Status Report: CMS Requests and Relativity Assessment Issues

<b>96413</b>	<b>Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug</b>	<b>Global:</b> XXX	<b>Issue:</b> Chemotherapy Administration	<b>Screen:</b> Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2013	<b>Tab</b> 29	<b>Specialty Developing Recommendation:</b> ACRh, ASCO, ASH, ASBMT	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 2,134,601	<b>2007 Work RVU:</b> 0.28 <b>2007 NF PE RVU:</b> 4.05 <b>2007 Fac PE RVU</b> NA <b>Result:</b> Maintain
<b>RUC Recommendation:</b> 0.28 and new PE inputs			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 0.28 <b>2013 NF PE RVU:</b> 3.88 <b>2013 Fac PE RVU:</b> NA
<b>96415</b>	<b>Chemotherapy administration, intravenous infusion technique; each additional hour (List separately in addition to code for primary procedure)</b>	<b>Global:</b> ZZZ	<b>Issue:</b> Chemotherapy Administration	<b>Screen:</b> CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> January 2013	<b>Tab</b> 29	<b>Specialty Developing Recommendation:</b> ACRh, ASCO, ASH, ASBMT	<b>First Identified:</b> January 2012	<b>2012 Est Medicare Utilization:</b> 1,240,795	<b>2007 Work RVU:</b> 0.19 <b>2007 NF PE RVU:</b> 0.74 <b>2007 Fac PE RVU</b> NA <b>Result:</b> Maintain
<b>RUC Recommendation:</b> 0.19 and new PE inputs			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 0.19 <b>2013 NF PE RVU:</b> 0.70 <b>2013 Fac PE RVU:</b> NA
<b>96416</b>	<b>Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump</b>	<b>Global:</b> XXX	<b>Issue:</b> Chemotherapy Administration	<b>Screen:</b> Codes Reported Together 75% or More-Part1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2010	<b>Tab</b> 20	<b>Specialty Developing Recommendation:</b> ACRh, ASCO, ASH	<b>First Identified:</b> February 2010	<b>2012 Est Medicare Utilization:</b> 120,685	<b>2007 Work RVU:</b> 0.21 <b>2007 NF PE RVU:</b> 4.47 <b>2007 Fac PE RVU</b> NA <b>Result:</b> PE Only
<b>RUC Recommendation:</b> New PE inputs			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>	<b>2013 Work RVU:</b> 0.21 <b>2013 NF PE RVU:</b> 3.91 <b>2013 Fac PE RVU:</b> NA

## Status Report: CMS Requests and Relativity Assessment Issues

**96417** Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to 1 hour (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Chemotherapy Administration **Screen:** CMS High Expenditure Procedural Codes **Complete?** Yes

**Most Recent RUC Meeting:** January 2013

**Tab** 29

**Specialty Developing Recommendation:**

ACRh, ASCO, ASH, ASBMT

**First Identified:** January 2012

**2012 Est Medicare Utilization:** 545,111

**2007 Work RVU:** 0.21

**2013 Work RVU:** 0.21

**2007 NF PE RVU:** 1.89

**2013 NF PE RVU:** 1.85

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** 0.21 and new PE inputs

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**96440** Chemotherapy administration into pleural cavity, requiring and including thoracentesis

**Global:** 000

**Issue:** Chemotherapy Administration

**Screen:** CMS Request - Practice Expense Review

**Complete?** Yes

**Most Recent RUC Meeting:** February 2008

**Tab** R

**Specialty Developing Recommendation:**

**First Identified:** NA

**2012 Est Medicare Utilization:** 50

**2007 Work RVU:** 2.37

**2013 Work RVU:** 2.37

**2007 NF PE RVU:** 7.48

**2013 NF PE RVU:** 23.70

**2007 Fac PE RVU** 1.17

**2013 Fac PE RVU:** 1.18

**Result:** PE Only

**RUC Recommendation:** New PE inputs

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

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

**Global:** XXX

**Issue:** Photodynamic Therapy

**Screen:** High Volume Growth1 / CMS Fastest Growing

**Complete?** Yes

**Most Recent RUC Meeting:** April 2008

**Tab** 57

**Specialty Developing Recommendation:** AAD

**First Identified:** February 2008

**2012 Est Medicare Utilization:** 109,632

**2007 Work RVU:** 0.00

**2013 Work RVU:** 0.00

**2007 NF PE RVU:** 2.4

**2013 NF PE RVU:** 4.22

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Remove from Screen

**RUC Recommendation:** Remove from screen

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

# Status Report: CMS Requests and Relativity Assessment Issues

**96920** Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm      **Global:** 000      **Issue:** Laser Treatment – Skin      **Screen:** CMS Fastest Growing      **Complete?** Yes

**Most Recent**      **Tab** 18      **Specialty Developing**      AAD  
**RUC Meeting:** January 2012      **Recommendation:**

**First Identified:** October 2008

**2012 Est Medicare Utilization:** 61,255

**2007 Work RVU:** 1.15  
**2007 NF PE RVU:** 2.8  
**2007 Fac PE RVU:** 0.57

**2013 Work RVU:** 1.15  
**2013 NF PE RVU:** 3.47  
**2013 Fac PE RVU:** 0.76

**RUC Recommendation:** 1.15 and develop CPT Assistant article.

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☒

**Published in CPT Asst:** Jun 2012

**Result:** Maintain

**96921** Laser treatment for inflammatory skin disease (psoriasis); 250 sq cm to 500 sq cm

**Global:** 000

**Issue:** Laser Treatment – Skin

**Screen:** High Volume Growth1 / CMS Fastest Growing

**Complete?** Yes

**Most Recent**      **Tab** 18      **Specialty Developing**      AAD  
**RUC Meeting:** January 2012      **Recommendation:**

**First Identified:** February 2008

**2012 Est Medicare Utilization:** 17,743

**2007 Work RVU:** 1.17  
**2007 NF PE RVU:** 2.82  
**2007 Fac PE RVU:** 0.57

**2013 Work RVU:** 1.30  
**2013 NF PE RVU:** 3.79  
**2013 Fac PE RVU:** 0.85

**RUC Recommendation:** 1.30 and develop CPT Assistant article.

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☒

**Published in CPT Asst:** Jun 2012

**Result:** Increase

**96922** Laser treatment for inflammatory skin disease (psoriasis); over 500 sq cm

**Global:** 000

**Issue:** Laser Treatment – Skin

**Screen:** High Volume Growth1 / CMS Fastest Growing

**Complete?** Yes

**Most Recent**      **Tab** 18      **Specialty Developing**      AAD  
**RUC Meeting:** January 2012      **Recommendation:**

**First Identified:** October 2008

**2012 Est Medicare Utilization:** 10,697

**2007 Work RVU:** 2.10  
**2007 NF PE RVU:** 3.77  
**2007 Fac PE RVU:** 0.73

**2013 Work RVU:** 2.10  
**2013 NF PE RVU:** 4.93  
**2013 Fac PE RVU:** 1.39

**RUC Recommendation:** 2.10 and develop CPT Assistant article.

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☒

**Published in CPT Asst:** Jun 2012

**Result:** Maintain

**97001** Physical therapy evaluation

**Global:** XXX

**Issue:** RAW review

**Screen:** CMS High Expenditure Procedural Codes

**Complete?** No

**Most Recent**      **Tab** 30      **Specialty Developing**  
**RUC Meeting:** January 2012      **Recommendation:**

**First Identified:** September 2011

**2012 Est Medicare Utilization:** 2,160,777

**2007 Work RVU:** 1.20  
**2007 NF PE RVU:** 0.73  
**2007 Fac PE RVU:** NA

**2013 Work RVU:** 1.20  
**2013 NF PE RVU:** 0.95  
**2013 Fac PE RVU:** NA

**RUC Recommendation:** Refer to CPT

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐

**Published in CPT Asst:** May 2013

**Result:**

# Status Report: CMS Requests and Relativity Assessment Issues

**97016** Application of a modality to 1 or more areas; vasopneumatic devices

**Global:** XXX

**Issue:** RAW

**Screen:** High Volume Growth2

**Complete?** No

**Most Recent**  
**RUC Meeting:**

**Tab**

**Specialty Developing**  
**Recommendation:**

**First**  
**Identified:** April 2013

**2012 Est**  
**Medicare**  
**Utilization:** 355,134

**2007 Work RVU:** 0.18

**2013 Work RVU:** 0.18

**2007 NF PE RVU:** 0.2

**2013 NF PE RVU:** 0.39

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:**

**RUC Recommendation:** Review Action Plan

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**97016** Application of a modality to 1 or more areas; vasopneumatic devices

**Global:** XXX

**Issue:** Physical Medicine and  
Rehabilitation Therapeutic  
Procedures

**Screen:** Codes Reported  
Together 75% or More-  
Part1

**Complete?** Yes

**Most Recent**  
**RUC Meeting:** April 2010

**Tab** 45

**Specialty Developing**  
**Recommendation:** AOTA,  
APTA,  
AAPM&R

**First**  
**Identified:** February 2010

**2012 Est**  
**Medicare**  
**Utilization:** 355,134

**2007 Work RVU:** 0.18

**2013 Work RVU:** 0.18

**2007 NF PE RVU:** 0.2

**2013 NF PE RVU:** 0.39

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** Maintain

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**97018** Application of a modality to 1 or more areas; paraffin bath

**Global:** XXX

**Issue:** Physical Medicine and  
Rehabilitation Therapeutic  
Procedures

**Screen:** Codes Reported  
Together 75% or More-  
Part1

**Complete?** Yes

**Most Recent**  
**RUC Meeting:** April 2010

**Tab** 45

**Specialty Developing**  
**Recommendation:** AOTA,  
APTA,  
AAPM&R

**First**  
**Identified:** February 2010

**2012 Est**  
**Medicare**  
**Utilization:** 123,145

**2007 Work RVU:** 0.06

**2013 Work RVU:** 0.06

**2007 NF PE RVU:** 0.12

**2013 NF PE RVU:** 0.26

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** Maintain

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**97035** Application of a modality to 1 or more areas; ultrasound, each 15 minutes

**Global:** XXX

**Issue:**

**Screen:** Low Value-High Volume

**Complete?** Yes

**Most Recent**  
**RUC Meeting:** February 2011

**Tab** 41

**Specialty Developing**  
**Recommendation:**

**First**  
**Identified:** October 2010

**2012 Est**  
**Medicare**  
**Utilization:** 3,600,591

**2007 Work RVU:** 0.21

**2013 Work RVU:** 0.21

**2007 NF PE RVU:** 0.1

**2013 NF PE RVU:** 0.15

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** Reaffirmed RUC recommendation

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**97110** Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility **Global:** XXX **Issue:** Physical Medicine and Rehabilitation Therapeutic Procedures **Screen:** Codes Reported Together 75% or More-Part1 / MPC List **Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab** 45

**Specialty Developing Recommendation:** AOTA, APTA, AAPM&R

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 44,238,381

**2007 Work RVU:** 0.45

**2013 Work RVU:** 0.45

**2007 NF PE RVU:** 0.28

**2013 NF PE RVU:** 0.48

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** Maintain

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**97112** Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities

**Global:** XXX

**Issue:** RAW review

**Screen:** CMS High Expenditure Procedural Codes

**Complete?** No

**Most Recent RUC Meeting:** January 2012

**Tab** 30

**Specialty Developing Recommendation:**

**First Identified:** September 2011

**2012 Est Medicare Utilization:** 7,335,238

**2007 Work RVU:** 0.45

**2013 Work RVU:** 0.45

**2007 NF PE RVU:** 0.32

**2013 NF PE RVU:** 0.52

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:**

**RUC Recommendation:** Refer to CPT

**CPT Action (if applicable):**

May 2013

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**97116** Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)

**Global:** XXX

**Issue:** Physical Medicine and Rehabilitation Therapeutic Procedures

**Screen:** Codes Reported Together 75% or More-Part1

**Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab** 45

**Specialty Developing Recommendation:** AOTA, APTA, AAPM&R

**First Identified:** February 2010

**2012 Est Medicare Utilization:** 1,653,552

**2007 Work RVU:** 0.40

**2013 Work RVU:** 0.40

**2007 NF PE RVU:** 0.25

**2013 NF PE RVU:** 0.42

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Maintain

**RUC Recommendation:** 0.40

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**97140** Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes

**Global:** XXX

**Issue:** RAW review

**Screen:** CMS High Expenditure  
Procedural Codes

**Complete?** No

**Most Recent  
RUC Meeting:** January 2012

**Tab** 30

**Specialty Developing  
Recommendation:**

**First  
Identified:** September 2011

**2012 Est  
Medicare  
Utilization:** 19,250,734

**2007 Work RVU:** 0.43

**2013 Work RVU:** 0.43

**2007 NF PE RVU:** 0.26

**2013 NF PE RVU:** 0.44

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** Refer to CPT

**CPT Action (if applicable):** May 2013

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:**

**97150** Therapeutic procedure(s), group (2 or more individuals)

**Global:** XXX

**Issue:** Group Therapeutic  
Procedure

**Screen:** CMS-Other - Utilization  
over 500,000

**Complete?** Yes

**Most Recent  
RUC Meeting:** January 2012

**Tab** 32

**Specialty Developing  
Recommendation:** APTA, AOTA

**First  
Identified:** April 2011

**2012 Est  
Medicare  
Utilization:** 743,134

**2007 Work RVU:** 0.27

**2013 Work RVU:** 0.29

**2007 NF PE RVU:** 0.19

**2013 NF PE RVU:** 0.21

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** 0.29

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Increase

**97530** Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes

**Global:** XXX

**Issue:** RAW review

**Screen:** CMS High Expenditure  
Procedural Codes

**Complete?** No

**Most Recent  
RUC Meeting:** January 2012

**Tab** 30

**Specialty Developing  
Recommendation:**

**First  
Identified:** September 2011

**2012 Est  
Medicare  
Utilization:** 7,309,156

**2007 Work RVU:** 0.44

**2013 Work RVU:** 0.44

**2007 NF PE RVU:** 0.34

**2013 NF PE RVU:** 0.58

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**RUC Recommendation:** Refer to CPT

**CPT Action (if applicable):** May 2013

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:**

## Status Report: CMS Requests and Relativity Assessment Issues

**97532** Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes **Global:** XXX **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** No

<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> April 2013	<b>2012 Est Medicare Utilization:</b> 223,201	<b>2007 Work RVU:</b> 0.44 <b>2007 NF PE RVU:</b> 0.21 <b>2007 Fac PE RVU Result:</b> NA	<b>2013 Work RVU:</b> 0.44 <b>2013 NF PE RVU:</b> 0.32 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Review Action Plan			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	

**97535** Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes **Global:** XXX **Issue:** Pulmonary Diagnostic Testing **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** No

<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b>	<b>Specialty Developing Recommendation:</b> AAFP, ACCP, ATS, ACP, APTA, AOTA	<b>First Identified:</b>	<b>2012 Est Medicare Utilization:</b> 887,885	<b>2007 Work RVU:</b> 0.45 <b>2007 NF PE RVU:</b> 0.34 <b>2007 Fac PE RVU</b> NA	<b>2013 Work RVU:</b> 0.45 <b>2013 NF PE RVU:</b> 0.56 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Refer to CPT Assistant			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input checked="" type="checkbox"/>		<b>Published in CPT Asst:</b>	

**97542** Wheelchair management (eg, assessment, fitting, training), each 15 minutes **Global:** XXX **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** No

<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> April 2013	<b>2012 Est Medicare Utilization:</b> 28,676	<b>2007 Work RVU:</b> 0.45 <b>2007 NF PE RVU:</b> 0.28 <b>2007 Fac PE RVU</b> NA	<b>2013 Work RVU:</b> 0.45 <b>2013 NF PE RVU:</b> 0.43 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Review Action Plan			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	

## Status Report: CMS Requests and Relativity Assessment Issues

**97597** Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less

**Global:** 000 **Issue:** Excision and Debridement **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab** 04 **Specialty Developing Recommendation:** APTA, APMA

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 1,079,349

**2007 Work RVU:** 0.58

**2013 Work RVU:** 0.51

**2007 NF PE RVU:** 0.77

**2013 NF PE RVU:** 1.74

**2007 Fac PE RVU:** 0.53

**2013 Fac PE RVU:** 0.13

**RUC Recommendation:** 0.54

**CPT Action (if applicable):** October 2009

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

**97598** Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

**Global:** ZZZ **Issue:** Excision and Debridement **Screen:** Site of Service Anomaly **Complete?** Yes

**Most Recent RUC Meeting:** April 2010

**Tab** 04 **Specialty Developing Recommendation:** APTA, APMA

**First Identified:** September 2007

**2012 Est Medicare Utilization:** 90,848

**2007 Work RVU:** 0.80

**2013 Work RVU:** 0.24

**2007 NF PE RVU:** 0.91

**2013 NF PE RVU:** 0.48

**2007 Fac PE RVU:** 0.64

**2013 Fac PE RVU:** 0.06

**RUC Recommendation:** 0.40

**CPT Action (if applicable):** October 2009

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:** Decrease

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

**Global:** XXX **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** No

**Most Recent RUC Meeting:**

**Tab** **Specialty Developing Recommendation:**

**First Identified:** April 2013

**2012 Est Medicare Utilization:** 39,725

**2007 Work RVU:** 0.55

**2013 Work RVU:** 0.55

**2007 NF PE RVU:** 0.36

**2013 NF PE RVU:** 0.62

**2007 Fac PE RVU:** 0.2

**2013 Fac PE RVU:** 0.14

**RUC Recommendation:** Review Action Plan

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**Result:**



## Status Report: CMS Requests and Relativity Assessment Issues

<b>97606</b>	Negative pressure wound therapy (eg, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters	<b>Global:</b> XXX	<b>Issue:</b> RAW	<b>Screen:</b> High Volume Growth2	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> April 2013	<b>2012 Est Medicare Utilization:</b> 11,065	<b>2007 Work RVU:</b> 0.60 <b>2007 NF PE RVU:</b> 0.37 <b>2007 Fac PE RVU Result:</b> 0.21 <b>2013 Work RVU:</b> 0.60 <b>2013 NF PE RVU:</b> 0.63 <b>2013 Fac PE RVU:</b> 0.16
<b>RUC Recommendation:</b> Review Action Plan			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>
<b>97755</b>	Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes	<b>Global:</b> XXX	<b>Issue:</b> Assistive Technology Assessment	<b>Screen:</b> High Volume Growth1	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> February 2008	<b>Tab</b> S	<b>Specialty Developing Recommendation:</b> AAPMR, APTA, AOTA	<b>First Identified:</b> February 2008	<b>2012 Est Medicare Utilization:</b> 4,022	<b>2007 Work RVU:</b> 0.62 <b>2007 NF PE RVU:</b> 0.28 <b>2007 Fac PE RVU Result:</b> NA <b>2013 Work RVU:</b> 0.62 <b>2013 NF PE RVU:</b> 0.40 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Remove from screen			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>
<b>97802</b>	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	<b>Global:</b> XXX	<b>Issue:</b> Medical Nutrition Therapy	<b>Screen:</b> CMS Request - Medical Nutrition Therapy	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2008	<b>Tab</b> 53	<b>Specialty Developing Recommendation:</b> ADA, AGA, AACE	<b>First Identified:</b> NA	<b>2012 Est Medicare Utilization:</b> 200,023	<b>2007 Work RVU:</b> 0.45 <b>2007 NF PE RVU:</b> 0.39 <b>2007 Fac PE RVU Result:</b> 0.38 <b>2013 Work RVU:</b> 0.53 <b>2013 NF PE RVU:</b> 0.48 <b>2013 Fac PE RVU:</b> 0.40
<b>RUC Recommendation:</b> 0.53			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>

# Status Report: CMS Requests and Relativity Assessment Issues

**97803** Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes **Global:** XXX **Issue:** Medical Nutrition Therapy **Screen:** CMS Request - Medical Nutrition Therapy **Complete?** Yes

**Most Recent RUC Meeting:** April 2008 **Tab** 53 **Specialty Developing Recommendation:** ADA, AGA, AACE **First Identified:** NA **2012 Est Medicare Utilization:** 160,798 **2007 Work RVU:** 0.37 **2013 Work RVU:** 0.45 **2007 NF PE RVU:** 0.38 **2013 NF PE RVU:** 0.42 **2007 Fac PE RVU:** 0.38 **2013 Fac PE RVU:** 0.34 **RUC Recommendation:** 0.45 **Result:** Increase

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**98925** Osteopathic manipulative treatment (OMT); 1-2 body regions involved **Global:** 000 **Issue:** Osteopathic Manipulative Treatment **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** February 2011 **Tab** 34 **Specialty Developing Recommendation:** AOA **First Identified:** February 2010 **2012 Est Medicare Utilization:** 77,821 **2007 Work RVU:** 0.45 **2013 Work RVU:** 0.46 **2007 NF PE RVU:** 0.31 **2013 NF PE RVU:** 0.43 **2007 Fac PE RVU:** 0.14 **2013 Fac PE RVU:** 0.19 **RUC Recommendation:** 0.50 **Result:** Increase

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**98926** Osteopathic manipulative treatment (OMT); 3-4 body regions involved **Global:** 000 **Issue:** Osteopathic Manipulative Treatment **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** February 2011 **Tab** 34 **Specialty Developing Recommendation:** AOA **First Identified:** October 2009 **2012 Est Medicare Utilization:** 111,145 **2007 Work RVU:** 0.65 **2013 Work RVU:** 0.71 **2007 NF PE RVU:** 0.4 **2013 NF PE RVU:** 0.57 **2007 Fac PE RVU:** 0.23 **2013 Fac PE RVU:** 0.28 **RUC Recommendation:** 0.75 **Result:** Increase

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

**98927** Osteopathic manipulative treatment (OMT); 5-6 body regions involved **Global:** 000 **Issue:** Osteopathic Manipulative Treatment **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

**Most Recent RUC Meeting:** February 2011 **Tab** 34 **Specialty Developing Recommendation:** AOA **First Identified:** October 2009 **2012 Est Medicare Utilization:** 103,218 **2007 Work RVU:** 0.87 **2013 Work RVU:** 0.96 **2007 NF PE RVU:** 0.49 **2013 NF PE RVU:** 0.72 **2007 Fac PE RVU:** 0.28 **2013 Fac PE RVU:** 0.36 **RUC Recommendation:** 1.00 **Result:** Increase

**CPT Action (if applicable):**  
**Referred to CPT Asst** ☐ **Published in CPT Asst:**

# Status Report: CMS Requests and Relativity Assessment Issues

**98928 Osteopathic manipulative treatment (OMT); 7-8 body regions involved**      **Global:** 000      **Issue:** Osteopathic Manipulative Treatment      **Screen:** Harvard Valued - Utilization over 100,000      **Complete?** Yes

**Most Recent RUC Meeting:** February 2011      **Tab** 34      **Specialty Developing Recommendation:** AOA      **First Identified:** February 2010      **2012 Est Medicare Utilization:** 87,661      **2007 Work RVU:** 1.03      **2013 Work RVU:** 1.21  
**2007 NF PE RVU:** 0.57      **2013 NF PE RVU:** 0.85  
**2007 Fac PE RVU:** 0.32      **2013 Fac PE RVU:** 0.46  
**Result:** Increase

**RUC Recommendation:** 1.25      **CPT Action (if applicable):**  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

**98929 Osteopathic manipulative treatment (OMT); 9-10 body regions involved**      **Global:** 000      **Issue:** Osteopathic Manipulative Treatment      **Screen:** Harvard Valued - Utilization over 100,000      **Complete?** Yes

**Most Recent RUC Meeting:** February 2011      **Tab** 34      **Specialty Developing Recommendation:** AOA      **First Identified:** February 2010      **2012 Est Medicare Utilization:** 59,471      **2007 Work RVU:** 1.19      **2013 Work RVU:** 1.46  
**2007 NF PE RVU:** 0.65      **2013 NF PE RVU:** 0.98  
**2007 Fac PE RVU:** 0.35      **2013 Fac PE RVU:** 0.52  
**Result:** Increase

**RUC Recommendation:** 1.50      **CPT Action (if applicable):**  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

**98940 Chiropractic manipulative treatment (CMT); spinal, 1-2 regions**      **Global:** 000      **Issue:** Chiropractic Manipulative Treatment      **Screen:** CMS High Expenditure Procedural Codes      **Complete?** Yes

**Most Recent RUC Meeting:** October 2012      **Tab** 25      **Specialty Developing Recommendation:** ACA      **First Identified:** September 2011      **2012 Est Medicare Utilization:** 6,873,108      **2007 Work RVU:** 0.45      **2013 Work RVU:** 0.45  
**2007 NF PE RVU:** 0.23      **2013 NF PE RVU:** 0.31  
**2007 Fac PE RVU:** 0.12      **2013 Fac PE RVU:** 0.15  
**Result:** Increase

**RUC Recommendation:** 0.46      **CPT Action (if applicable):**  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

**98941 Chiropractic manipulative treatment (CMT); spinal, 3-4 regions**      **Global:** 000      **Issue:** Chiropractic Manipulative Treatment      **Screen:** CMS High Expenditure Procedural Codes      **Complete?** Yes

**Most Recent RUC Meeting:** October 2012      **Tab** 25      **Specialty Developing Recommendation:** ACA      **First Identified:** September 2011      **2012 Est Medicare Utilization:** 13,288,912      **2007 Work RVU:** 0.65      **2013 Work RVU:** 0.65  
**2007 NF PE RVU:** 0.29      **2013 NF PE RVU:** 0.39  
**2007 Fac PE RVU:** 0.17      **2013 Fac PE RVU:** 0.22  
**Result:** Increase

**RUC Recommendation:** 0.71      **CPT Action (if applicable):**  
**Referred to CPT Asst** ☐      **Published in CPT Asst:**

# Status Report: CMS Requests and Relativity Assessment Issues

<b>98942</b>	Chiropractic manipulative treatment (CMT); spinal, 5 regions			<b>Global:</b> 000	<b>Issue:</b> Chiropractic Manipulative Treatment	<b>Screen:</b> CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b> 25	<b>Specialty Developing Recommendation:</b> ACA	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b> 1,558,454	<b>2007 Work RVU:</b> 0.87	<b>2013 Work RVU:</b> 0.87	
					<b>2007 NF PE RVU:</b> 0.36	<b>2013 NF PE RVU:</b> 0.47	
					<b>2007 Fac PE RVU</b> 0.23	<b>2013 Fac PE RVU:</b> 0.29	
<b>RUC Recommendation:</b> 0.96			<b>CPT Action (if applicable):</b>		<b>Result:</b> Increase		
			<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>			

<b>98943</b>	Chiropractic manipulative treatment (CMT); extraspinal, 1 or more regions			<b>Global:</b> XXX	<b>Issue:</b> Chiropractic Manipulative Treatment	<b>Screen:</b> CMS High Expenditure Procedural Codes	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> October 2012	<b>Tab</b> 25	<b>Specialty Developing Recommendation:</b> ACA	<b>First Identified:</b> September 2011	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> 0.40	<b>2013 Work RVU:</b> 0.40	
					<b>2007 NF PE RVU:</b> 0.22	<b>2013 NF PE RVU:</b> 0.28	
					<b>2007 Fac PE RVU</b> 0.14	<b>2013 Fac PE RVU:</b> 0.16	
<b>RUC Recommendation:</b> 0.46			<b>CPT Action (if applicable):</b>		<b>Result:</b> Increase		
			<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>			

<b>99174</b>	Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilateral			<b>Global:</b> XXX	<b>Issue:</b> Ocular photoscreening	<b>Screen:</b> CMS Request - Practice Expense Review	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b> April 2008	<b>Tab</b> 54	<b>Specialty Developing Recommendation:</b> AAP, AAO	<b>First Identified:</b> NA	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b>	<b>2013 Work RVU:</b> 0.00	
					<b>2007 NF PE RVU:</b>	<b>2013 NF PE RVU:</b> 0.89	
					<b>2007 Fac PE RVU</b>	<b>2013 Fac PE RVU:</b> NA	
<b>RUC Recommendation:</b> New PE inputs			<b>CPT Action (if applicable):</b>		<b>Result:</b> PE Only		
			<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>			

<b>99183</b>	Physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per session			<b>Global:</b> XXX	<b>Issue:</b> RAW	<b>Screen:</b> CMS-Other - Utilization over 250,000	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b>	<b>Tab</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> April 2013	<b>2012 Est Medicare Utilization:</b> 558,912	<b>2007 Work RVU:</b> 2.34	<b>2013 Work RVU:</b> 2.34	
					<b>2007 NF PE RVU:</b> 3.08	<b>2013 NF PE RVU:</b> 3.81	
					<b>2007 Fac PE RVU</b> 0.69	<b>2013 Fac PE RVU:</b> 0.92	
<b>RUC Recommendation:</b> Review Action Plan			<b>CPT Action (if applicable):</b>		<b>Result:</b>		
			<b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>			

# Status Report: CMS Requests and Relativity Assessment Issues

<b>G0101</b>	Cervical or vaginal cancer screening; pelvic and clinical breast examination			<b>Global:</b> XXX	<b>Issue:</b>	<b>Screen:</b> Low Value-High Volume / CMS-Other - Utilization over 250,000	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b>	February 2011	<b>Tab</b> 41	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> October 2010	<b>2012 Est Medicare Utilization:</b> 1,109,551	<b>2007 Work RVU:</b> 0.45 <b>2007 NF PE RVU:</b> 0.51 <b>2007 Fac PE RVU:</b> NA	<b>2013 Work RVU:</b> 0.45 <b>2013 NF PE RVU:</b> 0.64 <b>2013 Fac PE RVU:</b> 0.32
<b>RUC Recommendation:</b>	Review Action Plan. Removed from Low Value-High Volume screen			<b>CPT Action (if applicable):</b>		<b>Result:</b> Remove from Screen	
				<b>Referred to CPT Asst</b>	<input type="checkbox"/>	<b>Published in CPT Asst:</b>	
<hr/>							
<b>G0127</b>	Trimming of dystrophic nails, any number			<b>Global:</b> 000	<b>Issue:</b>	<b>Screen:</b> CMS-Other - Utilization over 500,000	<b>Complete?</b> Yes
<b>Most Recent RUC Meeting:</b>	September 2011	<b>Tab</b> 51	<b>Specialty Developing Recommendation:</b> APMA	<b>First Identified:</b> April 2011	<b>2012 Est Medicare Utilization:</b> 737,152	<b>2007 Work RVU:</b> 0.17 <b>2007 NF PE RVU:</b> 0.28 <b>2007 Fac PE RVU:</b> 0.07	<b>2013 Work RVU:</b> 0.17 <b>2013 NF PE RVU:</b> 0.51 <b>2013 Fac PE RVU:</b> 0.04
<b>RUC Recommendation:</b>	Remove from screen			<b>CPT Action (if applicable):</b>		<b>Result:</b> Remove from Screen	
				<b>Referred to CPT Asst</b>	<input type="checkbox"/>	<b>Published in CPT Asst:</b>	
<hr/>							
<b>G0179</b>	Physician re-certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient’s needs, per re-certification period			<b>Global:</b> XXX	<b>Issue:</b> Physician Recertification	<b>Screen:</b> CMS Fastest Growing / CMS-Other - Utilization over 250,000	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b>	February 2010	<b>Tab</b> 31	<b>Specialty Developing Recommendation:</b> AAFP, ACP, AAHCP	<b>First Identified:</b> October 2008	<b>2012 Est Medicare Utilization:</b> 1,285,989	<b>2007 Work RVU:</b> 0.45 <b>2007 NF PE RVU:</b> 0.89 <b>2007 Fac PE RVU:</b> NA	<b>2013 Work RVU:</b> 0.45 <b>2013 NF PE RVU:</b> 0.74 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b>	Review Action Plan. Removed from CMS Fastest Growing screen.			<b>CPT Action (if applicable):</b>		<b>Result:</b> Remove from Screen	
				<b>Referred to CPT Asst</b>	<input type="checkbox"/>	<b>Published in CPT Asst:</b>	

## Status Report: CMS Requests and Relativity Assessment Issues

<b>G0180</b>	Physician certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per certification period	<b>Global:</b> XXX	<b>Issue:</b> Physician Recertification	<b>Screen:</b> CMS Fastest Growing / CMS-Other - Utilization over 250,000	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> February 2010	<b>Tab</b> 31 <b>Specialty Developing Recommendation:</b> AAFP, ACP, AAHCP	<b>First Identified:</b> October 2008	<b>2012 Est Medicare Utilization:</b> 1,378,576	<b>2007 Work RVU:</b> 0.67 <b>2007 NF PE RVU:</b> 1.09 <b>2007 Fac PE RVU:</b> NA <b>Result:</b> Remove from Screen	<b>2013 Work RVU:</b> 0.67 <b>2013 NF PE RVU:</b> 0.85 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Review Action Plan. Removed from CMS Fastest Growing screen.		<b>CPT Action (if applicable):</b>			
		<b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	
<hr/>					
<b>G0181</b>	Physician supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more	<b>Global:</b> XXX	<b>Issue:</b> Home Healthcare Supervision	<b>Screen:</b> CMS Fastest Growing / CMS-Other - Utilization over 250,000	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> February 2009	<b>Tab</b> 38 <b>Specialty Developing Recommendation:</b> AAFP, ACP	<b>First Identified:</b> October 2008	<b>2012 Est Medicare Utilization:</b> 396,533	<b>2007 Work RVU:</b> 1.73 <b>2007 NF PE RVU:</b> 1.32 <b>2007 Fac PE RVU:</b> NA <b>Result:</b> Remove from Screen	<b>2013 Work RVU:</b> 1.73 <b>2013 NF PE RVU:</b> 1.28 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Review Action Plan. Removed from CMS Fastest Growing screen.		<b>CPT Action (if applicable):</b>			
		<b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	

## Status Report: CMS Requests and Relativity Assessment Issues

<b>G0202</b> Screening mammography, producing direct digital image, bilateral, all views			<b>Global:</b> XXX	<b>Issue:</b> Digital Mammography	<b>Screen:</b> CMS Fastest Growing / CMS-Other - Utilization over 250,000	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> April 2008	<b>Tab</b> 57	<b>Specialty Developing Recommendation:</b> ACR	<b>First Identified:</b> February 2008	<b>2012 Est Medicare Utilization:</b> 5,415,995	<b>2007 Work RVU:</b> 0.70 <b>2007 NF PE RVU:</b> 2.74 <b>2007 Fac PE RVU</b> NA <b>Result:</b> Remove from Screen	<b>2013 Work RVU:</b> 0.70 <b>2013 NF PE RVU:</b> 3.33 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Review Action Plan. Removed from CMS Fastest Growing screen.			<b>CPT Action (if applicable):</b>			
			<b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	
<b>G0204</b> Diagnostic mammography, producing direct digital image, bilateral, all views			<b>Global:</b> XXX	<b>Issue:</b> Digital Mammography	<b>Screen:</b> CMS Fastest Growing / CMS-Other - Utilization over 250,000	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> April 2008	<b>Tab</b> 57	<b>Specialty Developing Recommendation:</b> ACR	<b>First Identified:</b> February 2008	<b>2012 Est Medicare Utilization:</b> 641,256	<b>2007 Work RVU:</b> 0.87 <b>2007 NF PE RVU:</b> 2.87 <b>2007 Fac PE RVU</b> NA <b>Result:</b> Remove from Screen	<b>2013 Work RVU:</b> 0.87 <b>2013 NF PE RVU:</b> 4.04 <b>2013 Fac PE RVU:</b> NA
<b>RUC Recommendation:</b> Review Action Plan. Removed from CMS Fastest Growing screen.			<b>CPT Action (if applicable):</b>			
			<b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	
<b>G0206</b> Diagnostic mammography, producing direct digital image, unilateral, all views			<b>Global:</b> XXX	<b>Issue:</b> Digital Mammography	<b>Screen:</b> CMS Fastest Growing / CMS-Other - Utilization over 250,000	<b>Complete?</b> No
<b>Most Recent RUC Meeting:</b> April 2008	<b>Tab</b> 57	<b>Specialty Developing Recommendation:</b> ACR	<b>First Identified:</b> February 2008	<b>2012 Est Medicare Utilization:</b> 829,503	<b>2007 Work RVU:</b> 0.70 <b>2007 NF PE RVU:</b> 2.31 <b>2007 Fac PE RVU</b> NA <b>Result:</b> Remove from Screen	<b>2013 Work RVU:</b> 0.70 <b>2013 NF PE RVU:</b> 3.17 <b>2013 Fac PE RVU:</b> NANA
<b>RUC Recommendation:</b> Review Action Plan. Removed from CMS Fastest Growing screen.			<b>CPT Action (if applicable):</b>			
			<b>Referred to CPT Asst</b> <input type="checkbox"/>		<b>Published in CPT Asst:</b>	

## Status Report: CMS Requests and Relativity Assessment Issues

---

**G0237** Therapeutic procedures to increase strength or endurance of respiratory muscles, face to face, one on one, each 15 minutes (includes monitoring) **Global:** XXX **Issue:** Respiratory Therapy **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent** **Tab** 38 **Specialty Developing** ACCP/ATS **First** **2012 Est**  
**RUC Meeting:** February 2009 **Recommendation:** **Identified:** February 2008 **Medicare**  
**Utilization:** 128,305

**2007 Work RVU:** 0.00 **2013 Work RVU:** 0.00  
**2007 NF PE RVU:** 0.41 **2013 NF PE RVU:** 0.31  
**2007 Fac PE RVU** NA **2013 Fac PE RVU:** NA  
**Result:** Remove from Screen

**RUC Recommendation:** Remove from screen - RUC articulated concerns regarding claims reporting to CMS

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

---

**G0238** Therapeutic procedures to improve respiratory function, other than described by G0237, one on one, face to face, per 15 minutes (includes monitoring) **Global:** XXX **Issue:** Respiratory Therapy **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent** **Tab** 38 **Specialty Developing** ACCP/ATS **First** **2012 Est**  
**RUC Meeting:** February 2009 **Recommendation:** **Identified:** February 2008 **Medicare**  
**Utilization:** 170,229

**2007 Work RVU:** 0.00 **2013 Work RVU:** 0.00  
**2007 NF PE RVU:** 0.43 **2013 NF PE RVU:** 0.33  
**2007 Fac PE RVU** NA **2013 Fac PE RVU:** NA  
**Result:** Remove from Screen

**RUC Recommendation:** Remove from screen - RUC articulated concerns regarding claims reporting to CMS

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

---

**G0249** Provision of test materials and equipment for home INR monitoring of patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria; includes: provision of materials for use in the home and reporting of test results to physician; testing not occurring more frequently than once a week; testing materials, billing units of service include 4 tests **Global:** XXX **Issue:** Home INR Monitoring **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent** **Tab** 57 **Specialty Developing** ACC **First** **2012 Est**  
**RUC Meeting:** April 2008 **Recommendation:** **Identified:** February 2008 **Medicare**  
**Utilization:** 777,274

**2007 Work RVU:** 0.00 **2013 Work RVU:** 0.00  
**2007 NF PE RVU:** 3.57 **2013 NF PE RVU:** 3.29  
**2007 Fac PE RVU** NA **2013 Fac PE RVU:** NA  
**Result:** Remove from Screen

**RUC Recommendation:** Remove from screen

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**



## Status Report: CMS Requests and Relativity Assessment Issues

**G0250** Physician review, interpretation, and patient management of home INR testing for patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria; testing not occurring more frequently than once a week; billing units of service include 4 tests **Global:** XXX **Issue:** Home INR Monitoring **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent**  
**RUC Meeting:** April 2008

**Tab** 57 **Specialty Developing** ACC  
**Recommendation:**

**First**  
**Identified:** February 2008

**2012 Est**  
**Medicare**  
**Utilization:** 195,285

**2007 Work RVU:** 0.18 **2013 Work RVU:** 0.18

**2007 NF PE RVU:** 0.07 **2013 NF PE RVU:** 0.07

**2007 Fac PE RVU** NA **2013 Fac PE RVU:** NA

**Result:** Remove from Screen

**RUC Recommendation:** Remove from screen

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**G0268** Removal of impacted cerumen (one or both ears) by physician on same date of service as audiologic function testing **Global:** 000 **Issue:** Removal of Wax **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent**  
**RUC Meeting:** February 2009

**Tab** 26 **Specialty Developing** AAO-HNS  
**Recommendation:**

**First**  
**Identified:** October 2008

**2012 Est**  
**Medicare**  
**Utilization:** 133,473

**2007 Work RVU:** 0.61 **2013 Work RVU:** 0.61

**2007 NF PE RVU:** 0.63 **2013 NF PE RVU:** 0.91

**2007 Fac PE RVU** 0.23 **2013 Fac PE RVU:** 0.30

**Result:** Remove from Screen

**RUC Recommendation:** Remove from screen

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**G0270** Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes **Global:** XXX **Issue:** Medical Nutrition Therapy **Screen:** CMS Fastest Growing **Complete?** Yes

**Most Recent**  
**RUC Meeting:** February 2008

**Tab** S **Specialty Developing** ADA  
**Recommendation:**

**First**  
**Identified:** February 2008

**2012 Est**  
**Medicare**  
**Utilization:** 20,737

**2007 Work RVU:** 0.37 **2013 Work RVU:** 0.45

**2007 NF PE RVU:** 0.38 **2013 NF PE RVU:** 0.42

**2007 Fac PE RVU** 0.38 **2013 Fac PE RVU:** 0.34

**Result:** Remove from Screen

**RUC Recommendation:** Remove from screen

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

**G0283** Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care      **Global:** XXX      **Issue:**      **Screen:** Low Value-High Volume / CMS-Other - Utilization over 250,000      **Complete?** No

**Most Recent RUC Meeting:** February 2011

**Tab** 41

**Specialty Developing Recommendation:**

**First Identified:** October 2010

**2012 Est Medicare Utilization:** 6,885,732

**2007 Work RVU:** 0.18

**2013 Work RVU:** 0.18

**2007 NF PE RVU:** 0.12

**2013 NF PE RVU:** 0.21

**2007 Fac PE RVU** NA

**2013 Fac PE RVU:** NA

**Result:** Remove from Screen

**RUC Recommendation:** Review Action Plan. Removed from Low Value-High Volume screen

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**G0438** Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit

**Global:** XXX      **Issue:** RAW

**Screen:** CMS-Other - Utilization over 250,000

**Complete?** No

**Most Recent RUC Meeting:**

**Tab**

**Specialty Developing Recommendation:**

**First Identified:** April 2013

**2012 Est Medicare Utilization:** 1,531,078

**2007 Work RVU:**

**2013 Work RVU:** 2.43

**2007 NF PE RVU:**

**2013 NF PE RVU:** 2.43

**2007 Fac PE RVU**

**2013 Fac PE RVU:** NA

**Result:**

**RUC Recommendation:** Review Action Plan

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

**G0439** Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit

**Global:** XXX      **Issue:** RAW

**Screen:** CMS-Other - Utilization over 250,000

**Complete?** No

**Most Recent RUC Meeting:**

**Tab**

**Specialty Developing Recommendation:**

**First Identified:** April 2013

**2012 Est Medicare Utilization:** 1,554,667

**2007 Work RVU:**

**2013 Work RVU:** 1.50

**2007 NF PE RVU:**

**2013 NF PE RVU:** 1.76

**2007 Fac PE RVU**

**2013 Fac PE RVU:** NA

**Result:**

**RUC Recommendation:** Review Action Plan

**CPT Action (if applicable):**

**Referred to CPT Asst** ☐

**Published in CPT Asst:**

## Status Report: CMS Requests and Relativity Assessment Issues

<b>G0456</b>	Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area less than or equal to 50 square centimeters	<b>Global:</b> YYY	<b>Issue:</b> Negative Pressure Wound Therapy	<b>Screen:</b> CMS Request Final Rule for 2013	<b>Complete?</b> No	
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab 37</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> November 2012	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU</b> <b>Result:</b> No Rec	<b>2013 Work RVU:</b> 0.00 <b>2013 NF PE RVU:</b> 0.00 <b>2013 Fac PE RVU:</b> 0.00
<b>RUC Recommendation:</b> No specialty society interest			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

---

<b>G0457</b>	Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area greater than 50 square centimeters	<b>Global:</b> YYY	<b>Issue:</b> Negative Pressure Wound Therapy	<b>Screen:</b> CMS Request Final Rule for 2013	<b>Complete?</b> No	
<b>Most Recent RUC Meeting:</b> April 2013	<b>Tab 37</b>	<b>Specialty Developing Recommendation:</b>	<b>First Identified:</b> November 2012	<b>2012 Est Medicare Utilization:</b>	<b>2007 Work RVU:</b> <b>2007 NF PE RVU:</b> <b>2007 Fac PE RVU</b> <b>Result:</b> No Rec	<b>2013 Work RVU:</b> 0.00 <b>2013 NF PE RVU:</b> 0.00 <b>2013 Fac PE RVU:</b> 0.00
<b>RUC Recommendation:</b> No specialty society interest			<b>CPT Action (if applicable):</b> <b>Referred to CPT Asst</b> <input type="checkbox"/>	<b>Published in CPT Asst:</b>		

---

# Specialty and Acronym

## Society

## Acronym

AMA CPT Editorial Panel	AMA
AMA Staff	AMA
American Academy of Allergy, Asthma & Immunology	AAAAI
American Academy of Child and Adolescent Psychiatry	AACAP
American Academy of Dermatology	AAD
American Academy of Facial Plastic and Reconstructive Surgery	AAFPRS
American Academy of Family Physicians	AAFP
American Academy of Hospice and Palliative Medicine	AAHPM
American Academy of Neurology	AAN
American Academy of Ophthalmology	AAO
American Academy of Orthopaedic Surgeons	AAOS
American Academy of Otolaryngic Allergy	AAOA
American Academy of Otolaryngology - Head and Neck Surgery	AAO-HNS
American Academy of Pain Medicine	AAPM
American Academy of Pediatrics	AAP
American Academy of Pharmaceutical Physicians & Investigators	AAPPI
American Academy of Physical Medicine & Rehabilitation	AAPMR
American Academy of Physician Assistants	AAPA
American Academy of Sleep Medicine	AASM
American Association of Clinical Endocrinologists	AACE
American Association of Hip and Knee Surgeons	AAHKS
American Association of Neurological Surgeons	AANS
American Association of Neuromuscular & Electrodiagnostic	AANEM
American Association of Oral and Maxillofacial Surgeons	AAOMS
American Association of Plastic Surgeons	AAPS
American Burn Association	ABA
American Chiropractic Association	ACA
American Clinical Neurophysiology Society	ACNS

**Society****Acronym**

American College of Cardiology	ACC
American College of Chest Physicians	ACCP
American College of Emergency Physicians	ACEP
American College of Medical Genetics	ACMG
American College of Obstetricians and Gynecologists	ACOG
American College of Occupational and Environmental Medicine	ACOEM
American College of Physicians	ACP
American College of Preventive Medicine	ACPM
American College of Radiation Oncology	ACRO
American College of Radiology	ACR
American College of Rheumatology	ACR <sup>h</sup>
American College of Surgeons	ACS
American Dental Association	ADA
American Dietetic Association	AD <sup>i</sup> A
American Gastroenterological Association	AGA
American Geriatrics Society	AGS
American Institute of Ultrasound in Medicine	AIUM
American Medical Association	AMA
American Medical Directors Association	AMDA
American Nurses Association	ANA
American Occupational Therapy Association	AOTA
American Optometric Association	AOA
American Orthopaedic Association	AOA-Ortho
American Orthopaedic Foot and Ankle Society	AOFAS
American Osteopathic Association	AOA
American Pediatric Surgical Association	APSA
American Physical Therapy Association	APTA
American Podiatric Medical Association	APMA
American Psychiatric Association	APA
American Psychological Association	APA
American Roentgen Ray Society	ARRS

**Society****Acronym**

American Society for Aesthetic Plastic Surgery	ASAPS
American Society for Clinical Pathology	ASCP
American Society for Dermatologic Surgery	ASDS
American Society for Gastrointestinal Endoscopy	ASGE
American Society for Reproductive Medicine	ASRM
American Society for Surgery of the Hand	ASSH
American Society for Therapeutic Radiology and Oncology	ASTRO
American Society of Abdominal Surgeons	ASAS
American Society of Addiction Medicine	ASAM
American Society of Anesthesiologists	ASA
American Society of Breast Surgeons	ASBS
American Society of Cataract and Refractive Surgery	ASCRS(cat)
American Society of Clinical Oncology	ASCO
American Society of Colon and Rectal Surgeons	ASCRS(col)
American Society of Cytopathology	ASC
American Society of General Surgeons	ASGS
American Society of Hematology	ASH
American Society of Maxillofacial Surgeons	ASMS
American Society of Neuroimaging	ASN
American Society of Neuroradiology	ASNR
American Society of Ophthalmic Plastic and Reconstructive	ASOPRS
American Society of Plastic Surgeons	ASPS
American Society of Transplant Surgeons	ASTS
American Speech, Language, and Hearing Association	ASHA
American Thoracic Society	ATS
American Urological Association	AUA
Association Military Surgeons of the U.S.	AMSUS
Association of University Radiologists	AUR
Centers for Medicare and Medicaid Services	CMS
CMD	CMD
College of American Pathologists	CAP

**Society****Acronym**

Congress of Neurological Surgeons	CNS
Contact Lens Society of America	CLSA
Infectious Diseases Society of America	IDSA
International Spinal Injection Society	ISIS
International Spine Intervention Society	ISIS
Joint Council of Allergy Asthma and Immunology	JCAAI
Joint Council of Allergy, Asthma and Immunology	JCAAI
Medical Group Management Association	MGMA
MedPAC	MedPAC
National Association of Social Workers	NASW
North American Spine Society	NASS
Practice Expense Review Committee (PERC)	PERC
Radiological Society of North America	RSNA
Renal Physicians Association	RPA
Society for Vascular Surgery	SVS
Society of American Gastrointestinal and Endoscopic Surgeons	SAGES
Society of Critical Care Medicine	SCCM
Society of Interventional Radiology	SIR
Society of Nuclear Medicine	SNM
Society of Thoracic Surgeons	STS
The Endocrine Society	TES
The Triological Society	TTS

## ***RUC Recommendations to Develop CPT Assistant Articles - Incomplete Issues***

---

<b>51784</b>	<b>Electromyography studies (EMG) of anal or urethral sphincter, other than needle, any technique</b>	<u><b>Screen:</b></u> Codes Reported Together 75% or More-Part2	<u><b>RUC Meeting:</b></u> October 2012	<u><b>RUC Rec:</b></u> Refer to CPT Editorial Panel to add parenthetical and develop CPT assistant article indicating that 51792 and 51784 should not be reported together.	<u><b>Specialty Society:</b></u> AUA	<u><b>CPT Asst Status:</b></u>
--------------	---	---	--	--	---	--------------------------------

**Background:** Refer to CPT Editorial Panel to add parenthetical and develop CPT assistant article indicating that 51792 and 51784 should not be reported together.

---

<b>51792</b>	<b>Stimulus evoked response (eg, measurement of bulbocavernosus reflex latency time)</b>	<u><b>Screen:</b></u> Codes Reported Together 75% or More-Part2	<u><b>RUC Meeting:</b></u> October 2012	<u><b>RUC Rec:</b></u> Refer to CPT Editorial Panel to add parenthetical and develop CPT assistant article indicating that 51792 and 51784 should not be reported together.	<u><b>Specialty Society:</b></u> AUA	<u><b>CPT Asst Status:</b></u>
--------------	--	---	--	--	---	--------------------------------

**Background:** Refer to CPT Editorial Panel to add parenthetical and develop CPT assistant article indicating that 51792 and 51784 should not be reported together.

---

<b>70371</b>	<b>Complex dynamic pharyngeal and speech evaluation by cine or video recording</b>	<u><b>Screen:</b></u> Codes Reported Together 75% or More-Part2	<u><b>RUC Meeting:</b></u> October 2012	<u><b>RUC Rec:</b></u> Develop CPT Assistant article.	<u><b>Specialty Society:</b></u> ACR, AAFP	<u><b>CPT Asst Status:</b></u>
--------------	--	---	--	--	---	--------------------------------

**Background:** The Joint Workgroup recommended that the specialties develop a CPT Assistant article to provide education on the correct reporting of 70371 and 70373. The specialties were unsure why codes 70371 and 70373 are performed by Family Practice physicians by such a large proportion of the utilization. Timeline: No later than CPT 2015.

---



## *RUC Recommendations to Develop CPT Assistant Articles - Incomplete Issues*

---

94060	<b>Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration</b>	<u>Screen:</u> MPC List	<u>RUC Meeting:</u> October 2012	<u>RUC Rec:</u> Refer to CPT Assistant. 0.31	<u>Specialty Society:</u> ATS, ACCP	<u>CPT Asst Status:</u>
-------	--	----------------------------	-------------------------------------	---	--	-------------------------

**Background:** Code had not been reviewed by the RUC in the past 6 years. The RUC reviewed in April 2011 and recommended 0.31. In October 2012, the Joint Workgroup agreed with the specialties to create a CPT Assistant Article. The specialties also were asked to provide a detailed outline for the article to ensure that the content will be effective in negating the instances when these services are reported on the same day. The Workgroup reviewed this submission and agreed with that the content should go forward by CPT 2015 cycle. Codes: 94400-26, 94060-26  
94400-TC, 94060  
94668, 94640  
94668, G0237  
94770-26, 97535  
94770-TC, 97535  
94770-26, 94668  
94770-TC, 94668  
94770-26, 94640  
94770-TC, 94640  
94770-26, G0237  
94770-TC, G0237  
94770-26, G0238  
94770-TC, G0238

---

94400	<b>Breathing response to CO2 (CO2 response curve)</b>	<u>Screen:</u> Codes Reported Together 75% or More-Part2	<u>RUC Meeting:</u> October 2012	<u>RUC Rec:</u> Refer to CPT Assistant	<u>Specialty Society:</u> AAFP, ACCP, ATS, ACP, APTA, AOTA	<u>CPT Asst Status:</u>
-------	---	---	-------------------------------------	---	---	-------------------------

**Background:** The Joint Workgroup agreed with the specialties to create a CPT Assistant Article. The specialties also were asked to provide a detailed outline for the article to ensure that the content will be effective in negating the instances when these services are reported on the same day. The Workgroup reviewed this submission and agreed with that the content should go forward by CPT 2015 cycle. Codes: 94400-26, 94060-26  
94400-TC, 94060  
94668, 94640  
94668, G0237  
94770-26, 97535  
94770-TC, 97535  
94770-26, 94668  
94770-TC, 94668  
94770-26, 94640  
94770-TC, 94640  
94770-26, G0237  
94770-TC, G0237  
94770-26, G0238  
94770-TC, G0238

## *RUC Recommendations to Develop CPT Assistant Articles - Incomplete Issues*

---

94640	<b>Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes (eg, with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing [IPPB] device)</b>	<u>Screen:</u> Codes Reported Together 75% or More-Part2	<u>RUC Meeting:</u> October 2012	<u>RUC Rec:</u> Refer to CPT Assistant	<u>Specialty Society:</u> AAFP, ACCP, ATS, ACP, APTA, AOTA	<u>CPT Asst Status:</u>
-------	---	--	-------------------------------------	---	---	-------------------------

Background: The Joint Workgroup agreed with the specialties to create a CPT Assistant Article. The specialties also were asked to provide a detailed outline for the article to ensure that the content will be effective in negating the instances when these services are reported on the same day. The Workgroup reviewed this submission and agreed with that the content should go forward by CPT 2015 cycle. Codes: 94400-26, 94060-26

94400-TC, 94060  
94668, 94640  
94668, G0237  
94770-26, 97535  
94770-TC, 97535  
94770-26, 94668  
94770-TC, 94668  
94770-26, 94640  
94770-TC, 94640  
94770-26, G0237  
94770-TC, G0237  
94770-26, G0238  
94770-TC, G0238

---

94668	<b>Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; subsequent</b>	<u>Screen:</u> Codes Reported Together 75% or More-Part2	<u>RUC Meeting:</u> October 2012	<u>RUC Rec:</u> Refer to CPT Assistant	<u>Specialty Society:</u> AAFP, ACCP, ATS, ACP, APTA, AOTA	<u>CPT Asst Status:</u>
-------	--	--	-------------------------------------	---	---	-------------------------

Background: The Joint Workgroup agreed with the specialties to create a CPT Assistant Article. The specialties also were asked to provide a detailed outline for the article to ensure that the content will be effective in negating the instances when these services are reported on the same day. The Workgroup reviewed this submission and agreed with that the content should go forward by CPT 2015 cycle. Codes: 94400-26, 94060-26

94400-TC, 94060  
94668, 94640  
94668, G0237  
94770-26, 97535  
94770-TC, 97535  
94770-26, 94668  
94770-TC, 94668  
94770-26, 94640  
94770-TC, 94640  
94770-26, G0237  
94770-TC, G0237  
94770-26, G0238  
94770-TC, G0238

## *RUC Recommendations to Develop CPT Assistant Articles - Incomplete Issues*

---

94770	<b>Carbon dioxide, expired gas determination by infrared analyzer</b>	<u>Screen:</u> High Volume Growth / Codes Reported Together 75% or More-Part2	<u>RUC Meeting:</u> October 2012	<u>RUC Rec:</u> Refer to CPT Assistant. Remove office-based PE inputs	<u>Specialty Society:</u> ACCP/ATS	<u>CPT Asst Status:</u>
-------	---	--	-------------------------------------	--	---------------------------------------	-------------------------

**Background:** Volume increased after the service was priced in the office. Should not be performed in the office; RUC recommends CMS eliminate in-office values. In October 2012, the Joint Workgroup agreed with the specialties to create a CPT Assistant Article. The specialties also were asked to provide a detailed outline for the article to ensure that the content will be effective in negating the instances when these services are reported on the same day. The Workgroup reviewed this submission and agreed with that the content should go forward by CPT 2015 cycle. Codes: 94400-26, 94060-26

94400-TC, 94060  
94668, 94640  
94668, G0237  
94770-26, 97535  
94770-TC, 97535  
94770-26, 94668  
94770-TC, 94668  
94770-26, 94640  
94770-TC, 94640  
94770-26, G0237  
94770-TC, G0237  
94770-26, G0238  
94770-TC, G0238

---

97535	<b>Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes</b>	<u>Screen:</u> Codes Reported Together 75% or More-Part2	<u>RUC Meeting:</u> October 2012	<u>RUC Rec:</u> Refer to CPT Assistant	<u>Specialty Society:</u> AAFP, ACCP, ATS, ACP, APTA, AOTA	<u>CPT Asst Status:</u>
-------	--	---	-------------------------------------	---	---	-------------------------

**Background:** The Joint Workgroup agreed with the specialties to create a CPT Assistant Article. The specialties also were asked to provide a detailed outline for the article to ensure that the content will be effective in negating the instances when these services are reported on the same day. The Workgroup reviewed this submission and agreed with that the content should go forward by CPT 2015 cycle. Codes: 94400-26, 94060-26

94400-TC, 94060  
94668, 94640  
94668, G0237  
94770-26, 97535  
94770-TC, 97535  
94770-26, 94668  
94770-TC, 94668  
94770-26, 94640  
94770-TC, 94640  
94770-26, G0237  
94770-TC, G0237  
94770-26, G0238  
94770-TC, G0238

## *RUC Referrals to CPT Editorial Panel - Incomplete Issues*

22520	<b>Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; thoracic</b>	<u><a href="#">Screen:</a></u> CMS Request - Practice Expense Review / Codes Reported Together 75% or More-Part2	<u><a href="#">RUC Meeting:</a></u> February 2009	<u><a href="#">Specialty Society:</a></u> ACR, NASS, ASNR, SIR, ASIPP, AANS/CNS	<u><a href="#">CPT Meeting:</a></u> CPT 2015 cycle	<u><a href="#">CPT Tab:</a></u>
-------	---	---	--	--	---	---------------------------------

**Background:** Joint Workgroup recommends that 72291 be bundled with 22520, 22523, 22524 and 72292 be bundled with 22521 by the 2015 CPT cycle.

22521	<b>Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; lumbar</b>	<u><a href="#">Screen:</a></u> Site of Service Anomaly (99238-Only); CMS Request - PE Inputs / Codes Reported Together 75% or More-Part2	<u><a href="#">RUC Meeting:</a></u> February 2009	<u><a href="#">Specialty Society:</a></u> ACR, ASNR, NASS, SIR	<u><a href="#">CPT Meeting:</a></u> CPT 2015 cycle	<u><a href="#">CPT Tab:</a></u>
-------	---	---	--	---	---	---------------------------------

**Background:** Joint Workgroup recommends that 72291 be bundled with 22520, 22523, 22524 and 72292 be bundled with 22521 by the 2015 CPT cycle.

36870	<b>Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)</b>	<u><a href="#">Screen:</a></u> Site of Service Anomaly (99238-Only) / CMS High Expenditure Procedural Codes	<u><a href="#">RUC Meeting:</a></u> January 2013	<u><a href="#">Specialty Society:</a></u> ACR, SIR, SVS	<u><a href="#">CPT Meeting:</a></u>	<u><a href="#">CPT Tab:</a></u>
-------	--	--	---	--	-------------------------------------	---------------------------------

**Background:** The RUC reviewed the 2010 Medicare Claims 5% Billed Together sample file and noted there are three services commonly billed on the same date of service with 36870: 36147, 35476 and 36148. The specialties noted that in order to perform thrombectomy the access code, 36147, has to be billed on the same date. With this understanding, the RUC referred CPT code 36870 to the CPT Editorial Panel to bundle the appropriate services into 36870.

37205	<b>Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; initial vessel</b>	<u><a href="#">Screen:</a></u> High Volume Growth1 / Codes Reported Together 75% or More-Part1	<u><a href="#">RUC Meeting:</a></u> April 2010	<u><a href="#">Specialty Society:</a></u> SVS, ACS, SIR, ACR, ACC	<u><a href="#">CPT Meeting:</a></u> February 2013	<u><a href="#">CPT Tab:</a></u> 10
-------	--	---	---	--	--	---------------------------------------

**Background:** In February 2010, the CPT Editorial Panel revised this code as part of the larger Endovascular Revascularization issue. April 2010 - The Workgroup acknowledges that it is unclear what volume of services will remain described by these codes given the removal of the lower extremity revascularization services and agrees with the specialties to defer this issue for one year until the RUC has reviewed the lower extremity revascularization codes in April 2010 and the new codes are implemented. Currently, the Workgroup encourages the specialties to consider a bundled code for the 2012 CPT cycle. Specialties will address at the February 2013 CPT meeting. Specialties will address at the February 2013 CPT meeting.

## *RUC Referrals to CPT Editorial Panel - Incomplete Issues*

37206	<b>Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; each additional vessel (List separately in addition to code for primary procedure)</b>	<u>Screen:</u> High Volume Growth1	<u>RUC Meeting:</u> April 2010	<u>Specialty Society:</u> SVS, ACS, SIR, ACR, ACC	<u>CPT Meeting:</u> February 2013	<u>CPT Tab:</u> 10
-------	--	---------------------------------------	-----------------------------------	--	--------------------------------------	-----------------------

**Background:** In February 2010, the CPT Editorial Panel revised this code as part of the larger Endovascular Revascularization issue. April 2010 - The Workgroup acknowledges that it is unclear what volume of services will remain described by these codes given the removal of the lower extremity revascularization services and agrees with the specialties to defer this issue for one year until the RUC has reviewed the lower extremity revascularization codes in April 2010 and the new codes are implemented. Currently, the Workgroup encourages the specialties to consider a bundled code for the 2012 CPT cycle. Specialties will address at the February 2013 CPT meeting.

37207	<b>Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; initial vessel</b>	<u>Screen:</u> High Volume Growth1	<u>RUC Meeting:</u> April 2010	<u>Specialty Society:</u> SVS, ACS, SIR, ACR, ACC	<u>CPT Meeting:</u> February 2013	<u>CPT Tab:</u> 10
-------	---	---------------------------------------	-----------------------------------	--	--------------------------------------	-----------------------

**Background:** In February 2010, the CPT Editorial Panel revised this code as part of the larger Endovascular Revascularization issue. April 2010 - The Workgroup acknowledges that it is unclear what volume of services will remain described by these codes given the removal of the lower extremity revascularization services and agrees with the specialties to defer this issue for one year until the RUC has reviewed the lower extremity revascularization codes in April 2010 and the new codes are implemented. Currently, the Workgroup encourages the specialties to consider a bundled code for the 2012 CPT cycle. Specialty to address by the February 2012 CPT meeting.

37208	<b>Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; each additional vessel (List separately in addition to code for primary procedure)</b>	<u>Screen:</u> High Volume Growth1	<u>RUC Meeting:</u> April 2010	<u>Specialty Society:</u> SVS, ACS, SIR, ACR, ACC	<u>CPT Meeting:</u> February 2013	<u>CPT Tab:</u> 10
-------	---	---------------------------------------	-----------------------------------	--	--------------------------------------	-----------------------

**Background:** In February 2010, the CPT Editorial Panel revised this code as part of the larger Endovascular Revascularization issue. April 2010 - The Workgroup acknowledges that it is unclear what volume of services will remain described by these codes given the removal of the lower extremity revascularization services and agrees with the specialties to defer this issue for one year until the RUC has reviewed the lower extremity revascularization codes in April 2010 and the new codes are implemented. Currently, the Workgroup encourages the specialties to consider a bundled code for the 2012 CPT cycle. Specialty to address by the February 2013 CPT meeting.

43260	<b>Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)</b>	<u>Screen:</u> MPC List	<u>RUC Meeting:</u> April 2013	<u>Specialty Society:</u>	<u>CPT Meeting:</u> February 2013	<u>CPT Tab:</u> 13
-------	---	----------------------------	-----------------------------------	---------------------------	--------------------------------------	-----------------------

**Background:** Several specific codes identified by CMS through the MPC List screen were scheduled for review at the September 2011 RUC meeting. Review of the codes led to significant concerns with the survey data, and in some cases, coding and payment policy for the individual codes. The specialty societies representing gastroenterology indicated that appropriate surveys could not be conducted until after the specialty societies had an opportunity to resolve payment policy issues related to the provision of moderate sedation. The RUC understands that gastroenterology will be working with the CPT Editorial Panel and CMS to resolve this coding and payment policy question as it relates to over 100 GI endoscopy services. In the meantime, the RUC will not include any of these services on the MPC List. The specialty societies indicated that they plan to engage with the RUC on a workplan to survey this family of codes once the issues related to moderate sedation have been addressed.

## *RUC Referrals to CPT Editorial Panel - Incomplete Issues*

---

47500	Injection procedure for percutaneous transhepatic cholangiography	<u>Screen:</u> Codes Reported Together 75% or More-Part2	<u>RUC Meeting:</u> October 2012	<u>Specialty Society:</u> ACR, SIR	<u>CPT Meeting:</u> CPT 2016 cycle	<u>CPT Tab:</u>
-------	---	--	-------------------------------------	---------------------------------------	---------------------------------------	-----------------

**Background:** The Joint Workgroup recommends bundling 47500 and 74320, 47505 and 74305, 47510 and 75980 and 47511 and 75982 by CPT 2016 cycle.

---

47505	Injection procedure for cholangiography through an existing catheter (eg, percutaneous transhepatic or T-tube)	<u>Screen:</u> Codes Reported Together 75% or More-Part2	<u>RUC Meeting:</u> October 2012	<u>Specialty Society:</u> ACR, SIR	<u>CPT Meeting:</u> CPT 2016 cycle	<u>CPT Tab:</u>
-------	--	--	-------------------------------------	---------------------------------------	---------------------------------------	-----------------

**Background:** The Joint Workgroup recommends bundling 47500 and 74320, 47505 and 74305, 47510 and 75980 and 47511 and 75982 by CPT 2016 cycle.

---

47510	Introduction of percutaneous transhepatic catheter for biliary drainage	<u>Screen:</u> Codes Reported Together 75% or More-Part2	<u>RUC Meeting:</u> October 2012	<u>Specialty Society:</u> ACR, SIR	<u>CPT Meeting:</u> CPT 2016 cycle	<u>CPT Tab:</u>
-------	---	--	-------------------------------------	---------------------------------------	---------------------------------------	-----------------

**Background:** The Joint Workgroup recommends bundling 47500 and 74320, 47505 and 74305, 47510 and 75980 and 47511 and 75982 by CPT 2016 cycle.

---

47511	Introduction of percutaneous transhepatic stent for internal and external biliary drainage	<u>Screen:</u> Codes Reported Together 75% or More-Part2	<u>RUC Meeting:</u> October 2012	<u>Specialty Society:</u> ACR, SIR	<u>CPT Meeting:</u> CPT 2016 cycle	<u>CPT Tab:</u>
-------	--	--	-------------------------------------	---------------------------------------	---------------------------------------	-----------------

**Background:** The Joint Workgroup recommends bundling 47500 and 74320, 47505 and 74305, 47510 and 75980 and 47511 and 75982 by CPT 2016 cycle.

---

50392	Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous	<u>Screen:</u> Codes Reported Together 75% or More-Part2	<u>RUC Meeting:</u> October 2012	<u>Specialty Society:</u> ACR, SIR	<u>CPT Meeting:</u> CPT 2016 cycle	<u>CPT Tab:</u>
-------	---	--	-------------------------------------	---------------------------------------	---------------------------------------	-----------------

**Background:** The Joint Workgroup recommends bundling 50392 and 74475, 50393 and 74480, 50394 and 74425, 50398 and 75984 and 50392 by the CPT 2016 cycle.

---

50393	Introduction of ureteral catheter or stent into ureter through renal pelvis for drainage and/or injection, percutaneous	<u>Screen:</u> Codes Reported Together 75% or More-Part2	<u>RUC Meeting:</u> October 2012	<u>Specialty Society:</u> ACR, SIR	<u>CPT Meeting:</u> CPT 2016 cycle	<u>CPT Tab:</u>
-------	---	--	-------------------------------------	---------------------------------------	---------------------------------------	-----------------

**Background:** The Joint Workgroup recommends bundling 50392 and 74475, 50393 and 74480, 50394 and 74425, 50398 and 75984 and 50392 by the CPT 2016 cycle.

---

## *RUC Referrals to CPT Editorial Panel - Incomplete Issues*

---

50394	Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter	<u>Screen:</u> Codes Reported Together 75% or More-Part2	<u>RUC Meeting:</u> October 2012	<u>Specialty Society:</u> ACR, SIR	<u>CPT Meeting:</u> CPT 2016 cycle	<u>CPT Tab:</u>
-------	---	--	-------------------------------------	---------------------------------------	---------------------------------------	-----------------

**Background:** The Joint Workgroup recommends bundling 50392 and 74475, 50393 and 74480, 50394 and 74425, 50398 and 75984 and 50392 by the CPT 2016 cycle.

---

50398	Change of nephrostomy or pyelostomy tube	<u>Screen:</u> Codes Reported Together 75% or More-Part2	<u>RUC Meeting:</u> October 2012	<u>Specialty Society:</u> ACR, SIR	<u>CPT Meeting:</u> CPT 2016 cycle	<u>CPT Tab:</u>
-------	--	--	-------------------------------------	---------------------------------------	---------------------------------------	-----------------

**Background:** The Joint Workgroup recommends bundling 50392 and 74475, 50393 and 74480, 50394 and 74425, 50398 and 75984 and 50392 by the CPT 2016 cycle.

---

51784	Electromyography studies (EMG) of anal or urethral sphincter, other than needle, any technique	<u>Screen:</u> Codes Reported Together 75% or More-Part2	<u>RUC Meeting:</u> October 2012	<u>Specialty Society:</u> AUA	<u>CPT Meeting:</u> 2015 CPT cycle	<u>CPT Tab:</u>
-------	--	--	-------------------------------------	----------------------------------	---------------------------------------	-----------------

**Background:** The Joint Workgroup referred to CPT Editorial Panel to add parenthetical and develop CPT assistant article indicating that 51792 and 51784 should not be reported together.

---

51792	Stimulus evoked response (eg, measurement of bulbocavernosus reflex latency time)	<u>Screen:</u> Codes Reported Together 75% or More-Part2	<u>RUC Meeting:</u> October 2012	<u>Specialty Society:</u> AUA	<u>CPT Meeting:</u> 2015 CPT cycle	<u>CPT Tab:</u>
-------	---	--	-------------------------------------	----------------------------------	---------------------------------------	-----------------

**Background:** The Joint Workgroup referred to CPT Editorial Panel to add parenthetical and develop CPT assistant article indicating that 51792 and 51784 should not be reported together.

---

62284	Injection procedure for myelography and/or computed tomography, spinal (other than C1-C2 and posterior fossa)	<u>Screen:</u> Codes Reported Together 75% or More-Part2	<u>RUC Meeting:</u> October 2012	<u>Specialty Society:</u> ACR, ASNR	<u>CPT Meeting:</u> CPT 2015 cycle	<u>CPT Tab:</u>
-------	---	--	-------------------------------------	--	---------------------------------------	-----------------

**Background:** Joint Workgroup requests that codes 62284 be bundled with 72240, 72265 and 72270 by the 2015 CPT cycle.

---

## ***RUC Referrals to CPT Editorial Panel - Incomplete Issues***

66180	<b>Aqueous shunt to extraocular reservoir (eg, Molteno, Schocket, Denver-Krupin)</b>	<u><b>Screen:</b></u> Harvard-Valued Annual Allowed Charges Greater than \$10 million	<u><b>RUC Meeting:</b></u> April 2013	<u><b>Specialty Society:</b></u> AAO	<u><b>CPT Meeting:</b></u>	<u><b>CPT Tab:</b></u>
-------	--	--	--	---	----------------------------	------------------------

**Background:** In April 2013, the American Academy of Ophthalmology noted that based on data from the last meeting the specialty society was informed that 66180 is typically reported (73%) with 67255 Scleral reinforcement (separate procedure); with graft and it appears that these services should be surveyed as a bundled code. The specialty society requested that 66180 and 66185 be referred to CPT to create codes to describe with and without patch. The specialty society also noted that they will survey 67255 with this family of services. The RUC agreed and recommends that these services be referred to the CPT Editorial Panel for revision.

66185	<b>Revision of aqueous shunt to extraocular reservoir</b>	<u><b>Screen:</b></u> Harvard-Valued Annual Allowed Charges Greater than \$10 million	<u><b>RUC Meeting:</b></u> April 2013	<u><b>Specialty Society:</b></u> AAO	<u><b>CPT Meeting:</b></u>	<u><b>CPT Tab:</b></u>
-------	---	--	--	---	----------------------------	------------------------

**Background:** In April 2013, the American Academy of Ophthalmology noted that based on data from the last meeting the specialty society was informed that 66180 is typically reported (73%) with 67255 Scleral reinforcement (separate procedure); with graft and it appears that these services should be surveyed as a bundled code. The specialty society requested that 66180 and 66185 be referred to CPT to create codes to describe with and without patch. The specialty society also noted that they will survey 67255 with this family of services. The RUC agreed and recommends that these services be referred to the CPT Editorial Panel for revision.

68040	<b>Expression of conjunctival follicles (eg, for trachoma)</b>	<u><b>Screen:</b></u> High Volume Growth1	<u><b>RUC Meeting:</b></u> September 2011	<u><b>Specialty Society:</b></u> AAO	<u><b>CPT Meeting:</b></u>	<u><b>CPT Tab:</b></u>
-------	--	--	--	---	----------------------------	------------------------

**Background:** AAO to develop CPT Assistant article to educate providers about the intended use of this code and how to code for newer devices that we believe are erroneously being coded using CPT 68040. Additionally, AAO suggests that a parenthetical be added after CPT 68040, "(To report automated evacuation of Meibomian glands, see 0207T)". AAO will submit a CCP for the CPT 2014 cycle.

72170	<b>Radiologic examination, pelvis; 1 or 2 views</b>	<u><b>Screen:</b></u> Low Value-High Volume / Codes Reported Together 75% or More-Part2	<u><b>RUC Meeting:</b></u> April 2011	<u><b>Specialty Society:</b></u> ACR, AAOS	<u><b>CPT Meeting:</b></u> February 2015	<u><b>CPT Tab:</b></u>
-------	---	--	--	---	---	------------------------

**Background:** The Joint Workgroup recommended that 73500 and 72170 be bundled by the CPT 2016 cycle.

72240	<b>Myelography, cervical, radiological supervision and interpretation</b>	<u><b>Screen:</b></u> Codes Reported Together 75% or More-Part2	<u><b>RUC Meeting:</b></u> October 2012	<u><b>Specialty Society:</b></u> ACR, ASNR	<u><b>CPT Meeting:</b></u> CPT 2015 cycle	<u><b>CPT Tab:</b></u>
-------	---	---	--	---	--	------------------------

**Background:** Joint Workgroup requests that codes 62284 be bundled with 72240, 72265 and 72270 by the 2015 CPT cycle.



## *RUC Referrals to CPT Editorial Panel - Incomplete Issues*

72265	<b>Myelography, lumbosacral, radiological supervision and interpretation</b>	<u><a href="#">Screen:</a></u> Codes Reported Together 75% or More-Part2	<u><a href="#">RUC Meeting:</a></u> October 2012	<u><a href="#">Specialty Society:</a></u> ACR, ASNR	<u><a href="#">CPT Meeting:</a></u> CPT 2015 cycle	<u><a href="#">CPT Tab:</a></u>
-------	--	--	---	--	---	---------------------------------

**Background:** Joint Workgroup requests that codes 62284 be bundled with 72240, 72265 and 72270 by the 2015 CPT cycle.

72270	<b>Myelography, 2 or more regions (eg, lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical), radiological supervision and interpretation</b>	<u><a href="#">Screen:</a></u> Codes Reported Together 75% or More-Part2	<u><a href="#">RUC Meeting:</a></u> October 2012	<u><a href="#">Specialty Society:</a></u> ACR, ASNR	<u><a href="#">CPT Meeting:</a></u> CPT 2015 cycle	<u><a href="#">CPT Tab:</a></u>
-------	--	--	---	--	---	---------------------------------

**Background:** Joint Workgroup requests that codes 62284 be bundled with 72240, 72265 and 72270 by the 2015 CPT cycle.

72291	<b>Radiological supervision and interpretation, percutaneous vertebroplasty, vertebral augmentation, or sacral augmentation (sacroplasty), including cavity creation, per vertebral body or sacrum; under fluoroscopic guidance</b>	<u><a href="#">Screen:</a></u> Codes Reported Together 75% or More-Part2	<u><a href="#">RUC Meeting:</a></u> October 2012	<u><a href="#">Specialty Society:</a></u>	<u><a href="#">CPT Meeting:</a></u> CPT 2015 cycle	<u><a href="#">CPT Tab:</a></u>
-------	---	--	---	---	---	---------------------------------

**Background:** Joint Workgroup recommends that 72291 be bundled with 22520, 22523, 22524 and 72292 be bundled with 22521 by the 2015 CPT cycle.

72291	<b>Radiological supervision and interpretation, percutaneous vertebroplasty, vertebral augmentation, or sacral augmentation (sacroplasty), including cavity creation, per vertebral body or sacrum; under fluoroscopic guidance</b>	<u><a href="#">Screen:</a></u> Codes Reported Together 75% or More-Part2	<u><a href="#">RUC Meeting:</a></u> October 2012	<u><a href="#">Specialty Society:</a></u>	<u><a href="#">CPT Meeting:</a></u> CPT 2015 cycle	<u><a href="#">CPT Tab:</a></u>
-------	---	--	---	---	---	---------------------------------

**Background:** Joint Workgroup recommends that 72291 be bundled with 22520, 22523, 22524 and 72292 be bundled with 22521 by the 2015 CPT cycle.

73500	<b>Radiologic examination, hip, unilateral; 1 view</b>	<u><a href="#">Screen:</a></u> CMS-Other - Utilization over 500,000 / Codes Reported Together 75% or More-Part2	<u><a href="#">RUC Meeting:</a></u> January 2012	<u><a href="#">Specialty Society:</a></u> AAOS, ACR	<u><a href="#">CPT Meeting:</a></u> February 2015	<u><a href="#">CPT Tab:</a></u>
-------	--	--	---	--	--	---------------------------------

**Background:** In Jan 2012, the specialty society requested that this service be referred to CPT to clarify the descriptors or add editorial language/parentheticals as needed. This service was also identified by the Joint CPT/RUC workgroup to bundle this service. The Specialties will address at the February 2015 CPT meeting.

## *RUC Referrals to CPT Editorial Panel - Incomplete Issues*

73550	Radiologic examination, femur, 2 views	<u>Screen:</u> CMS-Other - Utilization over 500,000	<u>RUC Meeting:</u> January 2012	<u>Specialty Society:</u> AAOS, ACR	<u>CPT Meeting:</u> February 2015	<u>CPT Tab:</u>
-------	--	--	-------------------------------------	--	--------------------------------------	-----------------

**Background:** In Jan 2012, the specialty society requested that this service be referred to CPT to clarify the descriptors or add editorial language/parentheticals as needed. This service was also identified by the Joint CPT/RUC workgroup to bundle this service. The Specialties will address at the February 2015 CPT meeting.

74305	Cholangiography and/or pancreatography; through existing catheter, radiological supervision and interpretation	<u>Screen:</u> Codes Reported Together 75% or More-Part2	<u>RUC Meeting:</u> October 2012	<u>Specialty Society:</u> ACR, SIR	<u>CPT Meeting:</u> CPT 2016 cycle	<u>CPT Tab:</u>
-------	--	---	-------------------------------------	---------------------------------------	---------------------------------------	-----------------

**Background:** The Joint Workgroup recommends bundling 47500 and 74320, 47505 and 74305, 47510 and 75980 and 47511 and 75982 by CPT 2016 cycle.

74320	Cholangiography, percutaneous, transhepatic, radiological supervision and interpretation	<u>Screen:</u> Codes Reported Together 75% or More-Part2	<u>RUC Meeting:</u> October 2012	<u>Specialty Society:</u> ACR, SIR	<u>CPT Meeting:</u> CPT 2016 cycle	<u>CPT Tab:</u>
-------	--	---	-------------------------------------	---------------------------------------	---------------------------------------	-----------------

**Background:** The Joint Workgroup recommends bundling 47500 and 74320, 47505 and 74305, 47510 and 75980 and 47511 and 75982 by CPT 2016 cycle.

74425	Urography, antegrade (pyelostogram, nephrostogram, loopogram), radiological supervision and interpretation	<u>Screen:</u> Codes Reported Together 75% or More-Part2	<u>RUC Meeting:</u> October 2012	<u>Specialty Society:</u> ACR, SIR	<u>CPT Meeting:</u> CPT 2016 cycle	<u>CPT Tab:</u>
-------	--	---	-------------------------------------	---------------------------------------	---------------------------------------	-----------------

**Background:** The Joint Workgroup recommends bundling 50392 and 74475, 50393 and 74480, 50394 and 74425, 50398 and 75984 and 50392 by the CPT 2016 cycle.

74475	Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous, radiological supervision and interpretation	<u>Screen:</u> Codes Reported Together 75% or More-Part2	<u>RUC Meeting:</u> October 2012	<u>Specialty Society:</u> ACR, SIR	<u>CPT Meeting:</u> CPT 2016 cycle	<u>CPT Tab:</u>
-------	--	---	-------------------------------------	---------------------------------------	---------------------------------------	-----------------

**Background:** The Joint Workgroup recommends bundling 50392 and 74475, 50393 and 74480, 50394 and 74425, 50398 and 75984 and 50392 by the CPT 2016 cycle.

## *RUC Referrals to CPT Editorial Panel - Incomplete Issues*

74480	<b>Introduction of ureteral catheter or stent into ureter through renal pelvis for drainage and/or injection, percutaneous, radiological supervision and interpretation</b>	<u>Screen:</u> Codes Reported Together 75% or More-Part2	<u>RUC Meeting:</u> October 2012	<u>Specialty Society:</u> ACR, SIR	<u>CPT Meeting:</u> CPT 2016 cycle	<u>CPT Tab:</u>
-------	---	--	-------------------------------------	---------------------------------------	---------------------------------------	-----------------

**Background:** The Joint Workgroup recommends bundling 50392 and 74475, 50393 and 74480, 50394 and 74425, 50398 and 75984 and 50392 by the CPT 2016 cycle.

75894	<b>Transcatheter therapy, embolization, any method, radiological supervision and interpretation</b>	<u>Screen:</u> Codes Reported Together 75% or More-Part1	<u>RUC Meeting:</u> April 2010	<u>Specialty Society:</u> ACC, ACR, SIR, SVS	<u>CPT Meeting:</u> October 2012	<u>CPT Tab:</u>
-------	---	--	-----------------------------------	---	-------------------------------------	-----------------

**Background:** The Workgroup accepts the specialties' recommendation to submit a code change proposal that would address any duplication when this service is reported with 37201 on the same date by the same physician. ACC submitted a CCP for October 2012 CPT related to 75894, creating a new code for a particular cardiac procedure that is currently reported using that code.

75896	<b>Transcatheter therapy, infusion, other than for thrombolysis, radiological supervision and interpretation</b>	<u>Screen:</u> Codes Reported Together 75% or More-Part1	<u>RUC Meeting:</u> October 2012	<u>Specialty Society:</u>	<u>CPT Meeting:</u> February 2013	<u>CPT Tab:</u>
-------	--	--	-------------------------------------	---------------------------	--------------------------------------	-----------------

**Background:** AANS indicated that they will develop a CCP to bundle 75896 with 37201 and 37202 for CPT Feb 2013 for RUC review at the April 2013 meeting. At the October 2012 RUC meeting, the specialties reiterated to the RUC that under the current coding structure, CPT codes 75896 and 75898 are reported during thrombolytic therapy. However, with the CPT revisions for 2013, these two codes will no longer be reported during thrombolytic therapy. Given this, it is unknown exactly how these two orphan codes will be reported in 2013. The remaining non-thrombolysis use of these codes will be influenced by future CPT Editorial Panel changes. CPT code 75896 will be included in a multi-specialty coding revision effort led by neurosurgery. This coding proposal will describe intracranial infusion other than for thrombolysis (e.g. vasodilators in the setting of cerebral vasospasm). This coding change is expected to be reviewed by the CPT Editorial Panel in February 2013. CPT code 75898 will be addressed in the multi-specialty embolization coding revision due for CPT Editorial Panel review in February 2013 and RUC review in April 2013 as well. However, until recommendations are reviewed and submitted for 2014, the RUC continues to recommend carrier pricing for CPT codes 75896 and 75898.

75898	<b>Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis</b>	<u>Screen:</u> Codes Reported Together 75% or More-Part1	<u>RUC Meeting:</u> October 2012	<u>Specialty Society:</u>	<u>CPT Meeting:</u> February 2013	<u>CPT Tab:</u>
-------	---	--	-------------------------------------	---------------------------	--------------------------------------	-----------------

**Background:** The Workgroup accepts the specialties' recommendation to submit a code change proposal that would address any duplication when these services are reported together on the same date by the same physician. At the October 2012 RUC meeting, the specialties reiterated to the RUC that under the current coding structure, CPT codes 75896 and 75898 are reported during thrombolytic therapy. However, with the CPT revisions for 2013, these two codes will no longer be reported during thrombolytic therapy. Given this, it is unknown exactly how these two orphan codes will be reported in 2013. The remaining non-thrombolysis use of these codes will be influenced by future CPT Editorial Panel changes. CPT code 75896 will be included in a multi-specialty coding revision effort led by neurosurgery. This coding proposal will describe intracranial infusion other than for thrombolysis (e.g. vasodilators in the setting of cerebral vasospasm). This coding change is expected to be reviewed by the CPT Editorial Panel in February 2013. CPT code 75898 will be addressed in the multi-specialty embolization coding revision due for CPT Editorial Panel review in February 2013 and RUC review in April 2013 as well. However, until recommendations are reviewed and submitted for 2014, the RUC continues to recommend carrier pricing for CPT codes 75896 and 75898.

## *RUC Referrals to CPT Editorial Panel - Incomplete Issues*

75960	<b>Transcatheter introduction of intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity artery), percutaneous and/or open, radiological supervision and interpretation, each vessel</b>	<u><b>Screen:</b></u> High Volume Growth1 / Codes Reported Together 75% or More-Part1	<u><b>RUC Meeting:</b></u> October 2012	<u><b>Specialty Society:</b></u> ACC, ACR, SIR, SVS	<u><b>CPT Meeting:</b></u> February 2013	<u><b>CPT Tab:</b></u> 10
-------	--	--	--	--	---	------------------------------

**Background:** In February 2010, the CPT Editorial Panel revised this code as part of the larger Endovascular Revascularization issue. April 2010 - The Workgroup acknowledges that it is unclear what volume of services will remain described by these codes given the removal of the lower extremity revascularization services and agrees with the specialties to defer this issue for one year until the RUC has reviewed the lower extremity revascularization codes in April 2010 and the new codes are implemented. Currently, the Workgroup encourages the specialties to consider a bundled code for the 2012 CPT cycle. Timeline: Review complete no later than the February 2011 CPT Editorial Panel meeting. The Specialty societies indicated that this service will be part of the Intravascular Stent CCP submitted for review at the February 2013 CPT meeting.

75980	<b>Percutaneous transhepatic biliary drainage with contrast monitoring, radiological supervision and interpretation</b>	<u><b>Screen:</b></u> Codes Reported Together 75% or More-Part2	<u><b>RUC Meeting:</b></u> October 2012	<u><b>Specialty Society:</b></u> ACR, SIR	<u><b>CPT Meeting:</b></u> CPT 2016 cycle	<u><b>CPT Tab:</b></u>
-------	---	--	--	--	--	------------------------

**Background:** The Joint Workgroup recommends bundling 47500 and 74320, 47505 and 74305, 47510 and 75980 and 47511 and 75982 by CPT 2016 cycle.

75982	<b>Percutaneous placement of drainage catheter for combined internal and external biliary drainage or of a drainage stent for internal biliary drainage in patients with an inoperable mechanical biliary obstruction, radiological supervision and interpretation</b>	<u><b>Screen:</b></u> Codes Reported Together 75% or More-Part2	<u><b>RUC Meeting:</b></u> October 2012	<u><b>Specialty Society:</b></u> ACR, SIR	<u><b>CPT Meeting:</b></u> CPT 2016 cycle	<u><b>CPT Tab:</b></u>
-------	--	--	--	--	--	------------------------

**Background:** The Joint Workgroup recommends bundling 47500 and 74320, 47505 and 74305, 47510 and 75980 and 47511 and 75982 by CPT 2016 cycle.

75984	<b>Change of percutaneous tube or drainage catheter with contrast monitoring (eg, genitourinary system, abscess), radiological supervision and interpretation</b>	<u><b>Screen:</b></u> Codes Reported Together 75% or More-Part2	<u><b>RUC Meeting:</b></u> October 2012	<u><b>Specialty Society:</b></u> ACR, SIR	<u><b>CPT Meeting:</b></u> CPT 2016 cycle	<u><b>CPT Tab:</b></u>
-------	---	--	--	--	--	------------------------

**Background:** The Joint Workgroup recommends bundling 50392 and 74475, 50393 and 74480, 50394 and 74425, 50398 and 75984 and 50392 by the CPT 2016 cycle.

## *RUC Referrals to CPT Editorial Panel - Incomplete Issues*

---

77014	Computed tomography guidance for placement of radiation therapy fields	<u>Screen:</u> CMS Request - Practice Expense Review / CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes	<u>RUC Meeting:</u> January 2012	<u>Specialty Society:</u> ASTRO, ACR	<u>CPT Meeting:</u> May 2013	<u>CPT Tab:</u>
-------	--	--	-------------------------------------	---	---------------------------------	-----------------

**Background:** Specialty intends on revising this service may revise to include image guidance. The specialties will submit a CCP for review at the May 2013 CPT meeting.

---

77080	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)	<u>Screen:</u> CMS Request - NPRM for 2012 / Codes Reported Together 75% or More-Part2	<u>RUC Meeting:</u> January 2012	<u>Specialty Society:</u> AACE, ACR, ACRh, TES	<u>CPT Meeting:</u> 2015 CPT cycle	<u>CPT Tab:</u>
-------	---	---	-------------------------------------	---	---------------------------------------	-----------------

**Background:** In Oct 2012, the Joint Workgroup recommended to bundle 77082 and 77080 by the 2015 CPT cycle.

---

77082	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; vertebral fracture assessment	<u>Screen:</u> CMS Request - NPRM for 2012 / Codes Reported Together 75% or More-Part2	<u>RUC Meeting:</u> January 2012	<u>Specialty Society:</u> AACE, ACR, ACRh, TES	<u>CPT Meeting:</u> 2015 CPT cycle	<u>CPT Tab:</u>
-------	--	---	-------------------------------------	---	---------------------------------------	-----------------

**Background:** In Oct 2012, the Joint Workgroup recommended to bundle 77082 and 77080 by the 2015 CPT cycle.

---

77300	Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician	<u>Screen:</u> MPC List / Codes Reported Together 75% or More-Part2	<u>RUC Meeting:</u> February 2011	<u>Specialty Society:</u> ASTRO	<u>CPT Meeting:</u> CPT 2015 cycle	<u>CPT Tab:</u>
-------	--	--	--------------------------------------	------------------------------------	---------------------------------------	-----------------

**Background:** On 8-21-12, the Joint Workgroup convened a conference call with the specialty society to further discuss the physician work involved in these services and what if any overlap may occur when performed on the same date. The Workgroup recommends that all other code pairs (77300 with 77305, 77310, 77315, 77326 & 77327 (be referred to the CPT Editorial Panel for creation of a bundled code solution. Timeline: No later than CPT 2015 cycle.

---

## *RUC Referrals to CPT Editorial Panel - Incomplete Issues*

---

77305	<b>Teletherapy, isodose plan (whether hand or computer calculated); simple (1 or 2 parallel opposed unmodified ports directed to a single area of interest)</b>	<u>Screen:</u> Codes Reported Together 75% or More-Part2	<u>RUC Meeting:</u> October 2012	<u>Specialty Society:</u> ASTRO	<u>CPT Meeting:</u> 2015 CPT cycle	<u>CPT Tab:</u>
-------	---	--	-------------------------------------	------------------------------------	---------------------------------------	-----------------

**Background:** On 8-21-12, the Joint Workgroup convened a conference call with the specialty society to further discuss the physician work involved in these services and what if any overlap may occur when performed on the same date. The Workgroup recommends that all code pairs (77300 with 77305, 773010, 77315, 77326 & 77327( be referred to the CPT Editorial Panel for creation of a bundled code solution. Timeline: No later than CPT 2015 cycle.

---

77310	<b>Teletherapy, isodose plan (whether hand or computer calculated); intermediate (3 or more treatment ports directed to a single area of interest)</b>	<u>Screen:</u> Codes Reported Together 75% or More-Part2	<u>RUC Meeting:</u> October 2012	<u>Specialty Society:</u> ASTRO	<u>CPT Meeting:</u> 2015 CPT cycle	<u>CPT Tab:</u>
-------	--	--	-------------------------------------	------------------------------------	---------------------------------------	-----------------

**Background:** On 8-21-12, the Joint Workgroup convened a conference call with the specialty society to further discuss the physician work involved in these services and what if any overlap may occur when performed on the same date. The Workgroup recommends that all code pairs (77300 with 77305, 773010, 77315, 77326 & 77327( be referred to the CPT Editorial Panel for creation of a bundled code solution. Timeline: No later than CPT 2015 cycle.

---

77315	<b>Teletherapy, isodose plan (whether hand or computer calculated); complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex blocking, rotational beam, or special beam considerations)</b>	<u>Screen:</u> Codes Reported Together 75% or More-Part2	<u>RUC Meeting:</u> October 2012	<u>Specialty Society:</u> ASTRO	<u>CPT Meeting:</u> 2015 CPT cycle	<u>CPT Tab:</u>
-------	--	--	-------------------------------------	------------------------------------	---------------------------------------	-----------------

**Background:** On 8-21-12, the Joint Workgroup convened a conference call with the specialty society to further discuss the physician work involved in these services and what if any overlap may occur when performed on the same date. The Workgroup recommends that all code pairs (77300 with 77305, 773010, 77315, 77326 & 77327( be referred to the CPT Editorial Panel for creation of a bundled code solution. Timeline: No later than CPT 2015 cycle.

---

77327	<b>Brachytherapy isodose plan; intermediate (multiplane dosage calculations, application involving 5 to 10 sources/ribbons, remote afterloading brachytherapy, 9 to 12 sources)</b>	<u>Screen:</u> Codes Reported Together 75% or More-Part2	<u>RUC Meeting:</u> October 2012	<u>Specialty Society:</u> ASTRO	<u>CPT Meeting:</u> 2015 CPT cycle	<u>CPT Tab:</u>
-------	---	--	-------------------------------------	------------------------------------	---------------------------------------	-----------------

**Background:** On 8-21-12, the Joint Workgroup convened a conference call with the specialty society to further discuss the physician work involved in these services and what if any overlap may occur when performed on the same date. The Workgroup recommends that all code pairs (77300 with 77305, 773010, 77315, 77326 & 77327( be referred to the CPT Editorial Panel for creation of a bundled code solution. Timeline: No later than CPT 2015 cycle.

---

## *RUC Referrals to CPT Editorial Panel - Incomplete Issues*

77402	<b>Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; up to 5 MeV</b>	<u><a href="#">Screen:</a></u> Services with Stand-Alone PE Procedure Time	<u><a href="#">RUC Meeting:</a></u> April 2013	<u><a href="#">Specialty Society:</a></u>	<u><a href="#">CPT Meeting:</a></u>	<u><a href="#">CPT Tab:</a></u>
-------	--	--	---	---	-------------------------------------	---------------------------------

**Background:** At the April 2013 RUC meeting, the specialty indicated that as clinical practice has evolved, several issues have arisen which require CPT clarification. The specialty intends to address a number of interrelated issues and revise the entire treatment delivery family. The RUC recommends CPT codes 77402-77417 be referred to the CPT Editorial Panel for review.

77403	<b>Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 6-10 MeV</b>	<u><a href="#">Screen:</a></u> Services with Stand-Alone PE Procedure Time	<u><a href="#">RUC Meeting:</a></u> April 2013	<u><a href="#">Specialty Society:</a></u>	<u><a href="#">CPT Meeting:</a></u>	<u><a href="#">CPT Tab:</a></u>
-------	---	--	---	---	-------------------------------------	---------------------------------

**Background:** At the April 2013 RUC meeting, the specialty indicated that as clinical practice has evolved, several issues have arisen which require CPT clarification. The specialty intends to address a number of interrelated issues and revise the entire treatment delivery family. The RUC recommends CPT codes 77402-77417 be referred to the CPT Editorial Panel for review.

77404	<b>Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 11-19 MeV</b>	<u><a href="#">Screen:</a></u> Services with Stand-Alone PE Procedure Time	<u><a href="#">RUC Meeting:</a></u> April 2013	<u><a href="#">Specialty Society:</a></u>	<u><a href="#">CPT Meeting:</a></u>	<u><a href="#">CPT Tab:</a></u>
-------	--	--	---	---	-------------------------------------	---------------------------------

**Background:** At the April 2013 RUC meeting, the specialty indicated that as clinical practice has evolved, several issues have arisen which require CPT clarification. The specialty intends to address a number of interrelated issues and revise the entire treatment delivery family. The RUC recommends CPT codes 77402-77417 be referred to the CPT Editorial Panel for review.

77406	<b>Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 20 MeV or greater</b>	<u><a href="#">Screen:</a></u> Services with Stand-Alone PE Procedure Time	<u><a href="#">RUC Meeting:</a></u> April 2013	<u><a href="#">Specialty Society:</a></u>	<u><a href="#">CPT Meeting:</a></u>	<u><a href="#">CPT Tab:</a></u>
-------	--	--	---	---	-------------------------------------	---------------------------------

**Background:** At the April 2013 RUC meeting, the specialty indicated that as clinical practice has evolved, several issues have arisen which require CPT clarification. The specialty intends to address a number of interrelated issues and revise the entire treatment delivery family. The RUC recommends CPT codes 77402-77417 be referred to the CPT Editorial Panel for review.

77407	<b>Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; up to 5 MeV</b>	<u><a href="#">Screen:</a></u> Services with Stand-Alone PE Procedure Time	<u><a href="#">RUC Meeting:</a></u> April 2013	<u><a href="#">Specialty Society:</a></u>	<u><a href="#">CPT Meeting:</a></u>	<u><a href="#">CPT Tab:</a></u>
-------	--	--	---	---	-------------------------------------	---------------------------------

**Background:** At the April 2013 RUC meeting, the specialty indicated that as clinical practice has evolved, several issues have arisen which require CPT clarification. The specialty intends to address a number of interrelated issues and revise the entire treatment delivery family. The RUC recommends CPT codes 77402-77417 be referred to the CPT Editorial Panel for review.

## *RUC Referrals to CPT Editorial Panel - Incomplete Issues*

77408	<b>Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 6-10 MeV</b>	<u><a href="#">Screen:</a></u> Services with Stand-Alone PE Procedure Time	<u><a href="#">RUC Meeting:</a></u> April 2013	<u><a href="#">Specialty Society:</a></u>	<u><a href="#">CPT Meeting:</a></u>	<u><a href="#">CPT Tab:</a></u>
-------	---	--	---	---	-------------------------------------	---------------------------------

**Background:** At the April 2013 RUC meeting, the specialty indicated that as clinical practice has evolved, several issues have arisen which require CPT clarification. The specialty intends to address a number of interrelated issues and revise the entire treatment delivery family. The RUC recommends CPT codes 77402-77417 be referred to the CPT Editorial Panel for review.

77409	<b>Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 11-19 MeV</b>	<u><a href="#">Screen:</a></u> Services with Stand-Alone PE Procedure Time	<u><a href="#">RUC Meeting:</a></u> April 2013	<u><a href="#">Specialty Society:</a></u>	<u><a href="#">CPT Meeting:</a></u>	<u><a href="#">CPT Tab:</a></u>
-------	--	--	---	---	-------------------------------------	---------------------------------

**Background:** At the April 2013 RUC meeting, the specialty indicated that as clinical practice has evolved, several issues have arisen which require CPT clarification. The specialty intends to address a number of interrelated issues and revise the entire treatment delivery family. The RUC recommends CPT codes 77402-77417 be referred to the CPT Editorial Panel for review.

77411	<b>Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 20 MeV or greater</b>	<u><a href="#">Screen:</a></u> Services with Stand-Alone PE Procedure Time	<u><a href="#">RUC Meeting:</a></u> April 2013	<u><a href="#">Specialty Society:</a></u>	<u><a href="#">CPT Meeting:</a></u>	<u><a href="#">CPT Tab:</a></u>
-------	--	--	---	---	-------------------------------------	---------------------------------

**Background:** At the April 2013 RUC meeting, the specialty indicated that as clinical practice has evolved, several issues have arisen which require CPT clarification. The specialty intends to address a number of interrelated issues and revise the entire treatment delivery family. The RUC recommends CPT codes 77402-77417 be referred to the CPT Editorial Panel for review.

77412	<b>Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; up to 5 MeV</b>	<u><a href="#">Screen:</a></u> Services with Stand-Alone PE Procedure Time	<u><a href="#">RUC Meeting:</a></u> April 2013	<u><a href="#">Specialty Society:</a></u>	<u><a href="#">CPT Meeting:</a></u>	<u><a href="#">CPT Tab:</a></u>
-------	---	--	---	---	-------------------------------------	---------------------------------

**Background:** At the April 2013 RUC meeting, the specialty indicated that as clinical practice has evolved, several issues have arisen which require CPT clarification. The specialty intends to address a number of interrelated issues and revise the entire treatment delivery family. The RUC recommends CPT codes 77402-77417 be referred to the CPT Editorial Panel for review.

77413	<b>Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 6-10 MeV</b>	<u><a href="#">Screen:</a></u> Services with Stand-Alone PE Procedure Time	<u><a href="#">RUC Meeting:</a></u> April 2013	<u><a href="#">Specialty Society:</a></u>	<u><a href="#">CPT Meeting:</a></u>	<u><a href="#">CPT Tab:</a></u>
-------	--	--	---	---	-------------------------------------	---------------------------------

**Background:** At the April 2013 RUC meeting, the specialty indicated that as clinical practice has evolved, several issues have arisen which require CPT clarification. The specialty intends to address a number of interrelated issues and revise the entire treatment delivery family. The RUC recommends CPT codes 77402-77417 be referred to the CPT Editorial Panel for review.



## *RUC Referrals to CPT Editorial Panel - Incomplete Issues*

77414	<b>Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 11-19 MeV</b>	<u><a href="#">Screen:</a></u> Services with Stand-Alone PE Procedure Time	<u><a href="#">RUC Meeting:</a></u> April 2013	<u><a href="#">Specialty Society:</a></u>	<u><a href="#">CPT Meeting:</a></u>	<u><a href="#">CPT Tab:</a></u>
-------	---	--	---	---	-------------------------------------	---------------------------------

**Background:** At the April 2013 RUC meeting, the specialty indicated that as clinical practice has evolved, several issues have arisen which require CPT clarification. The specialty intends to address a number of interrelated issues and revise the entire treatment delivery family. The RUC recommends CPT codes 77402-77417 be referred to the CPT Editorial Panel for review.

77416	<b>Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 20 MeV or greater</b>	<u><a href="#">Screen:</a></u> Services with Stand-Alone PE Procedure Time	<u><a href="#">RUC Meeting:</a></u> April 2013	<u><a href="#">Specialty Society:</a></u>	<u><a href="#">CPT Meeting:</a></u>	<u><a href="#">CPT Tab:</a></u>
-------	---	--	---	---	-------------------------------------	---------------------------------

**Background:** At the April 2013 RUC meeting, the specialty indicated that as clinical practice has evolved, several issues have arisen which require CPT clarification. The specialty intends to address a number of interrelated issues and revise the entire treatment delivery family. The RUC recommends CPT codes 77402-77417 be referred to the CPT Editorial Panel for review.

77417	<b>Therapeutic radiology port film(s)</b>	<u><a href="#">Screen:</a></u> Services with Stand-Alone PE Procedure Time	<u><a href="#">RUC Meeting:</a></u> April 2013	<u><a href="#">Specialty Society:</a></u>	<u><a href="#">CPT Meeting:</a></u>	<u><a href="#">CPT Tab:</a></u>
-------	---	--	---	---	-------------------------------------	---------------------------------

**Background:** At the April 2013 RUC meeting, the specialty indicated that as clinical practice has evolved, several issues have arisen which require CPT clarification. The specialty intends to address a number of interrelated issues and revise the entire treatment delivery family. The RUC recommends CPT codes 77402-77417 be referred to the CPT Editorial Panel for review.

77421	<b>Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy</b>	<u><a href="#">Screen:</a></u> Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes / High Volume Growth2	<u><a href="#">RUC Meeting:</a></u> January 2012	<u><a href="#">Specialty Society:</a></u> ASTRO	<u><a href="#">CPT Meeting:</a></u> February 2013	<u><a href="#">CPT Tab:</a></u>
-------	--	--	---	--	--	---------------------------------

**Background:** In Jan 2012, the specialty indicated that it intends on bringing the IGRT family of codes (76950 and 77421) to CPT for revision. The specialties will submit a CCP for review at the February 2013 CPT meeting.

77778	<b>Interstitial radiation source application; complex</b>	<u><a href="#">Screen:</a></u> Codes Reported Together 75% or More-Part2	<u><a href="#">RUC Meeting:</a></u> October 2012	<u><a href="#">Specialty Society:</a></u> ASTRO	<u><a href="#">CPT Meeting:</a></u> CPT 2015 cycle	<u><a href="#">CPT Tab:</a></u>
-------	---	--	---	--	---	---------------------------------

**Background:** The Joint Workgroup recommends the specialty society creates a CCP to better describe the physician work performed for 77790 and to develop exclusionary parentheticals stating that 77778 and 77790 no be reported together. Timeline: No later than CPT 2015.

## *RUC Referrals to CPT Editorial Panel - Incomplete Issues*

77787	Remote afterloading high dose rate radionuclide brachytherapy; over 12 channels	<u>Screen:</u> High Volume Growth1 / CMS Fastest Growing/CMS Request - Practice Expense / Services with Stand-Alone PE Procedure Time / Codes Reported Together 75% or More-Part2	<u>RUC Meeting:</u> April 2013	<u>Specialty Society:</u> ASTRO	<u>CPT Meeting:</u> CPT 2015 cycle	<u>CPT Tab:</u>
-------	---	--	-----------------------------------	------------------------------------	---------------------------------------	-----------------

**Background:** In October 2012, the Joint Workgroup recommended that the specialty societies bundle 77787 and 77300, no later than the CPT 2015 cycle.

77790	Supervision, handling, loading of radiation source	<u>Screen:</u> Codes Reported Together 75% or More-Part2	<u>RUC Meeting:</u> October 2012	<u>Specialty Society:</u> ASTRO	<u>CPT Meeting:</u> CPT 2015 cycle	<u>CPT Tab:</u>
-------	--	--	-------------------------------------	------------------------------------	---------------------------------------	-----------------

**Background:** The Joint Workgroup recommends the specialty society creates a CCP to better describe the physician work performed for 77790 and to develop exclusionary parentheticals stating that 77778 and 77790 no be reported together. Timeline: No later than CPT 2015.

88365	In situ hybridization (eg, FISH), each probe	<u>Screen:</u> CMS Request - NPRM for 2012 / CMS Request Final Rule for 2013	<u>RUC Meeting:</u> April 2013	<u>Specialty Society:</u> CAP	<u>CPT Meeting:</u>	<u>CPT Tab:</u>
-------	--	---	-----------------------------------	----------------------------------	---------------------	-----------------

**Background:** In April 2013, the College of American Pathologists (CAP) noted that while preparing to survey these services they discovered that the vignette for 88365 required revision. Additionally, the code descriptors for 88365, 88367 and 88368 required revision to describe the typical practice of these services, such as specifying each separately identifiable antibody, cytologic preparation, or hematologic smear as was revised in the recent immunohistochemistry services. The RUC recommends that CPT codes 88365, 88367 and 88368 be referred to the CPT Editorial Panel for revision.

88367	Morphometric analysis, in situ hybridization (quantitative or semi-quantitative) each probe; using computer-assisted technology	<u>Screen:</u> CMS Request - NPRM for 2012 / CMS Request Final Rule for 2013	<u>RUC Meeting:</u> April 2013	<u>Specialty Society:</u> CAP	<u>CPT Meeting:</u>	<u>CPT Tab:</u>
-------	---	---	-----------------------------------	----------------------------------	---------------------	-----------------

**Background:** In April 2013, the College of American Pathologists (CAP) noted that while preparing to survey these services they discovered that the vignette for 88365 required revision. Additionally, the code descriptors for 88365, 88367 and 88368 required revision to describe the typical practice of these services, such as specifying each separately identifiable antibody, cytologic preparation, or hematologic smear as was revised in the recent immunohistochemistry services. The RUC recommends that CPT codes 88365, 88367 and 88368 be referred to the CPT Editorial Panel for revision.

## *RUC Referrals to CPT Editorial Panel - Incomplete Issues*

88368	<b>Morphometric analysis, in situ hybridization (quantitative or semi-quantitative) each probe; manual</b>	<u><a href="#">Screen:</a></u> CMS Request - NPRM for 2012 / CMS Request Final Rule for 2013	<u><a href="#">RUC Meeting:</a></u> April 2013	<u><a href="#">Specialty Society:</a></u> CAP	<u><a href="#">CPT Meeting:</a></u>	<u><a href="#">CPT Tab:</a></u>
-------	--	---	---	--	-------------------------------------	---------------------------------

**Background:** In April 2013, the College of American Pathologists (CAP) noted that while preparing to survey these services they discovered that the vignette for 88365 required revision. Additionally, the code descriptors for 88365, 88367 and 88368 required revision to describe the typical practice of these services, such as specifying each separately identifiable antibody, cytologic preparation, or hematologic smear as was revised in the recent immunohistochemistry services. The RUC recommends that CPT codes 88365, 88367 and 88368 be referred to the CPT Editorial Panel for revision.

97001	<b>Physical therapy evaluation</b>	<u><a href="#">Screen:</a></u> CMS High Expenditure Procedural Codes	<u><a href="#">RUC Meeting:</a></u> January 2012	<u><a href="#">Specialty Society:</a></u>	<u><a href="#">CPT Meeting:</a></u> May 2013	<u><a href="#">CPT Tab:</a></u>
-------	------------------------------------	---	---	---	---	---------------------------------

**Background:** In Jan 2012, the specialty intends on significantly revising the Physical Medicine and Rehabilitation Section of CPT and intend to submit a CCP by the May 2013 CPT meeting.

97112	<b>Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities</b>	<u><a href="#">Screen:</a></u> CMS High Expenditure Procedural Codes	<u><a href="#">RUC Meeting:</a></u> January 2012	<u><a href="#">Specialty Society:</a></u>	<u><a href="#">CPT Meeting:</a></u> May 2013	<u><a href="#">CPT Tab:</a></u>
-------	--	---	---	---	---	---------------------------------

**Background:** In Jan 2012, the specialty intends on significantly revising the Physical Medicine and Rehabilitation Section of CPT. Section of CPT and intend to submit a CCP by the May 2013 CPT meeting.

97140	<b>Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes</b>	<u><a href="#">Screen:</a></u> CMS High Expenditure Procedural Codes	<u><a href="#">RUC Meeting:</a></u> January 2012	<u><a href="#">Specialty Society:</a></u>	<u><a href="#">CPT Meeting:</a></u> May 2013	<u><a href="#">CPT Tab:</a></u>
-------	---	---	---	---	---	---------------------------------

**Background:** In Jan 2012, the specialty intends on significantly revising the Physical Medicine and Rehabilitation Section of CPT. Section of CPT and intend to submit a CCP by the May 2013 CPT meeting.

97530	<b>Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes</b>	<u><a href="#">Screen:</a></u> CMS High Expenditure Procedural Codes	<u><a href="#">RUC Meeting:</a></u> January 2012	<u><a href="#">Specialty Society:</a></u>	<u><a href="#">CPT Meeting:</a></u> May 2013	<u><a href="#">CPT Tab:</a></u>
-------	---	---	---	---	---	---------------------------------

**Background:** In Jan 2012, the specialty intends on significantly revising the Physical Medicine and Rehabilitation Section of CPT. Section of CPT and intend to submit a CCP by the May 2013 CPT meeting.

## *RUC Referrals to CPT Editorial Panel - Incomplete Issues*

---

G0456	<b>Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area less than or equal to 50 square centimeters</b>	<u>Screen:</u> CMS Request Final Rule for 2013	<u>RUC Meeting:</u> April 2013	<u>Specialty Society:</u>	<u>CPT Meeting:</u>	<u>CPT Tab:</u>
-------	---	---	-----------------------------------	---------------------------	---------------------	-----------------

**Background:** In January 2013, the RAW noted that industry individuals developed a CCP to describe the NPWT disposable device, however subsequently withdrew the proposal. The Workgroup recommends that codes G0456 and G0457 be placed on the LOI to allow the any specialties that may have an interest a chance to survey and develop new PE inputs. In April 2013, industry individuals have again submitted a CCP to create two category I codes to describe these services with the use of a disposable device. Depending on Panel Action, at the May CPT meeting, this issue may be on the LOI for the October 2013 RUC meeting.

---

G0457	<b>Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area greater than 50 square centimeters</b>	<u>Screen:</u> CMS Request Final Rule for 2013	<u>RUC Meeting:</u> April 2013	<u>Specialty Society:</u>	<u>CPT Meeting:</u>	<u>CPT Tab:</u>
-------	--	---	-----------------------------------	---------------------------	---------------------	-----------------

**Background:** In January 2013, the RAW noted that industry individuals developed a CCP to describe the NPWT disposable device, however subsequently withdrew the proposal. The Workgroup recommends that codes G0456 and G0457 be placed on the LOI to allow the any specialties that may have an interest a chance to survey and develop new PE inputs. In April 2013, industry individuals have again submitted a CCP to create two category I codes to describe these services with the use of a disposable device. Depending on Panel Action, at the May CPT meeting, this issue may be on the LOI for the October 2013 RUC meeting.

---

New, Revised, and CMS Screened Physician Time from RUC Meetings: October 2012, January 2013, and April 2013																
CPT Code	Pre-Service Evaluation	Pre-Service Positioning	Pre-Service Scrub Dress & Wait	Intra-Service	Immediate Post Service	99291	99231	99232	99233	99238	99239	99212	99213	99214	99215	Total Time
10030	21	5	5	30	20											81
17000	1	1		3	2							1				23
17003				1												1
17004	1	1		13	4							1				35
17311	14	1	5	110	8											138
17312	2	1	5	65												73
17313	14	1	5	100	8											128
17314	2	1	5	60												68
17315				30												30
19081	13	3	6	30	15											67
19082		1	4	25												30
19083	13	1	5	25	15											59
19084		1	4	20												25
19085	13	3	6	45	15											82
19086		1	4	38												43
19281	13	1	6	30	15											65
19282		1	4	20												25
19283	13	3	6	20	15											57
19284		1	4	20												25
19285	13	2	6	15	15											51
19286		1	4	19												24
19287	13	3	6	37	15											74
19288		1	4	30												35
23333	33	12	15	45	15					0.5		1	1			178
23334	40	15	20	120	20			2		1		1	3			418
23335	40	15	20	140	30			2		1		1	3			448
24160	40	12	20	120	30		1	1		1		1	3			405
24164	33	12	15	60	20					0.5			3			228
31237	17	1	5	20	5											48
31238	12	1	5	25	10											53
31239	33	3	10	60	20					0.5			1			168
31240	25	3	10	20	15											73
33282	19	1	5	25	15					0.5			1			107
33284	19	1	5	20	10					0.5			1			97
33366	50	15	20	195	45	1										395
37217	40	14	20	120	30			1	1	1			2			403
37236	33	3	5	90	30											161

New, Revised, and CMS Screened Physician Time from RUC Meetings: October 2012, January 2013, and April 2013																
CPT Code	Pre-Service Evaluation	Pre-Service Positioning	Pre-Service Scrub Dress & Wait	Intra-Service	Immediate Post Service	99291	99231	99232	99233	99238	99239	99212	99213	99214	99215	Total Time
37237	1			45	1											47
37238	33	3	5	60	30											131
37239	1			30	1											32
37241	19	3	5	90	30											147
37242	33	3	5	100	30											171
37243	33	3	5	120	45											206
37244	33	3	5	90	45											176
43191	35	6	10	20	15											86
43192	40	6	10	23	20											99
43193	40	6	10	30	20											106
43194	33	6	10	30	28											107
43195	33	6	10	30	15											94
43196	33	6	10	33	20											102
43197	17	1	7	15	10											50
43198	17	1	7	20	10											55
43200	19	3	5	15	10											52
43201	19	3	5	15	10											52
43202	19	3	5	15	10											52
43204	25	3	5	20	10											63
43205	25	3	5	20	10											63
43206	19	3	5	30	10											67
43211	33	3	5	45	18											104
43212	33	3	5	30	15											86
43213	33	3	5	45	15											101
43214	33	3	5	30	16											87
43215	25	3	5	20	10											63
43216	25	3	5	22	10											65
43217	25	3	5	30	10											73
43220	19	3	5	20	10											57
43226	19	3	5	25	10											62
43227	25	3	5	30	10											73
43229	32	3	5	45	15											100
43231	33	3	5	30	20											91
43232	33	3	5	45	20											106
43233	30	3	5	30	20											88
43235	19	3	5	15	12											54
43236	19	3	5	20	15											62

New, Revised, and CMS Screened Physician Time from RUC Meetings: October 2012, January 2013, and April 2013																
CPT Code	Pre-Service Evaluation	Pre-Service Positioning	Pre-Service Scrub Dress & Wait	Intra-Service	Immediate Post Service	99291	99231	99232	99233	99238	99239	99212	99213	99214	99215	Total Time
43237	30	3	5	35	20											93
43238	30	3	5	45	20											103
43239	19	3	5	15	12											54
43240	33	3	5	70	30											141
43241	25	3	5	30	15											78
43242	33	3	5	50	23											114
43243	33	3	5	30	20											91
43244	33	3	5	30	20											91
43245	25	3	5	23	15											71
43246	33	3	5	30	15											86
43247	15	3	5	30	15											68
43248	19	3	5	20	15											62
43249	19	3	5	20	15											62
43250	16	3	5	20	14											58
43251	25	3	5	20	10											63
43252	19	3	5	30	20											77
43253	33	3	5	40	23											104
43254	30	3	5	45	20											103
43255	33	3	5	30	20											91
43257	33	3	5	45	15											101
43259	33	3	5	45	20											106
43260	33	10	5	48	25											121
43261	33	10	5	55	23											126
43262	33	10	5	60	30											138
43263	33	10	5	60	30											138
43264	33	10	5	60	28											136
43265	33	10	5	78	28											154
43266	33	3	5	40	20											101
43270	33	3	5	45	15											101
43273				30												30
43274	33	10	5	68	23											139
43275	33	10	5	50	20											118
43276	33	10	5	60	25											133
43277	33	10	5	70	25											143
43278	33	10	5	75	30											153
49405	35	5	5	40	20											105
49406	35	5	5	40	20											105

New, Revised, and CMS Screened Physician Time from RUC Meetings: October 2012, January 2013, and April 2013																
CPT Code	Pre-Service Evaluation	Pre-Service Positioning	Pre-Service Scrub Dress & Wait	Intra-Service	Immediate Post Service	99291	99231	99232	99233	99238	99239	99212	99213	99214	99215	Total Time
49407	35	5	5	45	20											110
50360	90	3	20	210	45		1	2	2	1			1	2	1	774
52356	33	5	15	60	20											133
64616	10	5		15	5											35
64617	15	1		15	5											36
64642	10	5		20	5											40
64643		1		20												21
64644	10	5		25	5											45
64645		1		25												26
64646	10	5		20	5											40
64647	10	5		25	5											45
66183	10	5	5	45	10					0.5		3	5			257
67914	19	1	5	20	10					0.5		2	1			129
67915	17	1	5	10	5							2				70
67916	19	1	5	25	10					0.5		2	1			134
67917	19	1	5	33	10					0.5		2	1			142
67921	19	1	5	15	10					0.5		2	1			124
67922	17	1	5	10	10							2				75
67923	19	1	5	25	10					0.5		2	1			134
67924	19	1	5	40	10					0.5		2	1			149
69210	3	2		10	2											17
72141	5			20	5											30
72142	5			23	5											33
72146	5			20	5											30
72147	5			23	5											33
72148	5			20	5											30
72149	5			23	5											33
72156	5			25	5											35
72157	5			25	5											35
72158	5			25	5											35
72191	5			30	5											40
74174	5			30	5											40
74175	5			30	5											40
77001				9	4											13
77002	7			15	5											27
77003	7			15	5											27
77280	7			25	5											37



New, Revised, and CMS Screened Physician Time from RUC Meetings: October 2012, January 2013, and April 2013																
CPT Code	Pre-Service Evaluation	Pre-Service Positioning	Pre-Service Scrub Dress & Wait	Intra-Service	Immediate Post Service	99291	99231	99232	99233	99238	99239	99212	99213	99214	99215	Total Time
77285	7			40	5											52
77290	7			60	10											77
77293				45												45
77295	7			90	15											112
81161				60												60
88112				15												15
88342				20												20
88343				10												10
88375	5			25												30
90785					11											11
90839	10			60	20											90
90840				30												30
90863				15												15
92521	5			90	15											110
92522	5			60	20											85
92523	7			120	30											157
92524	5			60	10											75
93582	33	3	15	60	45											156
93583	40	3	15	90	40											188
95928	15			40	10											65
95929	15			40	10											65
99446	3			8	5											16
99447	3			15	5											23
99448	5			25	5											35
99449	9			31	10											50

### Detailed Description of Pre-Service Time Packages (Minutes)

		FACILITY						NON-FAC	
		1A	1B*	2A	2B*	3	4	5	6
	<b>Total Pre-Service Time</b>	<b>20</b>	<b>25</b>	<b>25</b>	<b>39</b>	<b>51</b>	<b>63</b>	<b>7</b>	<b>23</b>

#### **CATEGORY SUBTOTALS**

<b>A</b>	Pre-Service Evaluation (IWPUT =0.0224)	13	19	18	33	33	40	7	17
<b>B</b>	Pre-Service Positioning (IWPUT = 0.0224)	1	1	1	1	3	3	0	1
<b>C</b>	Pre-Service Scrub, Dress and Wait (IWPUT =0.0081)	6	5	6	5	15	20	0	5

#### **DETAILS**

<b>A</b>	History and Exam (Performance and review of appropriate Pre-Tests)	5	5	10	10	10	15	4	9
<b>A</b>	Prepare for Procedure (Check labs, plan, assess risks, review procedure)	2	2	2	2	2	4	1	1
<b>A</b>	Communicate with patient and/or family (Discuss procedure/ obtain consent)	3	3	3	5	5	5	2	3
<b>A</b>	Communicate with other professionals	0	1	0	3	5	5	0	2
<b>A</b>	Check/set-up room, supplies and equipment	1	1	1	1	5	5	0	1
<b>A</b>	Check/ prepare patient readiness (Gown, drape, prep, mark)	1	1	1	1	5	5	0	1
<b>A</b>	Prepare/ review/ confirm procedure	1	1	1	1	1	1	0	0
<b>A</b>	Administer moderate sedation/observe (wait) anesthesia care	0	5	0	10	0	0	0	0
<b>B</b>	Perform/ supervise patient positioning	1	1	1	1	3	3	0	1
<b>C</b>	Administer local anesthesia	1	0	1	0	0	0	0	5
<b>C</b>	Observe (wait anesthesia care)	0	0	0	0	10	15	0	0
<b>C</b>	Dress and scrub for procedure	5	5	5	5	5	5	0	0

\* Indicates packages that contain moderate sedation

- 1A** Straightforward Patient/Straightforward Procedure (No sedation/anesthesia care)
- 1B\*** Straightforward Patient/Straightforward Procedure (With sedation/anesthesia care)
- 2A** Difficult Patient/Straightforward Procedure (No sedation/anesthesia care)
- 2B\*** Difficult Patient/Straightforward Procedure (With sedation/anesthesia care)
- 3** Straightforward Patient/Difficult Procedure
- 4** Difficult Patient/Difficult Procedure
- 5** Procedure without sedation/anesthesia care
- 6** Procedure with sedation/anesthesia care

#### **Additional Positioning Times for Spinal Surgical Procedures**

<b>SS1</b>	Anterior Neck Surgery (Supine) (eg ACDF)	15 Minutes
<b>SS2</b>	Posterior Neck Surgery (Prone) (eg laminectomy)	25 Minutes
<b>SS3</b>	Posterior Thoracic/Lumbar (Prone) (eg laminectomy)	15 Minutes
<b>SS4</b>	Lateral Thoracic/Lumbar (Lateral) (eg corpectomy)	25 Minutes
<b>SS5</b>	Anterior Lumbar (Supine) (eg ALIF)	15 Minutes

#### **Additional Positioning Times for Spinal Injection Procedures**

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

#### **Notes:**

\*Roll-over cells for additional detail where available

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

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

straightforward patient undergoing a straightforward procedure (Package 1B), if the procedure is performed under general anesthesia and the surveys support additional pre-service time.

2014 PLI Crosswalk

CPT	RUC Recommended PLI Crosswalk
10030	37200
17000	17000
17003	17003
17004	17004
17311	17311
17312	17312
17313	17313
17314	17314
17315	17315
19081	32553
19082	64480
19083	32551
19084	64480
19085	36565
19086	76812
19281	50387
19282	76812
19283	50387
19284	76812
19285	36569
19286	76812
19287	32551
19288	76812
23333	23472
23334	23472
23335	23472
24160	24363
24164	23430
27130	27130
27236	27236
27446	27446
27447	27447
31237	31237
31238	31238
31239	31239
31240	31240
33282	33282
33284	33284
33366	33979
35301	35301
36245	36245
37217	37660
37236	36247
37237	37223
37238	36247
37239	37223
37241	37204
37242	37204
37243	37204
37244	37204

2014 PLI Crosswalk

CPT	RUC Recommended PLI Crosswalk
43191	31575
43192	31575
43193	31575
43194	31575
43195	31575
43196	31638
43197	31575
43198	31575
43200	43200
43201	43201
43202	43202
43204	43204
43205	43205
43206	43200
43211	43201
43212	43219
43213	43456
43214	43458
43215	43215
43216	43216
43217	43217
43220	43220
43226	43226
43227	43227
43229	43228
43231	43231
43232	43232
43233	43271
43235	43235
43236	43236
43237	43237
43238	43238
43239	43239
43240	43240
43241	43241
43242	43242
43243	43243
43244	43244
43245	43245
43246	43246
43247	43247
43248	43248
43249	43249
43250	43250
43251	43251
43252	43200
43253	43242
43254	43251
43255	43255
43257	43257

2014 PLI Crosswalk

CPT	RUC Recommended PLI Crosswalk
43259	43259
43260	43260
43261	43261
43262	43262
43263	43263
43264	43264
43265	43265
43266	43256
43270	43258
43273	43273
43274	43268
43275	43269
43276	43269
43277	43271
43278	43272
43453	43453
45450	43450
49405	37200
49406	37200
49407	37200
50360	50360
52356	52353
62310	62310
62311	62311
62318	62318
62319	62319
63047	63047
63048	63048
64616	64613
64617	31513
64642	64614
64643	64614
64644	64614
64645	64614
64646	64614
64647	64614
66183	65850
67914	67914
67915	67915
67916	67916
67917	67917
67921	67921
67922	67922
67923	67923
67924	67924
69210	69210
70450	70450
70460	70460
70551	70551
70552	70552

2014 PLI Crosswalk

CPT	RUC Recommended PLI Crosswalk
70553	70553
72141	72141
72142	72142
72146	72146
72147	72147
72148	72148
72149	72149
72156	72156
72157	72157
72158	72158
77001	77001
77002	77002
77003	77003
77280	77280
77285	77285
77290	77290
77293	77470
77295	77295
81161	81407
88112	88112
88342	88342
88343	88342
88375	86335
90785	90836
90839	90837
90840	90833
90863	90832
92521	96105
92522	96105
92523	96105
92524	92520
93010	93010
93582	93580
93583	93580
93880	93880
93882	93882
95816	95816
95819	95819
95822	95822
95928	95928
95929	95929
96365	96365
96366	96366
96367	96367
96368	96368
96413	96413
96415	96415
96417	96417
98940	98940
98941	98941

# 2014 PLI Crosswalk

CPT	RUC Recommended PLI Crosswalk
98942	98942
98943	98943
99446	99462
99447	99462
99448	99462
99449	99462

March 2013 RUC Submission  
Utilization Crosswalk

CPT Source	Deleted	Source 2011 Utilization	New/ Revised Code	New/Revised Code Utilization (reference 2011)	Percent	Source RVU	RUC Rec RVU	RUC Tab	New/ Revised Total RVUs	Total Source RVUs
27130		115280	27130	115280	1.000	21.79	19.60	02	2259488	2511951
27446		12570	27446	12570	1.000	16.38	17.48	02	219724	205897
27447		260125	27447	260125	1.000	23.25	19.60	02	5098450	6047906
35301		53,402	35301	53,402	1.000	19.61	21.16	03	1129986	1047213
36245		110,584	36245	110,584	1.000	4.67	4.90	04	541,862	516,427
36870		60,323	36870	60,323	1.000	5.20	CPT	05		
63047		85,531	63047	85,531	1.000	15.37	15.37	06	1,314,611	1,314,611
63048		124,208	63048	124,208	1.000	3.47	3.47	06	431,002	431,002
70551		858112	70551	858112	1.000	1.48	1.48	08	1270006	1270006
70552		25920	70552	25920	1.000	1.78	1.78	08	46138	46138
70553		964941	70553	964941	1.000	2.36	2.36	08	2277261	2277261
96365		1,395,462	96365	1,395,462	1.000	0.21	0.21	10	293,047	293,047
96366		684,011	96366	684,011	1.000	0.18	0.18	10	123,122	123,122
96367		2,151,404	96367	2,151,404	1.000	0.19	0.19	10	408,767	408,767
96368		197,573	96368	197,573	1.000	0.17	0.17	10	33,587	33,587
96413		2,224,065	96413	2,224,065	1.000	0.28	0.28	11	622,738	622,738
96415		1,317,027	96415	1,317,027	1.000	0.19	0.19	11	250,235	250,235
96417		581,015	96417	581,015	1.000	0.21	0.21	11	122,013	122,013

16442037 17521922

Total Source RVUs	17,521,922
Total New/Revised RVUs	16,442,037
RVU Difference	1,079,885
CF	34.0230
CF Redistribution	\$36,740,928



CPT 2014 Utilization Crosswalk  
May Submission

CPT Source	Deleted	Source 2011 Utilization	New/ Revised Code	New/Revised Code Utilization (reference 2011)	Percent	Source RVU	RUC Rec RVU	RUC Tab	New/ Revised Total RVUs	Total Source RVUs
NA			10030			0.00	3.00	01	0	0
32201	D	350	49405	350	1.000	3.99	4.25	01	1488	1397
47011	D	3223	49405	3223	1.000	3.69	4.25	01	13698	11893
48511	D	437	49405	437	1.000	3.99	4.25	01	1857	1744
50021	D	790	49405	790	1.000	3.37	4.25	01	3358	2662
44901	D	246	49406	246	1.000	3.37	4.25	01	1046	829
49021	D	21460	49406	21460	1.000	3.37	4.25	01	91205	72320
49041	D	1299	49406	1299	1.000	3.99	4.25	01	5521	5183
49061	D	7775	49406	7775	1.000	3.69	4.25	01	33044	28690
58823	D	297	49407	297	1.000	3.37	4.50	01	1337	1001
75989		70598	75989	37818	0.536	1.19	1.19	01	45004	45004
75989		70598	Savings	32780	0.464	1.19	0.00	01	0	39008
19103	D	108594	19081	43438	0.400	3.69	3.29	02	142,910	160,285
19103	D	7515	19082	1728	0.230	3.69	1.65	02	2,852	6,378
19103	D	108594	19083	59727	0.550	3.69	3.10	02	185,153	220,392
19103	D	7515	19084	5636	0.750	3.69	1.55	02	8,736	20,798
19103	D	108594	19085	5430	0.050	3.69	3.64	02	19,764	20,036
19103	D	7515	19086	150	0.020	3.69	1.82	02	274	555
19102	D	52625	19081	2631	0.050	1.00	3.29	02	8,657	2,631
19102	D	5336	19082	107	0.020	1.00	1.65	02	176	107
19102	D	52625	19083	48941	0.930	1.00	3.10	02	151,718	48,941
19102	D	5336	19084	5176	0.970	1.00	1.55	02	8,023	5,176
19102	D	52625	19085	1053	0.020	1.00	3.64	02	3,833	1,053
19102	D	5336	19086	53	0.010	1.00	1.82	02	96	53
19290	D	52702	19281	52702	1.000	1.27	2.00	02	105,404	66,932
19291	D	4276	19282	4276	1.000	0.63	1.00	02	4,276	2,694
19295	D	146660	Savings	146660	1.000	0.00	0.00	02	-	-
19499		1223	19283	100	0.082	0.00	2.00	02	200	-
19499		1223	19284	100	0.082	0.00	1.00	02	100	-
19499		1223	19285	100	0.082	0.00	1.70	02	170	-
19499		1223	19286	100	0.082	0.00	0.85	02	85	-
19499		1223	19287	100	0.082	0.00	3.02	02	302	-
19499		1223	19288	100	0.082	0.00	1.51	02	151	-
19499		1223	19499	623	0.509	0.00	0.00	02	-	-
76098		110744	76098	71736	0.648	0.16	0.16	02	11,478	11,478
76098		110744	Savings	39008	0.352	0.16	0.00	02	-	6,241
76942		1517153	76942	1475293	0.972	0.67	0.67	02	988,446	988,446
76942		1517153	Savings	41860	0.028	0.67	0.00	02	-	28,046
77021		4974	77021	3037	0.611	1.50	1.50	02	4,556	4,556

\*

\*\*

\*\*\*

\*\*\*\*

CPT 2014 Utilization Crosswalk  
May Submission

CPT Source	Deleted	Source 2011 Utilization	New/ Revised Code	New/Revised Code Utilization (reference 2011)	Percent	Source RVU	RUC Rec RVU	RUC Tab	New/ Revised Total RVUs	Total Source RVUs
77021		4974	Savings	1937	0.390	1.50	0.00	02	-	2,906
77031	D	66831	Savings	66831	1.000	1.59	0.00	02	-	106,261
77032	D	34943	Savings	34943	1.000	0.56	0.00	02	-	19,568
23331	D	1305	23333	653	0.500	7.63	6.00	03	3915	4979
23332	D	1109	23333	555	0.500	12.37	6.00	03	3327	6859
23331	D	1305	23334	652	0.500	7.63	18.89	03	12316	4975
23332	D	1109	23335	554	0.500	12.37	22.13	03	12260	6853
24160		348	24160	348	1.000	8.00	18.63	04	6483	2784
24164		89	24164	89	1.000	6.43	10.00	04	890	572
0318T	D	0	33366	332	1.000	0.00	40.00	05	13,280	-
0078T		78	34841	10	0.128	0.00	CP	06		
0078T		78	34842	10	0.128	0.00	CP	06		
0078T		78	34843	10	0.128	0.00	CP	06		
0078T		78	34844	10	0.128	0.00	CP	06		
0078T		78	34845	10	0.128	0.00	CP	06		
0078T		78	34846	10	0.128	0.00	CP	06		
0078T		78	34847	10	0.128	0.00	CP	06		
0078T		78	34848	8	0.103	0.00	CP	06		
0079T		148	34842	25	0.169	0.00	CP	06		
0079T		148	34843	25	0.169	0.00	CP	06		
0079T		148	34844	25	0.169	0.00	CP	06		
0079T		148	34846	25	0.169	0.00	CP	06		
0079T		148	34847	25	0.169	0.00	CP	06		
0079T		148	34848	23	0.155	0.00	CP	06		
0080T		60	34841	7	0.117	0.00	CP	06		
0080T		60	34842	7	0.117	0.00	CP	06		
0080T		60	34843	7	0.117	0.00	CP	06		
0080T		60	34844	7	0.117	0.00	CP	06		
0080T		60	34845	8	0.133	0.00	CP	06		
0080T		60	34846	8	0.133	0.00	CP	06		
0080T		60	34847	8	0.133	0.00	CP	06		
0080T		60	34848	8	0.133	0.00	CP	06		
37799		4198	37217	2519	0.600	0.00	22.00	07	55,418	-
37799		4198	37799	1679	0.400	0.00	0.00	07	-	-
37205	D	51981	37236	38986	0.750	8.27	9.00	08	350,872	322,412
37205	D	51981	37238	12995	0.250	8.27	6.29	08	81,740	107,471
37207	D	1679	37236	1259	0.750	8.27	9.00	08	11,333	10,414
37207	D	1679	37238	420	0.250	8.27	6.29	08	2,640	3,471
37206	D	5587	37237	4190	0.750	4.12	4.25	08	17,809	17,264

CPT 2014 Utilization Crosswalk  
May Submission

CPT Source	Deleted	Source 2011 Utilization	New/ Revised Code	New/Revised Code Utilization (reference 2011)	Percent	Source RVU	RUC Rec RVU	RUC Tab	New/ Revised Total RVUs	Total Source RVUs
37206	D	5587	37239	1397	0.250	4.12	3.34	08	4,665	5,755
37208	D	210	37237	158	0.752	4.12	4.25	08	672	651
37208	D	210	37239	52	0.248	4.12	3.34	08	174	214
75960	D	56,402	Savings	56,402	1.000	0.82	0.00	08	-	46,250
37204	D	31478	37241	3148	0.100	18.11	9.00	09	28,330	57,007
37204	D	31478	37242	7870	0.250	18.11	11.98	09	94,277	142,517
37204	D	31478	37243	14165	0.450	18.11	14.00	09	198,311	256,530
37210	D	358	37243	358	1.000	10.60	14.00	09	5,012	3,795
37204	D	31478	37244	6296	0.200	18.11	14.00	09	88,138	114,013
75894		36,341	75894	18934	0.521	0.72	0.72	09	13,632	13,632
75894		36,341	Savings	17407	0.479	0.72	0.00	09	-	12,533
75898		45,961	75898	28931	0.629	1.65	1.65	09	47,737	47,737
75898		45,961	Savings	17030	0.371	1.65	0.00	09	-	28,099
43235		397,520	43235	394,988	0.994	2.39	2.26	11	892,673	944,021
43237		848	43237	848	1.000	3.98	3.85	11	3,265	3,375
43238		701	43238	701	1.000	5.02	4.50	11	3,155	3,519
43239		1,469,536	43239	1,469,536	1.000	2.87	2.56	11	3,762,012	4,217,568
43240		314	43240	314	1.000	6.85	7.25	11	2,277	2,151
43241		3,109	43241	3,109	1.000	2.59	2.59	11	8,052	8,052
43242		26,392	43242	26,043	0.987	7.30	5.39	11	140,372	190,114
43242		26,392	Savings	349	0.013	7.30	0.00	11	0	2,548
43243		2,263	43243	2,263	1.000	4.56	4.37	11	9,889	10,319
43245		12,605	43245	12,605	1.000	3.18	3.18	11	40,084	40,084
43246		121,586	43246	121,586	1.000	4.32	4.32	11	525,252	525,252
43247		28,306	43247	28,306	1.000	3.38	3.27	11	92,561	95,674
43248		102,871	43248	102,871	1.000	3.15	3.01	11	309,642	324,044
43249		91,802	43249	91,802	1.000	2.90	2.90	11	266,226	266,226
43250		6,514	43250	6,514	1.000	3.20	3.07	11	19,998	20,845
43236		14,788	43236	14,345	0.970	2.92	2.57	11	36,867	41,887
43244		15,757	43244	15,314	0.972	5.04	4.50	11	68,913	77,183
43251		26,940	43251	26,497	0.984	3.69	3.57	11	94,594	97,774
43251		26,940	43254	443	0.016	1.30	5.25	11	2,326	576
43236		14,788	Savings	443	0.030	0.53	0.00	11	0	235
43244		15,757	Savings	443	0.028	5.04	0.00	11	0	2,233
43201		509	43211	15	0.030	0.50	4.58	10/11	70	8
43205		265	Savings	15	0.057	3.78	0.00	10/11	0	57
43217		220	Savings	15	0.068	1.31	0.00	10/11	0	20
43255		54,055	43255	54,055	1.000	4.81	4.20	11	227,031	260,005
43256	D	3,958	43266	3,958	1.000	4.34	4.40	11	17,415	17,178

CPT 2014 Utilization Crosswalk  
May Submission

CPT Source	Deleted	Source 2011 Utilization	New/ Revised Code	New/Revised Code Utilization (reference 2011)	Percent	Source RVU	RUC Rec RVU	RUC Tab	New/ Revised Total RVUs	Total Source RVUs
43257		89	43257	89	1.000	5.50	4.25	11	378	490
43258	D	16,695	43270	16,695	1.000	4.54	4.39	11	73,291	75,795
43259		34,919	43259	34,570	0.990	5.19	4.74	11	163,862	179,418
43259		34,919	43253	349	0.010	2.80	5.39	11	1,882	978
43458	D	1,561	43233	781	0.500	3.06	4.45	11	3,475	2,390
43458	D	1,561	43214	780	0.500	3.06	3.78	10/11	2,948	2,387
43200		15,007	Savings	780	0.052	0.80	0.00	10	0	620
43235		397,520	Savings	780	0.002	1.20	0.00	10	0	932
74360		3,861	74360	3,739	0.968	0.54	0.54	10	2,019	2,019
74360		3,861	Savings	122	0.032	0.54	0.00	10	0	66
43219	D	693	43212	346	0.499	2.80	3.73	10	1,291	969
43228	D	4,359	43229	3,000	0.688	3.76	3.72	10	11,160	11,280
43456	D	1,752	43213	1,752	1.000	2.57	5.00	10	8,760	4,503
43235		397,520	Savings	1,752	0.004	1.20	0.00	10	0	2,094
43200		15,007	Savings	1,752	0.117	0.80	0.00	10	0	1,393
43200		15,007	43252	400	0.027	1.59	3.06	11	1,224	636
43200		15,007	43191	6393	0.426	1.59	2.78	10	17,772	10,164
43200		15,007	43197	1065	0.071	1.59	1.59	10	1,694	1,694
43200		15,007	43206	61	0.004	1.59	2.39	10	145	97
43200		15,007	43200	4556	0.304	1.59	1.59	10	7,244	7,244
43499		634	Savings	409	0.645	0.00	0.00	10	0	0
43499		634	43499	225	0.355	0.00	0.00	10	0	0
43201		509	43192	128	0.251	2.09	3.21	10	411	268
43201		509	43201	366	0.719	2.09	1.90	10/11	695	765
43202		3849	43193	716	0.186	1.89	3.36	10	2,406	1,353
43202		3849	43198	119	0.031	1.89	1.89	10	225	225
43202		3849	43202	3014	0.783	1.89	1.89	10	5,696	5,696
43204		91	43204	91	1.000	3.76	2.89	10	263	342
43205		265	43205	250	0.943	3.78	3.00	10/11	750	945
43215		1632	43194	206	0.126	2.60	3.99	10	822	536
43215		1632	43215	1426	0.874	2.60	2.60	10	3,708	3,708
43216		75	43216	75	1.000	2.40	2.40	10	180	180
43217		220	43217	205	0.932	2.90	2.90	10/11	595	595
43219	D	693	Savings	347	0.501	2.80	0.00	10	0	972
43220		3041	43195	596	0.196	2.10	3.21	10	1,913	1,252
43220		3041	43220	2445	0.804	2.10	2.10	10	5,135	5,135
43226		2785	43196	390	0.140	2.34	3.36	10	1,310	913
43226		2785	43226	2395	0.860	2.34	2.34	10	5,604	5,604
43227		581	43227	581	1.000	3.59	3.26	10	1,894	2,086

CPT 2014 Utilization Crosswalk  
May Submission

CPT Source	Deleted	Source 2011 Utilization	New/ Revised Code	New/Revised Code Utilization (reference 2011)	Percent	Source RVU	RUC Rec RVU	RUC Tab	New/ Revised Total RVUs	Total Source RVUs
43228	D	4359	Savings	1359	0.312	3.76	0.00	10	0	5,110
43231		516	43231	516	1.000	3.19	3.19	10	1,646	1,646
43232		458	43232	458	1.000	4.47	3.83	10	1,754	2,047
44799		1368	44799	1019	0.745	0.00	0.00	10	0	0
44799		1368	Savings	349	0.255	0.00	0.00	10	0	0
43260		11,345	43260	11,345	1.000	5.95	5.95	12	67,503	67,503
43261		1,329	43261	1,329	1.000	6.26	6.25	12	8,306	8,320
43262		57,878	43262	22,525	0.389	7.38	6.60	12	148,665	166,235
43262		57,878	43277	5,788	0.100	7.38	7.11	12	41,153	42,715
43262		57,878	Savings	29,565	0.511	1.43	0.00	12	0	42,278
43263		683	43263	683	1.000	7.28	7.28	12	4,972	4,972
43264		45,885	43264	45,885	1.000	8.89	6.73	12	308,806	407,918
43265		2,786	43265	2,786	1.000	10.00	8.03	12	22,372	27,860
43273		4,025	43273	4,025	1.000	2.24	2.24	12	9,016	9,016
43268	D	36,493	43274	36,493	1.000	7.38	8.74	12	318,949	269,318
43267	D	236	Savings	236	1.000	1.43	0.00	12	0	337
43269	D	20,375	43275	12,225	0.600	8.20	6.96	12	85,086	100,245
43269	D	20,375	43276	8,150	0.400	8.20	9.10	12	74,165	66,830
43271	D	12,486	43278	3,122	0.250	7.38	8.08	12	25,226	23,040
43271	D	12,486	Savings	9,364	0.750	1.43	0.00	12	0	13,391
43272	D	302	Savings	302	1.000	1.43	0.00	12	0	432
52353		39918	52356	30000	0.752	7.50	8.00	13	240,000	225,000
52353		39918	52353	9918	0.248	7.50	7.50	13	74,385	74,385
52332		149782	52332	119782	0.800	2.82	2.82	13	337,785	337,785
52332		149782	savings	30000	0.200	1.41	0.00	13	-	42,300
64613	D	65,961	64616	44,985	0.682	1.53	1.79	14	80,524	68,827
64613	D	65,961	64617	20,976	0.318	1.53	2.06	14	43,210	32,093
95873		3,530	95873	3,332	0.944	0.37	0.37	14	1,233	1,233
95873		3,530	savings	198	0.056	0.37	0.00	14	-	73
95874		56,504	95874	35,726	0.632	0.37	0.37	14	13,219	13,219
95874		56,504	savings	20,778	0.368	0.37	0.00	14	-	7,688
64614	D	56,390	64642	25,376	0.450	2.20	1.65	15	41,870	55,826
64614	D	56,390	64643	8,459	0.150	2.20	1.32	15	11,165	18,609
64614	D	56,390	64644	11,278	0.200	2.20	1.82	15	20,526	24,812
64614	D	56,390	64645	5,639	0.100	2.20	1.52	15	8,571	12,406
64614	D	56,390	64646	2,820	0.050	2.20	1.80	15	5,075	6,203
64614	D	56,390	64647	2,820	0.050	2.20	2.11	15	5,949	6,203
0192T	D	5796	66183	5796	1.000	0.00	13.20	16	76,507	-

CPT 2014 Utilization Crosswalk  
May Submission

CPT Source	Deleted	Source 2011 Utilization	New/ Revised Code	New/Revised Code Utilization (reference 2011)	Percent	Source RVU	RUC Rec RVU	RUC Tab	New/ Revised Total RVUs	Total Source RVUs
69210		1473462	69210	1473462	1.000	0.61	0.58	17	854608	898812
69210		1473462	69210	147346	0.100	0.61	0.58	17	85461	89881
77280		287,242	77280	287,242	1.000	0.70	0.70	18	201,069	201,069
77285		4,399	77285	4,399	1.000	1.05	1.05	18	4,619	4,619
77290		345,400	77290	345,400	1.000	1.56	1.56	18	538,824	538,824
77295		142,132	77295	142,132	1.000	4.56	4.29	18	609,746	648,122
77470		117,526	77293	12000	0.102	2.09	2.00	18	24,000	25,080
77470		117,526	77470	105526	0.898	2.09	2.09	18	220,549	220,549
83912	D	182750	81161	50	0.000	0.37	1.85	19	93	19
83912	D	182750	Deleted	182700	1.000	-	-	19		
88342		3824136	88342	3441722	0.900	0.85	0.60	20	2065033	2925464
88342		3824136	88343	382414	0.100	0.85	0.24	20	91779	325052
88399		58	88375	25	0.431	0.00	1.08	21	27	-
88399		58	88399	33	0.569	0.00	0.00	21	-	-
91065		23489	91065	23489	1.000	0.20	0.20	22	4698	4698
93799		1,536	93582	200	0.130	0.00	14.00	23	2,800	-
93799		1,536	93583	1,000	0.651	0.00	18.00	24	18,000	-
93799		1,536	93799	336	0.219	0.00	0.00	24	-	-
0183T	D	312	97610		0.000	0.00	CP	26		-
99170		3	99170	3	1.000	1.75	1.75	27	5	5
N/A			99446		1.000		0.35	28	0	0
N/A			99447		1.000		0.70	28	0	0
N/A			99448		1.000		1.05	28	0	0
N/A			99449		1.000		1.40	28	0	0
0260T	D	0	99481	0	1.000	0.00	CP	29		
0261T	D	0	99482	0	1.000	0.00	CP	29		
17000		4910363	17000	4910363	1.000	0.65	0.61	30	2,995,321	3,191,736
17003		15449279	17003	15449279	1.000	0.07	0.04	30	617,971	1,081,450
17004		757250	17004	757250	1.000	1.85	1.37	30	1,037,433	1,400,913
17311		547315	17311	547315	1.000	6.20	6.20	31	3,393,353	3,393,353
17312		415936	17312	415936	1.000	3.30	3.30	31	1,372,589	1,372,589
17313		79616	17313	79616	1.000	5.56	5.56	31	442,665	442,665
17314		43282	17314	43282	1.000	3.06	3.06	31	132,443	132,443
17315		23238	17315	23238	1.000	0.87	0.87	31	20,217	20,217
31237		89,235	31237	89,235	1.000	2.98	2.60	32	232,011	265,920
31238		24,949	31238	24,949	1.000	3.26	2.74	32	68,360	81,334
31239		1,056	31239	1,056	1.000	9.33	9.04	32	9,546	9,852
31240		3,733	31240	3,733	1.000	2.61	2.61	32	9,743	9,743
33282		7460	33282	7460	1.000	4.80	3.50	33	26,110	35,808

CPT 2014 Utilization Crosswalk  
May Submission

CPT Source	Deleted	Source 2011 Utilization	New/ Revised Code	New/Revised Code Utilization (reference 2011)	Percent	Source RVU	RUC Rec RVU	RUC Tab	New/ Revised Total RVUs	Total Source RVUs
33284		3215	33284	3215	1.000	3.14	3.00	33	9,645	10,095
50360		9916	50360	9916	1.000	40.90	40.90	34	405,564	405,564
63650		45391	63650	45391	1.000	7.15	7.15	35	324,546	324,546
66180		11141	66180	11141	1.000	16.30	CPT	36		
66185		1790	66185	1790	1.000	9.58	CPT	36		
67914		2303	67914	2303	1.000	3.75	3.75	37	8,636	8,636
67915		525	67915	525	1.000	3.26	2.03	37	1,066	1,712
67916		3143	67916	3143	1.000	5.48	5.48	37	17,224	17,224
67917		28419	67917	28419	1.000	6.19	5.93	37	168,525	175,914
67921		5072	67921	5072	1.000	3.47	3.47	37	17,600	17,600
67922		252	67922	252	1.000	3.14	2.03	37	512	791
67923		2615	67923	2615	1.000	6.05	5.48	37	14,330	15,821
67924		12594	67924	12594	1.000	5.93	5.93	37	74,682	74,682
72141		510360	72141	510360	1.000	1.60	1.48	38	755,333	816,576
72142		4368	72142	4368	1.000	1.92	1.78	38	7,775	8,387
72146		185759	72146	185759	1.000	1.60	1.48	38	274,923	297,214
72147		3695	72147	3695	1.000	1.92	1.78	38	6,577	7,094
72148		1172929	72148	1172929	1.000	1.48	1.48	38	1,735,935	1,735,935
72149		7362	72149	7362	1.000	1.78	1.78	38	13,104	13,104
72156		99666	72156	99666	1.000	2.57	2.29	38	228,235	256,142
72157		76463	72157	76463	1.000	2.57	2.29	38	175,100	196,510
72158		268597	72158	268597	1.000	2.36	2.29	38	615,087	633,889
72191		118,637	72191	118,637	1.000	1.81	1.81	39	214,733	214,733
74174		107,215	74174	107,215	1.000	2.20	2.20	39	235,873	235,873
74175		177,183	74175	177,183	1.000	1.90	1.90	39	336,648	336,648
77001		463402	77001	463402	1.000	0.38	0.38	40	176,093	176,093
77002		247397	77002	247397	1.000	0.54	0.54	40	133,594	133,594
77003		1890663	77003	1890663	1.000	0.60	0.60	40	1,134,398	1,134,398
77301		98573	77301	98573	1.000	7.99	7.99	41	787,598	787,598
77338		118867	77338	118867	1.000	4.29	4.29	41	509,939	509,939
77600		3091	77600	3091	1.000	1.56	1.56	44	4,822	4,822
77785		24262	77785	24262	1.000	1.42	1.42	45	34,452	34,452
77786		34891	77786	34891	1.000	3.25	3.25	45	113,396	113,396
77787		5893	77787	5893	1.000	4.89	4.89	45	28,817	28,817
88112		1013395	88112	1013395	1.000	1.18	0.56	46	567,501	1,195,806
88365		43149	88365	43149	1.000	1.20	CPT	47		
88367		114948	88367	114948	1.000	1.30	CPT	47		
88368		280966	88368	280966	1.000	1.40	CPT	47		
See included worksheet for all psychotherapy services								48		-

CPT 2014 Utilization Crosswalk  
May Submission

CPT Source	Deleted	Source 2011 Utilization	New/ Revised Code	New/Revised Code Utilization (reference 2011)	Percent	Source RVU	RUC Rec RVU	RUC Tab	New/ Revised Total RVUs	Total Source RVUs
95928		18701	95928	1870	0.100	1.50	1.50	49	2,805	2,805
95928		18701	95939	16830	0.900	1.50	1.50	49	25,245	25,245
95929		19344	Savings	16830	0.870	2.25	0.00	49		
95929		19344	95929	2514	0.130	1.50	1.50	49	3,771	3,771
G0456			G0456		1.000	0.00	0.00	50		
G0457			G0457		1.000	0.00	0.00	50		
90863			90863		1.000	0.00	0.48	51		
92506	D	21523	92521	775	0.036	0.86	1.75	52	1,356	667
92506	D	21523	92522	8609	0.400	0.86	1.50	52	12,914	7,404
92506	D	21523	92523	4305	0.200	0.86	3.36	52	14,465	3,702
92506	D	21523	92524	7834	0.364	0.86	1.75	52	13,710	6,737
									36112810	40116757

Total Source RVUs	40,116,757
Total New/Revised RVUs	36,112,810
RVU Difference	4,003,947
CF	34.0230
CF Redistribution	\$136,226,292

## NOTES

### Tab 2

- \*Represents utilization of 19103 without a 51 modifier
- \*\*Represents utilization billed with mod 51
- \*\*\*Represents utilization of 19102 without a 51 modifier
- \*\*\*\*Represents utilization billed with mod 51

### Tab 19

Represents left over utilization from 83913 from CPT 2012 Molecular Pathology recommendations  
83912 was deleted for CPT 2013

### Tab 49

Savings accounted for in CPT 2012.



November 2012 RUC Submission  
Utilization Crosswalk

CPT Source	Deleted	Source 2011 Utilization	New/ Revised Code	New/Revised Code Utilization (reference 2011)	Percent	Source RVU	RUC Rec RVU	RUC Tab	New/ Revised Total RVUs	Total Source RVUs
27236		65459	27236	65459	1.000	17.61	17.61	01	1152732.99	1152732.99
62310		200003	62310	200003	1.000	1.91	1.68	02	336005	382006
62311		916994	62311	916994	1.000	1.54	1.54	02	1412171	1412171
62318		42417	62318	42417	1.000	2.04	2.04	02	86531	86531
62319		36032	62319	36032	1.000	1.87	1.87	02	67380	67380
70450		5257308	70450	5257308	1.000	0.85	0.85	03	4468711.8	4468711.8
70460		38429	70460	38429	1.000	1.13	1.13	03	43424.77	43424.77
93000		12025959	93000	12025959	1.000	0.17	0.17	04	2044413	2044413
93005		644631	93005	644631	1.000	0.00	0.00	04	0	0
93010		19261786	93010	19261786	1.000	0.17	0.17	04	3274504	3274504
93880		2885488	93880	2885488	1.000	0.60	0.80	05	2308390	1731293
93882		45496	93882	45496	1.000	0.40	0.50	05	22748	18198
95816		287895	95816	287895	1.000	1.08	1.08	06	310927	310927
95819		286047	95819	286047	1.000	1.08	1.08	06	308931	308931
95822		20154	95822	20154	1.000	1.08	1.08	06	21766	21766
43450		77991	43450	77991	1.000	1.38	1.38	07	107628	107628
43453		3142	43453	3142	1.000	1.51	1.51	07	4744	4744
98940		6734108	98940	6734108	1.000	0.45	0.46	HCPAC	3097690	3030349
98941		13968442	98941	13968442	1.000	0.65	0.71	HCPAC	9917594	9079487
98942		1690685	98942	1690685	1.000	0.87	0.96	HCPAC	1623058	1470896
98943		0	98943	0	0.000	0.40	0.46	HCPAC	0	0
									15971007	15435360

Total Source RVUs	15,435,360
Total New/Revised RVUs	15,971,007
RVU Difference	-535,647
CF	34.0230
CF Redistribution	-\$18,224,301

CPT 2013/2014  
Psychotherapy Utilization Crosswalk

CPT Source	Deleted	Source 2011 Utilization	New/ Revised Code	New/Revised Code Utilization (reference 2011)	Percent	Source RVU	RUC Rec RVU	RUC Tab	New/ Revised Total RVUs	Total Source RVUs
90801	D	1503164	90791	751582	0.500	2.80	3.00	35	2254746	2104430
90801	D	1503164	90792	751582	0.500	2.80	3.25	35	2442642	2104430
90802	D	4022	90791	2011	0.500	3.01	3.00	35	6033	6053
90802	D	4022	90792	2011	0.500	3.01	3.25	35	6536	6053
90802	D	4022	90785	4022	1.000	3.01	0.33	35	1327	12106
90804	D	761480	90832	761480	1.000	1.21	1.50	35	1142220	921391
90805	D	1504700	90833	1128525	0.750	1.37	1.50	35	1692788	1546079
90805	D	1504700	Savings	376175	0.250	1.37	0.00	35		515360
90805	D	1504700	99211	146708	0.097	0.00	0.18	35	26407	0
90805	D	1504700	99212	564263	0.375	0.00	0.48	35	270846	0
90805	D	1504700	99213	394984	0.263	0.00	0.97	35	383134	0
90805	D	1504700	99214	11285	0.007	0.00	1.50	35	16928	0
90805	D	1504700	99215	11285	0.007	0.00	2.11	35	23811	0
90806	D	6270188	90834	6270188	1.000	1.86	2.00	35	12540376	11662550
90806	D	6270188	90863	7500	0.001	0.00	0.98	35	7350	0
90807	D	957341	90836	718006	0.750	2.02	1.90	35	1364211	1450372
90807	D	957341	Savings	239335	0.250	2.02	0.00	35		483457
90807	D	957341	99211	93341	0.098	0.00	0.18	35	16801	0
90807	D	957341	99212	359003	0.375	0.00	0.48	35	172321	0
90807	D	957341	99213	251302	0.262	0.00	0.97	35	243763	0
90807	D	957341	99214	7180	0.007	0.00	1.50	35	10770	0
90807	D	957341	99215	7180	0.007	0.00	2.11	35	15150	0
90808	D	397592	90837	393616	0.990	2.79	3.00	35	1180848	1098189
90808	D	397592	90839	2982	0.008	0.00	3.13	35	9334	0
90808	D	397592	90840	994	0.003	0.00	1.50	35	1491	0
90809	D	35445	90838	26584	0.750	2.95	2.50	35	66460	78423
90809	D	35445	Savings	8861	0.250	2.95	0.00	35		26140
90809	D	35445	99211	3456	0.098	0.00	0.18	35	622	0
90809	D	35445	99212	13292	0.375	0.00	0.48	35	6380	0
90809	D	35445	99213	9304	0.262	0.00	0.97	35	9025	0
90809	D	35445	99214	266	0.008	0.00	1.50	35	399	0
90809	D	35445	99215	266	0.008	0.00	2.11	35	561	0
90810	D	6659	90832	6659	1.000	1.32	1.50	35	9989	8790
90810	D	6659	90785	6659	1.000	0.00	0.33	35	2197	0
90811	D	7477	90832	5608	0.750	1.48	1.50	35	8412	8300

CPT 2013/2014  
Psychotherapy Utilization Crosswalk

CPT Source	Deleted	Source 2011 Utilization	New/ Revised Code	New/Revised Code Utilization (reference 2011)	Percent	Source RVU	RUC Rec RVU	RUC Tab	New/ Revised Total RVUs	Total Source RVUs
90811	D	7477	90785	5608	0.750	0.00	0.33	35	1851	0
90811	D	7477	Savings	1869	0.250	1.48		35		2766
90811	D	7477	99211	729	0.097	0.00	0.18	35	131	0
90811	D	7477	99212	2804	0.375	0.00	0.48	35	1346	0
90811	D	7477	99213	1963	0.263	0.00	0.97	35	1904	0
90811	D	7477	99214	56	0.007	0.00	1.50	35	84	0
90811	D	7477	99215	56	0.007	0.00	2.11	35	118	0
90812	D	16358	90834	16358	1.000	1.97	2.00	35	32716	32225
90812	D	16358	90785	16358	1.000	0.00	0.33	35	5398	0
90813	D	2314	90836	1736	0.750	2.13	1.90	35	3298	3698
90813	D	2314	90785	1736	0.750	0.00	0.33	35	573	0
90813	D	2314	Savings	579	0.250	2.13	0.00	35		1233
90813	D	2314	99211	226	0.098	0.00	0.18	35	41	0
90813	D	2314	99212	868	0.375	0.00	0.48	35	417	0
90813	D	2314	99213	607	0.262	0.00	0.97	35	589	0
90813	D	2314	99214	17	0.007	0.00	1.50	35	26	0
90813	D	2314	99215	17	0.007	0.00	2.11	35	36	0
90814	D	5571	90837	5515	0.990	2.90	3.00	35	16545	15994
90814	D	5571	90785	5515	0.990	0.00	0.33	35	1820	0
90814	D	5571	90839	42	0.008	0.00	3.13	35	131	0
90814	D	5571	90840	14	0.003	0.00	1.50	35	21	0
90815	D	237	90838	178	0.751	2.90	2.50	35	445	516
90815	D	237	90785	178	0.751	0.00	0.33	35	59	0
90815	D	237	Savings	59	0.249	2.90	0.00	35	0	171
90815	D	237	99211	23	0.097	0.00	0.18	35	4	0
90815	D	237	99212	89	0.376	0.00	0.48	35	43	0
90815	D	237	99213	62	0.262	0.00	0.97	35	60	0
90815	D	237	99214	2	0.008	0.00	1.50	35	3	0
90815	D	237	99215	2	0.008	0.00	2.11	35	4	0
90816	D	1444154	90832	1444154	1.000	1.25	1.50	35	2166231	1805193
90817	D	404537	90832	303403	0.750	1.41	1.50	35	455105	427798
90817	D	404537	Savings	101134	0.250	1.41	0.00	35		142599
90817	D	404537	99231	151702	0.375	0.00	0.76	35	115294	0
90817	D	404537	99232	136531	0.337	0.00	1.39	35	189778	0
90817	D	404537	99233	15170	0.037	0.00	2.00	35	30340	0

CPT 2013/2014  
Psychotherapy Utilization Crosswalk

CPT Source	Deleted	Source 2011 Utilization	New/ Revised Code	New/Revised Code Utilization (reference 2011)	Percent	Source RVU	RUC Rec RVU	RUC Tab	New/ Revised Total RVUs	Total Source RVUs
90818	D	1448066	90834	1448066	1.000	1.89	2.00	35	2896132	2736845
90819	D	100561	90836	75421	0.750	2.05	1.90	35	143300	154613
90819	D	100561	Savings	25140	0.250	2.05	0.00	35		51537
90819	D	100561	99231	37711	0.375	0.00	0.76	35	28660	0
90819	D	100561	99232	33939	0.337	0.00	1.39	35	47175	0
90819	D	100561	99233	3771	0.037	0.00	2.00	35	7542	0
90821	D	22844	90837	22616	0.990	2.83	3.00	35	67848	64003
90821	D	22844	90839	171	0.007	0.00	3.13	35	535	0
90821	D	22844	90840	57	0.002	0.00	1.50	35	86	0
90822	D	5799	90838	4349	0.750	2.99	2.50	35	10873	13004
90822	D	5799	Savings	1450	0.250	2.99	0.00	35		4336
90822	D	5799	99211	566	0.098	0.00	0.18	35	102	0
90822	D	5799	99212	2175	0.375	0.00	0.48	35	1044	0
90822	D	5799	99213	1522	0.262	0.00	0.97	35	1476	0
90822	D	5799	99214	43	0.007	0.00	1.50	35	65	0
90822	D	5799	99215	43	0.007	0.00	2.11	35	91	0
90823	D	2176	90832	2176	1.000	1.36	1.50	35	3264	2959
90823	D	2176	90785	2176	1.000	0.00	0.33	35	718	0
90824	D	2419	90832	1814	0.750	1.52	1.50	35	2721	2757
90824	D	2419	90785	1814	0.750	0.00	0.33	35	599	0
90824	D	2419	Savings	605	0.250	1.52	0.00	35		920
90824	D	2419	99231	907	0.375	0.00	0.76	35	689	0
90824	D	2419	99232	816	0.337	0.00	1.39	35	1134	0
90824	D	2419	99233	91	0.038	0.00	2.00	35	182	0
90826	D	1564	90834	1564	1.000	2.01	2.00	35	3128	3144
90826	D	1564	90785	1564	1.000	0.00	0.33	35	516	0
90827	D	220	90836	165	0.750	2.16	1.90	35	314	356
90827	D	220	90785	165	0.750	0.00	0.33	35	54	0
90827	D	220	Savings	55	0.250	2.16	0.00	35		119
90827	D	220	99231	83	0.377	0.00	0.76	35	63	0
90827	D	220	99232	74	0.336	0.00	1.39	35	103	0
90827	D	220	99233	8	0.036	0.00	2.00	35	16	0
90828	D	20	90837	19	0.950	2.94	3.00	35	57	56
90828	D	20	90785	19	0.950	0.00	0.33	35	6	0
90828	D	20	90839	1	0.050	0.00	3.13	35	3	0

CPT 2013/2014  
Psychotherapy Utilization Crosswalk

CPT Source	Deleted	Source 2011 Utilization	New/ Revised Code	New/Revised Code Utilization (reference 2011)	Percent	Source RVU	RUC Rec RVU	RUC Tab	New/ Revised Total RVUs	Total Source RVUs
90828	D	20	90840	1	0.050	0.00	1.50	35	2	0
90829	D	14	90838	11	0.786	3.10	2.50	35	28	34
90829	D	14	90785	11	0.786	0.00	0.33	35	4	0
90829	D	14	Savings	3	0.214	3.10	0.00	35		9
90829	D	14	99231	5	0.357	0.00	0.76	35	4	0
90829	D	14	99232	5	0.357	0.00	1.39	35	7	0
90829	D	14	99233	1	0.071	0.00	2.00	35	2	0
90845		5365	90845	5365	1.000	1.79	2.10	35	11267	9603
90846		26202	90846	26202	1.000	1.83	2.40	35	62885	47950
90847		222713	90847	222713	1.000	2.21	2.50	35	556783	492196
90853		1265355	90853	1265355	1.000	0.59	0.59	35	746559	746559
90857	D	32524	90853	32524	1.000	0.63	0.59	35	19189	20490
90857	D	32524	90785	32524	1.000	0.00	0.33	35	10733	0
90862	D	5348548	99211	695311	0.130	0.95	0.18	35	125156	660545
90862	D	5348548	99212	2139419	0.400	0.95	0.48	35	1026921	2032448
90862	D	5348548	99213	1925477	0.360	0.95	0.97	35	1867713	1829203
90862	D	5348548	99214	53485	0.010	0.95	1.50	35	80228	50811
90862	D	5348548	99215	53485	0.010	0.95	2.11	35	112853	50811
90862	D	5348548	99231	320913	0.060	0.95	0.76	35	243894	304867
90862	D	5348548	99232	160456	0.030	0.95	1.39	35	223034	152434

35264044 33896923

Total Source RVUs	33,896,923
Total New/Revised RVUs	35,264,044
RVU Difference	-1,367,121
CF	34
CF Redistribution	-46,533,525

## ***New Technology/New Services List***

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
0318T	Implantation of catheter-delivered prosthetic aortic heart valve, open thoracic approach, (eg, transapical, other than transaortic)	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	September 2016		<input type="checkbox"/>
14302	Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)	Apr 2009	Adjacent Tissue Transfer	4	CPT 2010	September 2013		<input type="checkbox"/>
15271	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	September 2015		<input type="checkbox"/>
15272	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	September 2015		<input type="checkbox"/>
15273	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	September 2015		<input type="checkbox"/>
15274	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	September 2015		<input type="checkbox"/>
15275	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	September 2015		<input type="checkbox"/>

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
15276	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	September 2015		<input type="checkbox"/>
15277	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	September 2015		<input type="checkbox"/>
15278	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	September 2015		<input type="checkbox"/>
15777	Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (eg, breast, trunk) (List separately in addition to code for primary procedure)	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	September 2015		<input type="checkbox"/>
17106	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm	Oct 2008	Destruction of Skin Lesions	11	CPT 2009	September 2013		<input type="checkbox"/>
17107	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm	Oct 2008	Destruction of Skin Lesions	11	CPT 2009	September 2013		<input type="checkbox"/>
17108	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm	Oct 2008	Destruction of Skin Lesions	11	CPT 2009	September 2013		<input type="checkbox"/>
19105	Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma	Apr 2006	Fibroadenoma Cryoablation	11	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
20696	Application of multiplane (pins or wires in more than 1 plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; initial and subsequent alignment(s), assessment(s), and computation(s) of adjustment schedule(s)	Apr 2008	Computer Dependent External Fixation	6	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
20697	Application of multiplane (pins or wires in more than 1 plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; exchange (ie, removal and replacement) of strut, each	Apr 2008	Computer Dependent External Fixation	6	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
20985	Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (List separately in addition to code for primary procedure)	Apr 2007	Computer Navigation	7	CPT 2008	September 2011	Resurvey for January 2012	<input checked="" type="checkbox"/>
20986	Code Deleted	Apr 2007	Computer Navigation	7	CPT 2008	September 2011	Code Deleted CPT 2009	<input checked="" type="checkbox"/>
20987	Code Deleted	Apr 2007	Computer Navigation	7	CPT 2008	September 2011	Code Deleted CPT 2009	<input checked="" type="checkbox"/>
21011	Excision, tumor, soft tissue of face or scalp, subcutaneous; less than 2 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
21012	Excision, tumor, soft tissue of face or scalp, subcutaneous; 2 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>



<i>CPT Code</i>	<i>2013 Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>Tab</i>	<i>CPT Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
21013	Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); less than 2 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
21014	Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); 2 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
21015	Radical resection of tumor (eg, malignant neoplasm), soft tissue of face or scalp; less than 2 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
21016	Radical resection of tumor (eg, malignant neoplasm), soft tissue of face or scalp; 2 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
21552	Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
21554	Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>

<i>CPT Code</i>	<i>2013 Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>Tab</i>	<i>CPT Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
21555	Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
21556	Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
21557	Radical resection of tumor (eg, malignant neoplasm), soft tissue of neck or anterior thorax; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
21558	Radical resection of tumor (eg, malignant neoplasm), soft tissue of neck or anterior thorax; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
21930	Excision, tumor, soft tissue of back or flank, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
21931	Excision, tumor, soft tissue of back or flank, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
21932	Excision, tumor, soft tissue of back or flank, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
21933	Excision, tumor, soft tissue of back or flank, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
21935	Radical resection of tumor (eg, malignant neoplasm), soft tissue of back or flank; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
21936	Radical resection of tumor (eg, malignant neoplasm), soft tissue of back or flank; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
22526	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level	Apr 2006	Percutaneous Intradiscal Annuloplast	13	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
22527	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels (List separately in addition to code for primary procedure)	Apr 2006	Percutaneous Intradiscal Annuloplast	13	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
22856	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophylectomy for nerve root or spinal cord decompression and microdissection), single interspace, cervical	Apr 2008	Cervical Arthroplasty	7	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
22857	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar	Feb 2006	Lumbar Arthroplasty	8	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
22861	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical	Apr 2008	Cervical Arthroplasty	7	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
22862	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar	Feb 2006	Lumbar Arthroplasty	8	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
22864	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical	Apr 2008	Cervical Arthroplasty	7	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
22865	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar	Feb 2006	Lumbar Arthroplasty	8	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
22900	Excision, tumor, soft tissue of abdominal wall, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
22901	Excision, tumor, soft tissue of abdominal wall, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>

<i>CPT Code</i>	<i>2013 Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>Tab</i>	<i>CPT Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
22902	Excision, tumor, soft tissue of abdominal wall, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
22903	Excision, tumor, soft tissue of abdominal wall, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
22904	Radical resection of tumor (eg, malignant neoplasm), soft tissue of abdominal wall; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
22905	Radical resection of tumor (eg, malignant neoplasm), soft tissue of abdominal wall; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
23071	Excision, tumor, soft tissue of shoulder area, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
23073	Excision, tumor, soft tissue of shoulder area, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>

<i>CPT Code</i>	<i>2013 Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>Tab</i>	<i>CPT Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
23075	Excision, tumor, soft tissue of shoulder area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
23076	Excision, tumor, soft tissue of shoulder area, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
23077	Radical resection of tumor (eg, malignant neoplasm), soft tissue of shoulder area; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
23078	Radical resection of tumor (eg, malignant neoplasm), soft tissue of shoulder area; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
23200	Radical resection of tumor; clavicle	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
23210	Radical resection of tumor; scapula	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>

<i>CPT Code</i>	<i>2013 Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>Tab</i>	<i>CPT Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
23220	Radical resection of tumor, proximal humerus	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
24073	Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
24075	Excision, tumor, soft tissue of upper arm or elbow area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
24076	Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
24077	Radical resection of tumor (eg, malignant neoplasm), soft tissue of upper arm or elbow area; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
24079	Radical resection of tumor (eg, malignant neoplasm), soft tissue of upper arm or elbow area; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>

<i>CPT Code</i>	<i>2013 Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>Tab</i>	<i>CPT Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
24150	Radical resection of tumor, shaft or distal humerus	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
24152	Radical resection of tumor, radial head or neck	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
25071	Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
25073	Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
25075	Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
25076	Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>



<i>CPT Code</i>	<i>2013 Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>Tab</i>	<i>CPT Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
25077	Radical resection of tumor (eg, malignant neoplasm), soft tissue of forearm and/or wrist area; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
25078	Radical resection of tumor (eg, malignant neoplasm), soft tissue of forearm and/or wrist area; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
25170	Radical resection of tumor, radius or ulna	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
26111	Excision, tumor or vascular malformation, soft tissue of hand or finger, subcutaneous; 1.5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
26113	Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); 1.5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
26115	Excision, tumor or vascular malformation, soft tissue of hand or finger, subcutaneous; less than 1.5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>

<i>CPT Code</i>	<i>2013 Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>Tab</i>	<i>CPT Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
26116	Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); less than 1.5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
26117	Radical resection of tumor (eg, malignant neoplasm), soft tissue of hand or finger; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
26118	Radical resection of tumor (eg, malignant neoplasm), soft tissue of hand or finger; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
26250	Radical resection of tumor, metacarpal	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
26260	Radical resection of tumor, proximal or middle phalanx of finger	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
26262	Radical resection of tumor, distal phalanx of finger	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>

<i>CPT Code</i>	<i>2013 Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>Tab</i>	<i>CPT Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
27043	Excision, tumor, soft tissue of pelvis and hip area, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
27045	Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
27047	Excision, tumor, soft tissue of pelvis and hip area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
27048	Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
27049	Radical resection of tumor (eg, malignant neoplasm), soft tissue of pelvis and hip area; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
27059	Radical resection of tumor (eg, malignant neoplasm), soft tissue of pelvis and hip area; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>

<i>CPT Code</i>	<i>2013 Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>Tab</i>	<i>CPT Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
27075	Radical resection of tumor; wing of ilium, 1 pubic or ischial ramus or symphysis pubis	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
27076	Radical resection of tumor; ilium, including acetabulum, both pubic rami, or ischium and acetabulum	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
27077	Radical resection of tumor; innominate bone, total	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
27078	Radical resection of tumor; ischial tuberosity and greater trochanter of femur	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
27327	Excision, tumor, soft tissue of thigh or knee area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
27328	Excision, tumor, soft tissue of thigh or knee area, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>

<i>CPT Code</i>	<i>2013 Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>Tab</i>	<i>CPT Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
27329	Radical resection of tumor (eg, malignant neoplasm), soft tissue of thigh or knee area; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
27337	Excision, tumor, soft tissue of thigh or knee area, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
27339	Excision, tumor, soft tissue of thigh or knee area, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
27364	Radical resection of tumor (eg, malignant neoplasm), soft tissue of thigh or knee area; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
27365	Radical resection of tumor, femur or knee	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
27615	Radical resection of tumor (eg, malignant neoplasm), soft tissue of leg or ankle area; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>

<i>CPT Code</i>	<i>2013 Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>Tab</i>	<i>CPT Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
27616	Radical resection of tumor (eg, malignant neoplasm), soft tissue of leg or ankle area; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
27618	Excision, tumor, soft tissue of leg or ankle area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
27619	Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
27632	Excision, tumor, soft tissue of leg or ankle area, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
27634	Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
27645	Radical resection of tumor; tibia	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>

<i>CPT Code</i>	<i>2013 Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>Tab</i>	<i>CPT Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
27646	Radical resection of tumor; fibula	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
27647	Radical resection of tumor; talus or calcaneus	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
28039	Excision, tumor, soft tissue of foot or toe, subcutaneous; 1.5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
28041	Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); 1.5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
28043	Excision, tumor, soft tissue of foot or toe, subcutaneous; less than 1.5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
28045	Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); less than 1.5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
28046	Radical resection of tumor (eg, malignant neoplasm), soft tissue of foot or toe; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
28047	Radical resection of tumor (eg, malignant neoplasm), soft tissue of foot or toe; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
28171	Radical resection of tumor; tarsal (except talus or calcaneus)	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
28173	Radical resection of tumor; metatarsal	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
28175	Radical resection of tumor; phalanx of toe	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	September 2015	Review in 3 years after additional data and coding introductory language and education have taken effect.	<input type="checkbox"/>
29582	Application of multi-layer compression system; thigh and leg, including ankle and foot, when performed	Oct 2010	Multi-Layer Compression System-HCPAC	74	CPT 2012	September 2015		<input type="checkbox"/>
29583	Application of multi-layer compression system; upper arm and forearm	Oct 2010	Multi-Layer Compression System-HCPAC	74	CPT 2012	September 2015		<input type="checkbox"/>



<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
29584	Application of multi-layer compression system; upper arm, forearm, hand, and fingers	Oct 2010	Multi-Layer Compression System-HCPAC	74	CPT 2012	September 2015		<input type="checkbox"/>
29828	Arthroscopy, shoulder, surgical; biceps tenodesis	Apr 2007	Arthroscopic Biceps Tenodesis	17	CPT 2008	September 2011	Resurvey for January 2012	<input checked="" type="checkbox"/>
29914	Arthroscopy, hip, surgical; with femoroplasty (ie, treatment of cam lesion)	Apr 2010	Hip Arthroscopy	5	CPT 2011	September 2014		<input type="checkbox"/>
29915	Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)	Apr 2010	Hip Arthroscopy	5	CPT 2011	September 2014		<input type="checkbox"/>
29916	Arthroscopy, hip, surgical; with labral repair	Apr 2010	Hip Arthroscopy	5	CPT 2011	September 2014		<input type="checkbox"/>
31295	Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa	Feb 2010	Nasal Sinus Endoscopy with Ballooon Dilation	6	CPT 2011	September 2014		<input type="checkbox"/>
31296	Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation)	Feb 2010	Nasal Sinus Endoscopy with Ballooon Dilation	6	CPT 2011	September 2014		<input type="checkbox"/>
31297	Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (eg, balloon dilation)	Feb 2010	Nasal Sinus Endoscopy with Ballooon Dilation	6	CPT 2011	September 2014		<input type="checkbox"/>
31626	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple	Apr 2009	Fiducial Marker Placement	6	CPT 2010	September 2013		<input type="checkbox"/>
31627	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with computer-assisted, image-guided navigation (List separately in addition to code for primary procedure[s])	Feb 2009	Navigational Bronchoscopy	9	CPT 2010	September 2013		<input type="checkbox"/>
31634	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, with assessment of air leak, with administration of occlusive substance (eg, fibrin glue), if performed	Feb 2010	Bronchoscopy with Balloon Occlusion	7	CPT 2011	September 2014		<input type="checkbox"/>

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
31647	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), initial lobe	Apr 2012	Bronchial Valve Procedures	09	CPT 2013	September 2016		<input type="checkbox"/>
31648	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), initial lobe	Apr 2012	Bronchial Valve Procedures	09	CPT 2013	September 2016		<input type="checkbox"/>
31649	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure)	Apr 2012	Bronchial Valve Procedures	09	CPT 2013	September 2016		<input type="checkbox"/>
31651	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure[s])	Apr 2012	Bronchial Valve Procedures	09	CPT 2013	September 2016		<input type="checkbox"/>
32553	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple	Apr 2009	Fiducial Marker Placement	6	CPT 2010	September 2013		<input type="checkbox"/>
32998	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, radiofrequency, unilateral	Apr 2006	Percutaneous RF Pulmonary Tumor Ablation	15	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
33254	Operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure)	Apr 2006	Atrial Tissue Ablation and Reconstruction	17	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
33255	Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); without cardiopulmonary bypass	Apr 2006	Atrial Tissue Ablation and Reconstruction	17	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
33256	Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); with cardiopulmonary bypass	Apr 2006	Atrial Tissue Ablation and Reconstruction	17	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
33257	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), limited (eg, modified maze procedure) (List separately in addition to code for primary procedure)	Apr 2007	Add-on Maze Procedures	23	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
33258	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), without cardiopulmonary bypass (List separately in addition to code for primary procedure)	Apr 2007	Add-on Maze Procedures	23	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
33259	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), with cardiopulmonary bypass (List separately in addition to code for primary procedure)	Apr 2007	Add-on Maze Procedures	23	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
33265	Endoscopy, surgical; operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure), without cardiopulmonary bypass	Apr 2006	Atrial Tissue Ablation and Reconstruction	17	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
33266	Endoscopy, surgical; operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure), without cardiopulmonary bypass	Apr 2006	Atrial Tissue Ablation and Reconstruction	17	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
33361	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	September 2016		<input type="checkbox"/>
33362	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	September 2016		<input type="checkbox"/>
33363	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	September 2016		<input type="checkbox"/>

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
33364	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	September 2016		<input type="checkbox"/>
33365	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy)	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	September 2016		<input type="checkbox"/>
33367	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels) (List separately in addition to code for primary procedure)	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	September 2016		<input type="checkbox"/>
33368	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels) (List separately in addition to code for primary procedure)	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	September 2016		<input type="checkbox"/>
33369	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary artery) (List separately in addition to code for primary procedure)	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	September 2016		<input type="checkbox"/>
33620	Application of right and left pulmonary artery bands (eg, hybrid approach stage 1)	Feb 2010	Cardiac Hybrid Procedures	8	CPT 2011	September 2014		<input type="checkbox"/>
33621	Transthoracic insertion of catheter for stent placement with catheter removal and closure (eg, hybrid approach stage 1)	Feb 2010	Cardiac Hybrid Procedures	8	CPT 2011	September 2014		<input type="checkbox"/>

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
33622	Reconstruction of complex cardiac anomaly (eg, single ventricle or hypoplastic left heart) with palliation of single ventricle with aortic outflow obstruction and aortic arch hypoplasia, creation of cavopulmonary anastomosis, and removal of right and left pulmonary bands (eg, hybrid approach stage 2, Norwood, bidirectional Glenn, pulmonary artery debanding)	Feb 2010	Cardiac Hybrid Procedures	8	CPT 2011	September 2014		<input type="checkbox"/>
33864	Ascending aorta graft, with cardiopulmonary bypass with valve suspension, with coronary reconstruction and valve-sparing aortic root remodeling (eg, David Procedure, Yacoub Procedure)	Apr 2007	Valve Sparing Aortic Annulus Reconstruction	24	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
34806	Transcatheter placement of wireless physiologic sensor in aneurysmal sac during endovascular repair, including radiological supervision and interpretation, instrument calibration, and collection of pressure data (List separately in addition to code for primary procedure)	Apr 2007	Wireless Pressure Sensor Implantation	25	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
37192	Repositioning of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed	Apr 2011	IVC Transcatheter Procedure	12	CPT 2012	September 2015		<input type="checkbox"/>
37193	Retrieval (removal) of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed	Apr 2011	IVC Transcatheter Procedure	12	CPT 2012	September 2015		<input type="checkbox"/>
37197	Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), includes radiological supervision and interpretation, and imaging guidance (ultrasound or fluoroscopy), when performed	Jan 2012	Stereotactic Body Radiation	07	CPT 2013	September 2016		<input type="checkbox"/>

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
38900	Intraoperative identification (eg, mapping) of sentinel lymph node(s) includes injection of non-radioactive dye, when performed (List separately in addition to code for primary procedure)	Apr 2010	Sentinel Lymph Node Mapping	8	CPT 2011	September 2014		<input type="checkbox"/>
43273	Endoscopic cannulation of papilla with direct visualization of common bile duct(s) and/or pancreatic duct(s) (List separately in addition to code(s) for primary procedure)	Apr 2008	Cholangioscopy-Pancreatascopy	13	CPT 2009	September 2012	Specialty to survey Feb 2013 with family of services	<input type="checkbox"/>
43279	Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed	Apr 2008	Laparoscopic Heller Myotomy	12	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
43281	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh	Apr 2009	Laparoscopic Paraesophageal Hernia Repair	12	CPT 2010	September 2013		<input type="checkbox"/>
43282	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh	Apr 2009	Laparoscopic Paraesophageal Hernia Repair	12	CPT 2010	September 2013		<input type="checkbox"/>
43647	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum	Apr 2006	Gastric Antrum Neurostimulation	26	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
43648	Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum	Apr 2006	Gastric Antrum Neurostimulation	26	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)	Apr 2009	Laparoscopic Longitudinal Gastrectomy	14	CPT 2010	September 2013		<input type="checkbox"/>
43881	Implantation or replacement of gastric neurostimulator electrodes, antrum, open	Apr 2006	Gastric Antrum Neurostimulation	26	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
43882	Revision or removal of gastric neurostimulator electrodes, antrum, open	Apr 2006	Gastric Antrum Neurostimulation	26	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
44705	Preparation of fecal microbiota for instillation, including assessment of donor specimen	Apr 2012	Fecal Bacteriotherapy	18	CPT 2013	September 2016		<input type="checkbox"/>
46707	Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS])	Apr 2009	Fistula Plug	15	CPT 2010	September 2013		<input type="checkbox"/>
49327	Laparoscopy, surgical; with placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), intra-abdominal, intrapelvic, and/or retroperitoneum, including imaging guidance, if performed, single or multiple (List separately in addition to code for primary procedure)	Apr 2010	Fiducial Marker Placement	10	CPT 2011	September 2014		<input type="checkbox"/>
49411	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum, single or multiple	Apr 2009	Fiducial Marker Placement	6	CPT 2010	September 2013		<input type="checkbox"/>
49412	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), open, intra-abdominal, intrapelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple (List separately in addition to code for primary procedure)	Apr 2010	Fiducial Marker Placement	10	CPT 2011	September 2014		<input type="checkbox"/>
49652	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible	Feb 2011	Laparoscopic Hernia Repair	30	CPT 2012	September 2015		<input type="checkbox"/>
49653	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated	Feb 2011	Laparoscopic Hernia Repair	30	CPT 2012	September 2015		<input type="checkbox"/>
49654	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible	Feb 2011	Laparoscopic Hernia Repair	30	CPT 2012	September 2015		<input type="checkbox"/>

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
49655	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated	Feb 2011	Laparoscopic Hernia Repair	30	CPT 2012	September 2015		<input type="checkbox"/>
50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy	Apr 2007	Percutaneous Renal Tumor Cryotherapy	A	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
53855	Insertion of a temporary prostatic urethral stent, including urethral measurement	Feb 2009	Temporary Prostatic Urethral Stent Insertion	12	CPT 2010	September 2013		<input type="checkbox"/>
53860	Transurethral radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence	Apr 2010	Transurethral Radiofrequency Bladder Neck and Urethra	12	CPT 2011	September 2014		<input type="checkbox"/>
55706	Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance	Apr 2008	Saturation Biopsies	15	CPT 2009	September 2014	Review in 2 years (Sept 2014), as volume is higher than predicted.	<input type="checkbox"/>
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed	Oct 2009	Laparoscopic Radical Prostatectomy	14	CPT 2011	September 2014		<input type="checkbox"/>
57423	Paravaginal defect repair (including repair of cystocele, if performed), laparoscopic approach	Apr 2007	Laparoscopic Paravaginal Defect Repair	C	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
57425	Laparoscopy, surgical, colpopexy (suspension of vaginal apex)	Oct 2008	Laparoscopic Revision of Prosthetic Vaginal Graft	7	CPT 2010	September 2013		<input type="checkbox"/>
57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach	Oct 2008	Laparoscopic Revision of Prosthetic Vaginal Graft	7	CPT 2010	September 2013		<input type="checkbox"/>
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;	Feb 2006	Laparoscopic Supracervical Hysterectomy	13	CPT 2007	September 2013	Review in 3 years (Sept 2013). Specifically review site of service and length of stay.	<input type="checkbox"/>



<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>CPT Tab</b></i>	<i><b>Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	Feb 2006	Laparoscopic Supracervical Hysterectomy	13	CPT 2007	September 2013	Review in 3 years (Sept 2013). Specifically review site of service and length of stay.	<input type="checkbox"/>
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;	Feb 2006	Laparoscopic Supracervical Hysterectomy	13	CPT 2007	September 2013	Review in 3 years (Sept 2013). Specifically review site of service and length of stay.	<input type="checkbox"/>
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	Feb 2006	Laparoscopic Supracervical Hysterectomy	13	CPT 2007	September 2013	Review in 3 years (Sept 2013). Specifically review site of service and length of stay.	<input type="checkbox"/>
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;	Apr 2007	Laparoscopic Total Hysterectomy	D	CPT 2008	September 2013	Review in 2 years (Sept 2013), specialty society to identify codes and claims data for all hysterectomy procedures when re-reviewed.	<input type="checkbox"/>
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	Apr 2007	Laparoscopic Total Hysterectomy	D	CPT 2008	September 2013	Review in 2 years (Sept 2013), specialty society to identify codes and claims data for all hysterectomy procedures when re-reviewed.	<input type="checkbox"/>
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g;	Apr 2007	Laparoscopic Total Hysterectomy	D	CPT 2008	September 2013	Review in 2 years (Sept 2013), specialty society to identify codes and claims data for all hysterectomy procedures when re-reviewed.	<input type="checkbox"/>

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	Apr 2007	Laparoscopic Total Hysterectomy	D	CPT 2008	September 2013	Review in 2 years (Sept 2013), specialty society to identify codes and claims data for all hysterectomy procedures when re-reviewed.	<input type="checkbox"/>
63620	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion	Apr 2008	Stereotactic Radiosurgery	16	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
63621	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional spinal lesion (List separately in addition to code for primary procedure)	Apr 2008	Stereotactic Radiosurgery	16	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
64566	Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming	Apr 2010	Posterior Tibial Nerve Stimulation	13	CPT 2011	September 2014		<input type="checkbox"/>
64569	Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator	Feb 2010	Vagus Nerve Stimulator	14	CPT 2011	September 2014		<input type="checkbox"/>
64570	Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	Feb 2010	Vagus Nerve Stimulator	14	CPT 2011	September 2014		<input type="checkbox"/>
65756	Keratoplasty (corneal transplant); endothelial	Apr 2008	Endothelial Keratoplasty	20	CPT 2009	September 2012	Remove, code does not need to be re-evaluated. Though volume grew faster than expected, there was a decrease in other services of similar magnitude, that were previously reported and had similar work RVUs. All remained work neutral.	<input checked="" type="checkbox"/>

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
65757	Backbench preparation of corneal endothelial allograft prior to transplantation (List separately in addition to code for primary procedure)	Apr 2008	Endothelial Keratoplasty	20	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
65778	Placement of amniotic membrane on the ocular surface for wound healing; self-retaining	Feb 2010	Amniotic Membrane Placement	15	CPT 2011	September 2014		<input type="checkbox"/>
65779	Placement of amniotic membrane on the ocular surface for wound healing; single layer, sutured	Feb 2010	Amniotic Membrane Placement	15	CPT 2011	September 2014		<input type="checkbox"/>
65780	Ocular surface reconstruction; amniotic membrane transplantation, multiple layers	Oct 2011	Relativity Assessment Workgroup	51	CPT 2011	September 2014		<input type="checkbox"/>
66174	Transluminal dilation of aqueous outflow canal; without retention of device or stent	Apr 2010	Open Angle Glaucoma Procedures	15	CPT 2011	September 2014		<input type="checkbox"/>
66175	Transluminal dilation of aqueous outflow canal; with retention of device or stent	Apr 2010	Open Angle Glaucoma Procedures	15	CPT 2011	September 2014		<input type="checkbox"/>
6618X1	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach	April 2013	Insertion of Anterior Segment	14	CPT 2014	September 2017		<input type="checkbox"/>
68816	Probing of nasolacrimal duct, with or without irrigation; with transluminal balloon catheter dilation	Apr 2007	Nasolacrimal Duct Balloon Catheter Dilation	E	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
70554	Magnetic resonance imaging, brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration	Feb 2006	Functional MRI	15	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
70555	Magnetic resonance imaging, brain, functional MRI; requiring physician or psychologist administration of entire neurofunctional testing	Feb 2006	Functional MRI	15	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
74261	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material	Apr 2009	CT Colonography	19	CPT 2010	September 2013		<input type="checkbox"/>

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
74262	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed	Apr 2009	CT Colonography	19	CPT 2010	September 2013		<input type="checkbox"/>
74263	Computed tomographic (CT) colonography, screening, including image postprocessing	Apr 2009	CT Colonography	19	CPT 2010	September 2013		<input type="checkbox"/>
75557	Cardiac magnetic resonance imaging for morphology and function without contrast material;	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Remove, as utilization is appropriate due to shift of utilization for deleted code which included "with flow/velocity quantification", code 75558.	<input checked="" type="checkbox"/>
75558	Code Deleted	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Code Deleted CPT 2010	<input checked="" type="checkbox"/>
75559	Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
75560	Code Deleted	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Code Deleted CPT 2010	<input checked="" type="checkbox"/>
75561	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences;	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Remove, as utilization is appropriate due to shift of utilization for deleted code which included "with flow/velocity quantification", code 75560.	<input checked="" type="checkbox"/>
75562	Code Deleted	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Code Deleted CPT 2010	<input checked="" type="checkbox"/>

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
75563	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
75564	Code Deleted	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Code Deleted CPT 2010	<input checked="" type="checkbox"/>
75571	Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium	Feb 2009	Coronary Computed Tomographic Angiography	15	CPT 2010	September 2013		<input type="checkbox"/>
75572	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)	Feb 2009	Coronary Computed Tomographic Angiography	15	CPT 2010	September 2013		<input type="checkbox"/>
75573	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed)	Feb 2009	Coronary Computed Tomographic Angiography	15	CPT 2010	September 2013		<input type="checkbox"/>
75574	Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)	Feb 2009	Coronary Computed Tomographic Angiography	15	CPT 2010	September 2013		<input type="checkbox"/>
76881	Ultrasound, extremity, nonvascular, real-time with image documentation; complete	Apr 2010	Ultrasound of Extremity	17	CPT 2011	September 2014		<input type="checkbox"/>
76882	Ultrasound, extremity, nonvascular, real-time with image documentation; limited, anatomic specific	Apr 2010	Ultrasound of Extremity	17	CPT 2011	September 2014		<input type="checkbox"/>
772X1	Respiratory motion management simulation	January 2013	Respiratory Motion Management Simulation	14	CPT 2014	September 2017		<input type="checkbox"/>

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based	Sep 2005	Stereotactic Radiation Tx Delivery	7	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
77372	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based	Sep 2005	Stereotactic Radiation Tx Delivery	7	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	Apr 2006	Stereotactic Body Radiation Therapy	B	CPT 2007	September 2010	Practice expense review (Feb 2011).	<input checked="" type="checkbox"/>
77435	Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	Feb 2011	Stereotactic Body Radiation Delivery	32	CPT 2012	September 2015		<input type="checkbox"/>
77435	Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	Apr 2006	Stereotactic Body Radiation Therapy	B	CPT 2007	September 2010	Survey (work) and PE review (Feb 2011).	<input checked="" type="checkbox"/>
78072	Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization	Apr 2012	Parathyroid Imaging	23	CPT 2013	September 2016		<input type="checkbox"/>
78811	Positron emission tomography (PET) imaging; limited area (eg, chest, head/neck)	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Review Sept 2013 to affirm editorial nature of coding changes to remove "tumor imaging." Review migration in new technology (PET w CT scanners) & monitor util related to coverage determinations (if coverage is expanded to include scans for infection)	<input type="checkbox"/>

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
78812	Positron emission tomography (PET) imaging; skull base to mid-thigh	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Review Sept 2013 to affirm editorial nature of coding changes to remove "tumor imaging." Review migration in new technology (PET w CT scanners) & monitor util related to coverage determinations (if coverage is expanded to include scans for infection)	<input type="checkbox"/>
78813	Positron emission tomography (PET) imaging; whole body	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Review Sept 2013 to affirm editorial nature of coding changes to remove "tumor imaging." Review migration in new technology (PET w CT scanners) & monitor util related to coverage determinations (if coverage is expanded to include scans for infection)	<input type="checkbox"/>
78814	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; limited area (eg, chest, head/neck)	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Review Sept 2013 to affirm editorial nature of coding changes to remove "tumor imaging." Review migration in new technology (PET w CT scanners) & monitor util related to coverage determinations (if coverage is expanded to include scans for infection)	<input type="checkbox"/>

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
78815	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Review Sept 2013 to affirm editorial nature of coding changes to remove "tumor imaging." Review migration in new technology (PET w CT scanners) & monitor util related to coverage determinations (if coverage is expanded to include scans for infection)	<input type="checkbox"/>
78816	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; whole body	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Review Sept 2013 to affirm editorial nature of coding changes to remove "tumor imaging." Review migration in new technology (PET w CT scanners) & monitor util related to coverage determinations (if coverage is expanded to include scans for infection)	<input type="checkbox"/>
81161X	DMD (dystrophin) (eg, Duchenne/Becker muscular dystrophy) deletion analysis, and duplication analysis, if performed	Oct 2012	Molecular Pathology -Tier 1	11	CPT 2014	September 2017	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81161X	DMD (dystrophin) (eg, Duchenne/Becker muscular dystrophy) deletion analysis, and duplication analysis, if performed	Oct 2012	Molecular Pathology-Tier 1	11	CPT 2014	September 2017	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>



<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
81201	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence	Apr 2012	Molecular Pathology- Adenomatous Polyposis Coli	24	CPT 2013	September 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81202	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; known familial variants	Apr 2012	Molecular Pathology- Adenomatous Polyposis Coli	24	CPT 2013	September 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81203	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; duplication/deletion variants	Apr 2012	Molecular Pathology- Adenomatous Polyposis Coli	24	CPT 2013	September 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81206	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; major breakpoint, qualitative or quantitative	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81207	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; minor breakpoint, qualitative or quantitative	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81208	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; other breakpoint, qualitative or quantitative	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
81210	BRAF (v-raf murine sarcoma viral oncogene homolog B1) (eg, colon cancer), gene analysis, V600E variant	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81210	BRAF (v-raf murine sarcoma viral oncogene homolog B1) (eg, colon cancer), gene analysis, V600E variant	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81216	BRCA2 (breast cancer 2) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81217	BRCA2 (breast cancer 2) (eg, hereditary breast and ovarian cancer) gene analysis; known familial variant	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81220	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; common variants (eg, ACMG/ACOG guidelines)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81221	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; known familial variants	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
81222	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; duplication/deletion variants	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81223	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; full gene sequence	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81224	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; intron 8 poly-T analysis (eg, male infertility)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81225	CYP2C19 (cytochrome P450, family 2, subfamily C, polypeptide 19) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *8, *17)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81225	CYP2C19 (cytochrome P450, family 2, subfamily C, polypeptide 19) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *8, *17)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81227	CYP2C9 (cytochrome P450, family 2, subfamily C, polypeptide 9) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *5, *6)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
81235	EGFR (epidermal growth factor receptor) (eg, non-small cell lung cancer) gene analysis, common variants (eg, exon 19 LREA deletion, L858R, T790M, G719A, G719S, L861Q)	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	September 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81240	F2 (prothrombin, coagulation factor II) (eg, hereditary hypercoagulability) gene analysis, 20210G>A variant	Apr 2011	Molecular Pathology Test - Tier 1	15	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81241	F5 (coagulation Factor V) (eg, hereditary hypercoagulability) gene analysis, Leiden variant	Apr 2011	Molecular Pathology Test - Tier 1	15	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81243	FMR1 (Fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81244	FMR1 (Fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; characterization of alleles (eg, expanded size and methylation status)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81245	FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia), gene analysis, internal tandem duplication (ITD) variants (ie, exons 14, 15)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
81252	GJB2 (gap junction protein, beta 2, 26kDa; connexin 26) (eg, nonsyndromic hearing loss) gene analysis; full gene sequence	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	September 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81253	GJB2 (gap junction protein, beta 2, 26kDa; connexin 26) (eg, nonsyndromic hearing loss) gene analysis; known familial variants	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	September 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81254	GJB6 (gap junction protein, beta 6, 30kDa, connexin 30) (eg, nonsyndromic hearing loss) gene analysis, common variants (eg, 309kb [del(GJB6-D13S1830)] and 232kb [del(GJB6-D13S1854)])	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	September 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81256	HFE (hemochromatosis) (eg, hereditary hemochromatosis) gene analysis, common variants (eg, C282Y, H63D)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81257	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis, for common deletions or variant (eg, Southeast Asian, Thai, Filipino, Mediterranean, alpha3.7, alpha4.2, alpha20.5, and Constant Spring)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81261	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); amplified methodology (eg, polymerase chain reaction)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
81262	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); direct probe methodology (eg, Southern blot)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81263	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemia and lymphoma, B-cell), variable region somatic mutation analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81264	IGK@ (Immunoglobulin kappa light chain locus) (eg, leukemia and lymphoma, B-cell), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81265	Comparative analysis using Short Tandem Repeat (STR) markers; patient and comparative specimen (eg, pre-transplant recipient and donor germline testing, post-transplant non-hematopoietic recipient germline [eg, buccal swab or other germline tissue sample] and donor testing, twin zygosity testing, or maternal cell contamination of fetal cells)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81266	Comparative analysis using Short Tandem Repeat (STR) markers; each additional specimen (eg, additional cord blood donor, additional fetal samples from different cultures, or additional zygosity in multiple birth pregnancies) (List separately in addition to code for primary procedure)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
81267	Chimerism (engraftment) analysis, post transplantation specimen (eg, hematopoietic stem cell), includes comparison to previously performed baseline analyses; without cell selection	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81268	Chimerism (engraftment) analysis, post transplantation specimen (eg, hematopoietic stem cell), includes comparison to previously performed baseline analyses; with cell selection (eg, CD3, CD33), each cell type	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81270	JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, p.Val617Phe (V617F) variant	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81275	KRAS (v-Ki-ras2 Kirsten rat sarcoma viral oncogene) (eg, carcinoma) gene analysis, variants in codons 12 and 13	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81291	MTHFR (5,10-methylenetetrahydrofolate reductase) (eg, hereditary hypercoagulability) gene analysis, common variants (eg, 677T, 1298C)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81292	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
81293	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81294	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81295	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81296	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81297	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81298	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑



<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
81299	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81300	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81301	Microsatellite instability analysis (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) of markers for mismatch repair deficiency (eg, BAT25, BAT26), includes comparison of neoplastic and normal tissue, if performed	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81302	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81303	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; known familial variant	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81304	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; duplication/deletion variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
81315	PML/RARalpha, (t(15;17)), (promyelocytic leukemia/retinoic acid receptor alpha) (eg, promyelocytic leukemia) translocation analysis; common breakpoints (eg, intron 3 and intron 6), qualitative or quantitative	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81316	PML/RARalpha, (t(15;17)), (promyelocytic leukemia/retinoic acid receptor alpha) (eg, promyelocytic leukemia) translocation analysis; single breakpoint (eg, intron 3, intron 6 or exon 6), qualitative or quantitative	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81317	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81318	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81319	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81321	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	September 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
81322	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; known familial variant	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	September 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81323	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; duplication/deletion variant	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	September 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81331	SNRPN/UBE3A (small nuclear ribonucleoprotein polypeptide N and ubiquitin protein ligase E3A) (eg, Prader-Willi syndrome and/or Angelman syndrome), methylation analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81332	SERPINA1 (serpin peptidase inhibitor, clade A, alpha-1 antiproteinase, antitrypsin, member 1) (eg, alpha-1-antitrypsin deficiency), gene analysis, common variants (eg, *S and *Z)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81340	TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using amplification methodology (eg, polymerase chain reaction)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81341	TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using direct probe methodology (eg, Southern blot)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
81342	TRG@ (T cell antigen receptor, gamma) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81350	UGT1A1 (UDP glucuronosyltransferase 1 family, polypeptide A1) (eg, irinotecan metabolism), gene analysis, common variants (eg, *28, *36, *37)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81355	VKORC1 (vitamin K epoxide reductase complex, subunit 1) (eg, warfarin metabolism), gene analysis, common variants (eg, -1639/3673)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81370	HLA Class I and II typing, low resolution (eg, antigen equivalents); HLA-A, -B, -C, -DRB1/3/4/5, and -DQB1	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81371	HLA Class I and II typing, low resolution (eg, antigen equivalents); HLA-A, -B, and -DRB1/3/4/5 (eg, verification typing)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81372	HLA Class I typing, low resolution (eg, antigen equivalents); complete (ie, HLA-A, -B, and -C)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
81373	HLA Class I typing, low resolution (eg, antigen equivalents); one locus (eg, HLA-A, -B, or -C), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81374	HLA Class I typing, low resolution (eg, antigen equivalents); one antigen equivalent (eg, B*27), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81375	HLA Class II typing, low resolution (eg, antigen equivalents); HLA-DRB1/3/4/5 and -DQB1	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81376	HLA Class II typing, low resolution (eg, antigen equivalents); one locus (eg, HLA-DRB1/3/4/5, -DQB1, -DQA1, -DPB1, or -DPA1), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81377	HLA Class II typing, low resolution (eg, antigen equivalents); one antigen equivalent, each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81378	HLA Class I and II typing, high resolution (ie, alleles or allele groups), HLA-A, -B, -C, and -DRB1	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
81379	HLA Class I typing, high resolution (ie, alleles or allele groups); complete (ie, HLA-A, -B, and -C)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81380	HLA Class I typing, high resolution (ie, alleles or allele groups); one locus (eg, HLA-A, -B, or -C), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81381	HLA Class I typing, high resolution (ie, alleles or allele groups); one allele or allele group (eg, B*57:01P), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81382	HLA Class II typing, high resolution (ie, alleles or allele groups); one locus (eg, HLA-DRB1, -DRB3, -DRB4, -DRB5, -DQB1, -DQA1, -DPB1, or -DPA1), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81383	HLA Class II typing, high resolution (ie, alleles or allele groups); one allele or allele group (eg, HLA-DQB1*06:02P), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
81400	Molecular pathology procedure, Level 1 (eg, identification of single germline variant [eg, SNP] by techniques such as restriction enzyme digestion or melt curve analysis) ABCC8 (ATP-binding cassette, sub-family C [CFTR/MRP], member 8) (eg, familial hyperinsulinism), F1388del variant ACADM (acyl-CoA dehydrogenase, C-4 to C-12 straight chain, MCAD) (eg, medium chain acyl dehydrogenase deficiency), K304E variant ACE (angiotensin converting enzyme) (eg, hereditary blood pressure regulation), insertion/deletion variant AGTR1 (angiotensin II receptor, type 1) (eg, essential hypertension), 1166A>C variant CCR5 (chemokine C-C motif receptor 5) (eg, HIV resistance), 32-bp deletion mutation/794 825del32 deletion CLRN1 (clarin 1) (eg, Usher syndrome, type 3), N48K variant DPYD (dihydropyrimidine dehydrogenase) (eg, 5-fluorouracil/5-FU and capecitabine drug metabolism), IVS14+1G>A variant F2 (coagulation factor 2) (eg, hereditary hypercoagulability), 1199G>A variant F5 (coagulation factor V) (eg, hereditary hypercoagulability), HR2 variant F7 (coagulation factor VII [serum prothrombin conversion accelerator]) (eg, hereditary hypercoagulability), R353Q variant F13B (coagulation factor XIII, B polypeptide) (eg, hereditary hypercoagulability), V34L variant FGB (fibrinogen beta chain) (eg, hereditary ischemic heart disease), -455G>A variant FGFR3 (fibroblast growth factor receptor 3) (eg, Muenke syndrome), P250R variant Human Platelet Antigen 1 genotyping (HPA-1), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa], antigen CD61 [GPIIIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), HPA-1a/b (L33P) Human Platelet Antigen 2 genotyping (HPA-2), GP1BA (glycoprotein Ib [platelet], alpha polypeptide [GPIba]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>

<i>CPT Code</i>	<i>2013 Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>CPT Tab</i>	<i>Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
	<p>purpura), HPA-2a/b (T145M) Human Platelet Antigen 3 genotyping (HPA-3), ITGA2B (integrin, alpha 2b [platelet glycoprotein IIb of IIb/IIIa complex], antigen CD41 [GPIIb]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), HPA-3a/b (I843S) Human Platelet Antigen 4 genotyping (HPA-4), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa], antigen CD61 [GPIIIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), HPA-4a/b (R143Q) Human Platelet Antigen 5 genotyping (HPA-5), ITGA2 (integrin, alpha 2 [CD49B, alpha 2 subunit of VLA-2 receptor] [GPIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), HPA-5a/b (K505E) Human Platelet Antigen 6 genotyping (HPA-6w), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa, antigen CD61] [GPIIIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), HPA-6a/b (R489Q) Human Platelet Antigen 9 genotyping (HPA-9w), ITGA2B (integrin, alpha 2b [platelet glycoprotein IIb of IIb/IIIa complex, antigen CD41] [GPIIb]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), HPA-9a/b (V837M) Human Platelet Antigen 15 genotyping (HPA-15), CD109 (CD109 molecule) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), HPA-15a/b (S682Y) IVD (isovaleryl-CoA dehydrogenase) (eg, isovaleric acidemia), A282V variant SERPINE1 (serpine peptidase inhibitor clade E, member 1, plasminogen activator inhibitor -1, PAI-1) (eg, thrombophilia), 4G variant SHOC2 (soc-2 suppressor of clear homolog) (eg, Noonan-like syndrome with loose anagen hair), S2G variant SMN1 (survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy), exon 7 deletion SRY (sex determining region Y) (eg, 46,XX testicular disorder of sex development, gonadal dysgenesis), gene analysis TOR1A (torsin family 1, member A [torsin A])(eg, early-onset primary</p>							



<i>CPT Code</i>	<i>2013 Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>Tab</i>	<i>CPT Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
	dystonia [DYT1]), 907_909delGAG (904_906delGAG) variant							

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
81401	Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat) ABL (c-abl oncogene 1, receptor tyrosine kinase) (eg, acquired imatinib resistance), T315I variant ACADM (acyl-CoA dehydrogenase, C-4 to C-12 straight chain, MCAD) (eg, medium chain acyl dehydrogenase deficiency), commons variants (eg, K304E, Y42H) ADRB2 (adrenergic beta-2 receptor surface) (eg, drug metabolism), common variants (eg, G16R, Q27E) APOE (apolipoprotein E) (eg, hyperlipoproteinemia type III, cardiovascular disease, Alzheimer disease), common variants (eg, *2, *3, *4) CBFB/MYH11 (inv(16)) (eg, acute myeloid leukemia), qualitative, and quantitative, if performed CCND1/IGH (BCL1/IgH, t(11;14)) (eg, mantle cell lymphoma) translocation analysis, major breakpoint, qualitative, and quantitative, if performed CFH/ARMS2 (complement factor H/age-related maculopathy susceptibility 2) (eg, macular degeneration), common variants (eg, Y402H [CFH], A69S [ARMS2]) CYP3A4 (cytochrome P450, family 3, subfamily A, polypeptide 4) (eg, drug metabolism), common variants (eg, *2, *3, *4, *5, *6) CYP3A5 (cytochrome P450, family 3, subfamily A, polypeptide 5) (eg, drug metabolism), common variants (eg, *2, *3, *4, *5, *6) DMPK (dystrophia myotonica-protein kinase) (eg, myotonic dystrophy, type 1), evaluation to detect abnormal (eg, expanded) alleles F11 (coagulation factor XI) (eg, coagulation disorder), common variants (eg, E117X [Type II], F283L [Type III], IVS14del14, and IVS14+1G>A [Type I]) FGFR3 (fibroblast growth factor receptor 3) (eg, achondroplasia), common variants (eg, 1138G>A, 1138G>C) FIP1L1/PDGFR (del[4q12]) (eg, imatinib-sensitive chronic eosinophilic leukemia), qualitative, and quantitative, if performed GALT (galactose-1-phosphate uridylyltransferase) (eg,	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>

<i>CPT Code</i>	<i>2013 Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>CPT Tab</i>	<i>Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
	galactosemia), common variants (eg, Q188R, S135L, K285N, T138M, L195P, Y209C, IVS2-2A>G, P171S, del5kb, N314D, L218L/N314D) HBB (hemoglobin, beta) (eg, sickle cell anemia, hemoglobin C, hemoglobin E), common variants (eg, HbS, HbC, HbE) HTT (huntingtin) (eg, Huntington disease), evaluation to detect abnormal (eg, expanded) alleles RUNX1/RUNX1T1 (t(8;21)) (eg, acute myeloid leukemia) translocation analysis, qualitative, and quantitative, if performed SEPT9 (Septin 9) (eg, colon cancer), methylation analysis TPMT (thiopurine S-methyltransferase) (eg, drug metabolism), common variants (eg, *2, *3) VWF (von Willebrand factor) (eg, von Willebrand disease type 2N), common variants (eg, T791M, R816W, R854Q)							

<i>CPT Code</i>	<i>2013 Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>Tab</i>	<i>CPT Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
81402	Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants of 1 exon, loss of heterozygosity [LOH], uniparental disomy [UPD]) Chromosome 18q- (eg, D18S55, D18S58, D18S61, D18S64, and D18S69) (eg, colon cancer), allelic imbalance assessment (ie, loss of heterozygosity) CYP21A2 (cytochrome P450, family 21, subfamily A, polypeptide 2) (eg, congenital adrenal hyperplasia, 21-hydroxylase deficiency), common variants (eg, IVS2-13G, P30L, I172N, exon 6 mutation cluster [I235N, V236E, M238K], V281L, L307FfsX6, Q318X, R356W, P453S, G110VfsX21, 30-kb deletion variant) ESR1/PGR (receptor 1/progesterone receptor) ratio (eg, breast cancer) KIT (v-kit Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog) (eg, mastocytosis), common variants (eg, D816V, D816Y, D816F) MEFV (Mediterranean fever) (eg, familial Mediterranean fever), common variants (eg, E148Q, P369S, F479L, M680I, I692del, M694V, M694I, K695R, V726A, A744S, R761H) MPL (myeloproliferative leukemia virus oncogene, thrombopoietin receptor, TPOR) (eg, myeloproliferative disorder), common variants (eg, W515A, W515K, W515L, W515R) TCD@ (T cell antigen receptor, delta) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population Uniparental disomy (UPD) (eg, Russell-Silver syndrome, Prader-Willi/Angelman syndrome), short tandem repeat (STR) analysis	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
81403	Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons) ABL1 (c-abl oncogene 1, receptor tyrosine kinase) (eg, acquired imatinib tyrosine kinase inhibitor resistance), variants in the kinase domain ANG (angiogenin, ribonuclease, RNase A family, 5) (eg, amyotrophic lateral sclerosis), full gene sequence CEBPA (CCAAT/enhancer binding protein [C/EBP], alpha) (eg, acute myeloid leukemia), full gene sequence CEL (carboxyl ester lipase [bile salt-stimulated lipase]) (eg, maturity-onset diabetes of the young [MODY]), targeted sequence analysis of exon 11 (eg, c.1785delC, c.1686delT) DAZ/SRY (deleted in azoospermia and sex determining region Y) (eg, male infertility), common deletions (eg, AZFa, AZFb, AZFc, AZFd) F8 (coagulation factor VIII) (eg, hemophilia A), inversion analysis, intron 1 and intron 22A FGFR3 (fibroblast growth factor receptor 3) (eg, isolated craniosynostosis), targeted sequence analysis (eg, exon 7) (For targeted sequence analysis of multiple FGFR3 exons, use 81404) GJB1 (gap junction protein, beta 1) (eg, Charcot-Marie-Tooth X-linked), full gene sequence HBB (hemoglobin, beta, beta-globin) (eg, beta thalassemia), duplication/deletion analysis HRAS (v-Ha-ras Harvey rat sarcoma viral oncogene homolog) (eg, Costello syndrome), exon 2 sequence IDH1 (isocitrate dehydrogenase 1 [NADP+], soluble) (eg, glioma), common exon 4 variants (eg, R132H, R132C) IDH2 (isocitrate dehydrogenase 2 [NADP+], mitochondrial) (eg, glioma), common exon 4 variants (eg, R140W, R172M) JAK2 (Janus kinase 2) (eg, myeloproliferative disorder), exon 12 sequence and exon 13 sequence, if performed Known familial variant not otherwise specified, for gene listed in Tier 1 or Tier 2, DNA	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>

<i>CPT Code</i>	<i>2013 Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>CPT Tab</i>	<i>Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
	sequence analysis, each variant exon (For a known familial variant that is considered a common variant, use specific common variant Tier 1 or Tier 2 code) KRAS (v-Ki-ras2 Kirsten rat sarcoma viral oncogene) (eg, carcinoma), gene analysis, variant(s) in exon 3 (eg, codon 61) MPL (myeloproliferative leukemia virus oncogene, thrombopoietin receptor, TPOR) (eg, myeloproliferative disorder), exon 10 sequence MT-RNR1 (mitochondrially encoded 12S RNA) (eg, nonsyndromic hearing loss), full gene sequence MT-TS1 (mitochondrially encoded tRNA serine 1) (eg, nonsyndromic hearing loss), full gene sequence SMN1 (survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy), known familial sequence variant(s) VHL (von Hippel-Lindau tumor suppressor) (eg, von Hippel-Lindau familial cancer syndrome), deletion/duplication analysis VWF (von Willebrand factor) (eg, von Willebrand disease types 2A, 2B, 2M), targeted sequence analysis (eg, exon 28)							

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
81404	Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis) ACADS (acyl-CoA dehydrogenase, C-2 to C-3 short chain) (eg, short chain acyl-CoA dehydrogenase deficiency), targeted sequence analysis (eg, exons 5 and 6) AQP2 (aquaporin 2 [collecting duct]) (eg, nephrogenic diabetes insipidus), full gene sequence ARX (aristaless related homeobox) (eg, X-linked lissencephaly with ambiguous genitalia, X-linked mental retardation), full gene sequence BTD (biotinidase) (eg, biotinidase deficiency), full gene sequence CAV3 (caveolin 3) (eg, CAV3-related distal myopathy, limb-girdle muscular dystrophy type 1C), full gene sequence CDKN2A (cyclin-dependent kinase inhibitor 2A) (eg, CDKN2A-related cutaneous malignant melanoma, familial atypical mole-malignant melanoma syndrome), full gene sequence CLRN1 (clarin 1) (eg, Usher syndrome, type 3), full gene sequence CPT2 (carnitine palmitoyltransferase 2) (eg, carnitine palmitoyltransferase II deficiency), full gene sequence CYP1B1 (cytochrome P450, family 1, subfamily B, polypeptide 1) (eg, primary congenital glaucoma), full gene sequence DMPK (dystrophia myotonica-protein kinase) (eg, myotonic dystrophy type 1), characterization of abnormal (eg, expanded) alleles EGR2 (early growth response 2) (eg, Charcot-Marie-Tooth), full gene sequence FGFR2 (fibroblast growth factor receptor 2) (eg, craniosynostosis, Apert syndrome, Crouzon syndrome), targeted sequence analysis (eg, exons 8, 10) FGFR3 (fibroblast growth factor receptor 3) (eg, achondroplasia, hypochondroplasia), targeted sequence analysis (eg, exons 8, 11, 12, 13) FKR1P (Fukutin related protein) (eg, congenital muscular dystrophy type 1C [MDC1C], limb-girdle muscular dystrophy [LGMD] type 2I), full gene	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>

<i>CPT Code</i>	<i>2013 Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>CPT Tab</i>	<i>Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
	sequence FOXP1 (forkhead box G1) (eg, Rett syndrome), full gene sequence FSHMD1A (facioscapulohumeral muscular dystrophy 1A) (eg, facioscapulohumeral muscular dystrophy), evaluation to detect abnormal (eg, deleted) alleles FSHMD1A (facioscapulohumeral muscular dystrophy 1A) (eg, facioscapulohumeral muscular dystrophy), characterization of haplotype(s) (ie, chromosome 4A and 4B haplotypes) FXN (frataxin) (eg, Friedreich ataxia), full gene sequence HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia), duplication/deletion analysis (For common deletion variants of alpha globin 1 and alpha globin 2 genes, use 81257) HBB (hemoglobin, beta, Beta-Globin) (eg, thalassemia), full gene sequence HNF1B (HNF1 homeobox B) (eg, maturity-onset diabetes of the young [MODY]), duplication/deletion analysis HRAS (v-Ha-ras Harvey rat sarcoma viral oncogene homolog) (eg, Costello syndrome), full gene sequence KCNJ10 (potassium inwardly-rectifying channel, subfamily J, member 10) (eg, SeSAME syndrome, EAST syndrome, sensorineural hearing loss), full gene sequence KIT (C-kit) (v-kit Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog) (eg, GIST, acute myeloid leukemia, melanoma), targeted gene analysis (eg, exons 8, 11, 13, 17, 18) LITAF (lipopolysaccharide-induced TNF factor) (eg, Charcot-Marie-Tooth), full gene sequence MEFV (Mediterranean fever) (eg, familial Mediterranean fever), full gene sequence MEN1 (multiple endocrine neoplasia I) (eg, multiple endocrine neoplasia type 1, Wermer syndrome), duplication/deletion analysis NRAS (neuroblastoma RAS viral oncogene homolog) (eg, colorectal carcinoma), exon 1 and exon 2 sequences PDGFRA (platelet-derived growth factor receptor alpha polypeptide) (eg, gastrointestinal stromal tumor), targeted sequence analysis (eg, exons 12, 18) PDX1 (pancreatic and duodenal homeobox 1) (eg, maturity-onset diabetes of the young [MODY]),							



<i>CPT Code</i>	<i>2013 Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>CPT Tab</i>	<i>Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
	full gene sequence PRNP (prion protein) (eg, genetic prion disease), full gene sequence PRSS1 (protease, serine, 1 [trypsin 1]) (eg, hereditary pancreatitis), full gene sequence RAF1 (v-raf-1 murine leukemia viral oncogene homolog 1) (eg, LEOPARD syndrome), targeted sequence analysis (eg, exons 7, 12, 14, 17) RET (ret proto-oncogene) (eg, multiple endocrine neoplasia, type 2B and familial medullary thyroid carcinoma), common variants (eg, M918T, 2647_2648delinsTT, A883F) SDHD (succinate dehydrogenase complex, subunit D, integral membrane protein) (eg, hereditary paraganglioma), full gene sequence SLC25A4 (solute carrier family 25 [mitochondrial carrier; adenine nucleotide translocator], member 4) (eg, progressive external ophthalmoplegia), full gene sequence TP53 (tumor protein 53) (eg, tumor samples), targeted sequence analysis of 2-5 exons TTR (transthyretin) (eg, familial transthyretin amyloidosis), full gene sequence TYR (tyrosinase [oculocutaneous albinism IA]) (eg, oculocutaneous albinism IA), full gene sequence USH1G (Usher syndrome 1G [autosomal recessive]) (eg, Usher syndrome, type 1), full gene sequence VHL (von Hippel-Lindau tumor suppressor) (eg, von Hippel-Lindau familial cancer syndrome), full gene sequence VWF (von Willebrand factor) (eg, von Willebrand disease type 1C), targeted sequence analysis (eg, exons 26, 27, 37)							

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
81405	Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons) ABCD1 (ATP-binding cassette, sub-family D [ALD], member 1) (eg, adrenoleukodystrophy), full gene sequence ACADS (acyl-CoA dehydrogenase, C-2 to C-3 short chain) (eg, short chain acyl-CoA dehydrogenase deficiency), full gene sequence ACTC1 (actin, alpha, cardiac muscle 1) (eg, familial hypertrophic cardiomyopathy), full gene sequence APTX (aprataxin) (eg, ataxia with oculomotor apraxia 1), full gene sequence AR (androgen receptor) (eg, androgen insensitivity syndrome), full gene sequence CHRNA4 (cholinergic receptor, nicotinic, alpha 4) (eg, nocturnal frontal lobe epilepsy), full gene sequence CHRN2 (cholinergic receptor, nicotinic, beta 2 [neuronal]) (eg, nocturnal frontal lobe epilepsy), full gene sequence CYP21A2 (cytochrome P450, family 21, subfamily A, polypeptide2) (eg, steroid 21-hydroxylase isoform, congenital adrenal hyperplasia), full gene sequence DFNB59 (deafness, autosomal recessive 59) (eg, autosomal recessive nonsyndromic hearing impairment), full gene sequence DHCR7 (7-dehydrocholesterol reductase) (eg, Smith-Lemli-Opitz syndrome), full gene sequence EYA1 (eyes absent homolog 1 [Drosophila]) (eg, branchio-oto-renal [BOR] spectrum disorders), duplication/deletion analysis F9 (coagulation factor IX) (eg, hemophilia B), full gene sequence FH (fumarate hydratase) (eg, fumarate hydratase deficiency, hereditary leiomyomatosis with renal cell cancer), full gene sequence FKTN (fukutin) (eg, limb-girdle muscular dystrophy [LGMD] type 2M or 2L), full gene sequence GFAP (glial fibrillary acidic protein) (eg, Alexander disease), full gene sequence GLA (galactosidase, alpha) (eg, Fabry disease), full gene sequence HBA1/HBA2 (alpha globin 1 and alpha globin 2)	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>

<i>CPT Code</i>	<i>2013 Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>CPT Tab</i>	<i>Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
	(eg, thalassemia), full gene sequence HNF1A (HNF1 homeobox A) (eg, maturity-onset diabetes of the young [MODY]), full gene sequence HNF1B (HNF1 homeobox B) (eg, maturity-onset diabetes of the young [MODY]), full gene sequence KRAS (v-Ki-ras2 Kirsten rat sarcoma viral oncogene homolog) (eg, Noonan syndrome), full gene sequence LAMP2 (lysosomal-associated membrane protein 2) (eg, Danon disease), full gene sequence MEN1 (multiple endocrine neoplasia I) (eg, multiple endocrine neoplasia type 1, Wermer syndrome), full gene sequence MPZ (myelin protein zero) (eg, Charcot-Marie-Tooth), full gene sequence MYL2 (myosin, light chain 2, regulatory, cardiac, slow) (eg, familial hypertrophic cardiomyopathy), full gene sequence MYL3 (myosin, light chain 3, alkali, ventricular, skeletal, slow) (eg, familial hypertrophic cardiomyopathy), full gene sequence MYOT (myotilin) (eg, limb-girdle muscular dystrophy), full gene sequence NEFL (neurofilament, light polypeptide) (eg, Charcot-Marie-Tooth), full gene sequence NF2 (neurofibromin 2 [merlin]) (eg, neurofibromatosis, type 2), duplication/deletion analysis NSD1 (nuclear receptor binding SET domain protein 1) (eg, Sotos syndrome), duplication/deletion analysis OTC (ornithine carbamoyltransferase) (eg, ornithine transcarbamylase deficiency), full gene sequence PDHB (pyruvate dehydrogenase [lipoamide] beta) (eg, lactic acidosis), full gene sequence PSEN1 (presenilin 1) (eg, Alzheimer disease), full gene sequence RET (ret proto-oncogene) (eg, multiple endocrine neoplasia, type 2A and familial medullary thyroid carcinoma), targeted sequence analysis (eg, exons 10, 11, 13-16) SDHB (succinate dehydrogenase complex, subunit B, iron sulfur) (eg, hereditary paraganglioma), full gene sequence SDHC (succinate dehydrogenase complex, subunit C, integral membrane protein, 15kDa) (eg, hereditary paraganglioma-pheochromocytoma syndrome), full gene sequence SGCA (sarcoglycan, alpha [50kDa)							

<i>CPT Code</i>	<i>2013 Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>CPT Tab</i>	<i>Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
	dystrophin-associated glycoprotein]) (eg, limb-girdle muscular dystrophy), full gene sequence SGCB (sarcoglycan, beta [43kDa dystrophin-associated glycoprotein]) (eg, limb-girdle muscular dystrophy), full gene sequence SGCD (sarcoglycan, delta [35kDa dystrophin-associated glycoprotein]) (eg, limb-girdle muscular dystrophy), full gene sequence SGCG (sarcoglycan, gamma [35kDa dystrophin-associated glycoprotein]) (eg, limb-girdle muscular dystrophy), full gene sequence SHOC2 (soc-2 suppressor of clear homolog) (eg, Noonan-like syndrome with loose anagen hair), full gene sequence SMN1 (survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy), full gene sequence SPRED1 (sprouty-related, EVH1 domain containing 1) (eg, Legius syndrome), full gene sequence TGFBR1 (transforming growth factor, beta receptor 1) (eg, Marfan syndrome), full gene sequence TGFBR2 (transforming growth factor, beta receptor 2) (eg, Marfan syndrome), full gene sequence THRB (thyroid hormone receptor, beta) (eg, thyroid hormone resistance, thyroid hormone beta receptor deficiency), full gene sequence or targeted sequence analysis of >5 exons TNNI3 (troponin I, type 3 [cardiac]) (eg, familial hypertrophic cardiomyopathy), full gene sequence TP53 (tumor protein 53) (eg, Li-Fraumeni syndrome, tumor samples), full gene sequence or targeted sequence analysis of >5 exons TPM1 (tropomyosin 1 [alpha]) (eg, familial hypertrophic cardiomyopathy), full gene sequence TSC1 (tuberous sclerosis 1) (eg, tuberous sclerosis), duplication/deletion analysis VWF (von Willebrand factor) (eg, von Willebrand disease type 2N), targeted sequence analysis (eg, exons 18-20, 23-25)							

<i>CPT Code</i>	<i>2013 Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>Tab</i>	<i>CPT Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
81406	Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia) CAPN3 (Calpain 3) (eg, limb-girdle muscular dystrophy [LGMD] type 2A, calpainopathy), full gene sequence Cytogenomic microarray analysis, neoplasia (eg, interrogation of copy number, and loss-of-heterozygosity via single nucleotide polymorphism [SNP]-based comparative genomic hybridization [CGH] microarray analysis) GALT (galactose-1-phosphate uridylyltransferase) (eg, galactosemia), full gene sequence HEXA (hexosaminidase A, alpha polypeptide) (eg, Tay-Sachs disease), full gene sequence LMNA (lamin A/C) (eg, Emery-Dreifuss muscular dystrophy [EDMD1, 2 and 3] limb-girdle muscular dystrophy [LGMD] type 1B, dilated cardiomyopathy [CMD1A], familial partial lipodystrophy [FPLD2]), full gene sequence PAH (phenylalanine hydroxylase) (eg, phenylketonuria), full gene sequence POLG (polymerase [DNA directed], gamma) (eg, Alpers-Huttenlocher syndrome, autosomal dominant progressive external ophthalmoplegia), full gene sequence POMGNT1 (protein O-linked mannose beta1,2-N acetylglucosaminyltransferase) (eg, muscle-eye-brain disease, Walker-Warburg syndrome), full gene sequence POMT1 (protein-O-mannosyltransferase 1) (eg, limb-girdle muscular dystrophy [LGMD] type 2K, Walker-Warburg syndrome), full gene sequence POMT2 (protein-O-mannosyltransferase 2) (eg, limb-girdle muscular dystrophy [LGMD] type 2N, Walker-Warburg syndrome), full gene sequence RYR1 (ryanodine receptor 1, skeletal) (eg, malignant hyperthermia), targeted sequence analysis of exons with functionally-confirmed mutations VWF (von Willebrand factor) (von Willebrand disease type 2A), extended targeted sequence analysis (eg, exons 11-16, 24-26, 51, 52)	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
81407	Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform) ABCC8 (ATP-binding cassette, sub-family C [CFTR/MRP], member 8) (eg, familial hyperinsulinism), full gene sequence CHD7 (chromodomain helicase DNA binding protein 7) (eg, CHARGE syndrome), full gene sequence F8 (coagulation factor VIII) (eg, hemophilia A), full gene sequence JAG1 (jagged 1) (eg, Alagille syndrome), full gene sequence MYBPC3 (myosin binding protein C, cardiac) (eg, familial hypertrophic cardiomyopathy), full gene sequence MYH6 (myosin, heavy chain 6, cardiac muscle, alpha) (eg, familial dilated cardiomyopathy), full gene sequence MYH7 (myosin, heavy chain 7, cardiac muscle, beta) (eg, familial hypertrophic cardiomyopathy, Liang distal myopathy), full gene sequence MYO7A (myosin VIIA) (eg, Usher syndrome, type 1), full gene sequence NOTCH1 (notch 1) (eg, aortic valve disease), full gene sequence OPA1 (optic atrophy 1) (eg, optic atrophy), full gene sequence PCDH15 (protocadherin-related 15) (eg, Usher syndrome, type 1), full gene sequence SCN1A (sodium channel, voltage-gated, type 1, alpha subunit) (eg, generalized epilepsy with febrile seizures), full gene sequence SCN5A (sodium channel, voltage-gated, type V, alpha subunit) (eg, familial dilated cardiomyopathy), full gene sequence TSC2 (tuberous sclerosis 2) (eg, tuberous sclerosis), full gene sequence USH1C (Usher syndrome 1C [autosomal recessive, severe]) (eg, Usher syndrome, type 1), full gene sequence	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
81408	Molecular pathology procedure, Level 9 (eg, analysis of >50 exons in a single gene by DNA sequence analysis) ATM (ataxia telangiectasia mutated) (eg, ataxia telangiectasia), full gene sequence CDH23 (cadherin-related 23) (eg, Usher syndrome, type 1), full gene sequence COL1A1 (collagen, type I, alpha 1) (eg, osteogenesis imperfecta, type I), full gene sequence COL1A2 (collagen, type I, alpha 2) (eg, osteogenesis imperfecta, type I), full gene sequence DYSF (dysferlin, limb girdle muscular dystrophy 2B [autosomal recessive]) (eg, limb-girdle muscular dystrophy), full gene sequence FBN1 (fibrillin 1) (eg, Marfan syndrome), full gene sequence NF1 (neurofibromin 1) (eg, neurofibromatosis, type 1), full gene sequence RYR1 (ryanodine receptor 1, skeletal) (eg, malignant hyperthermia), full gene sequence USH2A (Usher syndrome 2A [autosomal recessive, mild]) (eg, Usher syndrome, type 2), full gene sequence VWF (von Willebrand factor) (eg, von Willebrand disease types 1 and 3), full gene sequence	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012	September 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
86152	Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood);	Apr 2012	Cell Enumeration Circulating Tumor Cells	25	CPT 2013	September 2016		<input type="checkbox"/>
86153	Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood); physician interpretation and report, when required	Apr 2012	Cell Enumeration Circulating Tumor Cells	25	CPT 2013	September 2016		<input type="checkbox"/>
88375	Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session	January 2013	Optical Endomicroscopy	15	CPT 2014	September 2017		<input type="checkbox"/>
88380	Microdissection (ie, sample preparation of microscopically identified target); laser capture	Feb 2007	Manual Microdissection	12	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
88381	Microdissection (ie, sample preparation of microscopically identified target); manual	Feb 2007	Manual Microdissection	12	CPT 2008	September 2013	Review in 2 years (Sept 2013) to gather more data and determine if there are more efficiencies.	<input type="checkbox"/>
88384	Array-based evaluation of multiple molecular probes; 11 through 50 probes	Apr 2005	Multiple Molecular Marker Array-Based Evaluation	30	CPT 2006	September 2010	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
88385	Array-based evaluation of multiple molecular probes; 51 through 250 probes	Apr 2005	Multiple Molecular Marker Array-Based Evaluation	30	CPT 2006	September 2010	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
88386	Array-based evaluation of multiple molecular probes; 251 through 500 probes	Apr 2005	Multiple Molecular Marker Array-Based Evaluation	30	CPT 2006	September 2010	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
88387	Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); each tissue preparation (eg, a single lymph node)	Apr 2009	Tissue Examination for Molecular Studies	21	CPT 2010	September 2013		<input type="checkbox"/>
88388	Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node) (List separately in addition to code for primary procedure)	Apr 2009	Tissue Examination for Molecular Studies	21	CPT 2010	September 2013		<input type="checkbox"/>
90769	Code Deleted	Apr 2007	Immune Globulin Subcutaneous Infusion	H	CPT 2008	September 2011	Code Deleted CPT 2009	<input checked="" type="checkbox"/>
90770	Code Deleted	Apr 2007	Immune Globulin Subcutaneous Infusion	H	CPT 2008	September 2011	Code Deleted CPT 2009	<input checked="" type="checkbox"/>
90771	Code Deleted	Apr 2007	Immune Globulin Subcutaneous Infusion	H	CPT 2008	September 2011	Code Deleted CPT 2009	<input checked="" type="checkbox"/>



<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
90867	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management	Feb 2011	Transcranial Magnetic Stimulation	15	CPT 2012	September 2015		<input type="checkbox"/>
90868	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session	Feb 2011	Transcranial Magnetic Stimulation	15	CPT 2012	September 2015		<input type="checkbox"/>
90869	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management	Feb 2011	Transcranial Magnetic Stimulation	15	CPT 2012	September 2015		<input type="checkbox"/>
91112	Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report	Apr 2012	Wireless Motility Capsule	27	CPT 2013	September 2016		<input type="checkbox"/>
91117	Colon motility (manometric) study, minimum 6 hours continuous recording (including provocation tests, eg, meal, intracolonic balloon distension, pharmacologic agents, if performed), with interpretation and report	Apr 2010	Colon Motility	21	CPT 2011	September 2014		<input type="checkbox"/>
92132	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral	Apr 2010	Anterior Segment Imaging	22	CPT 2011	September 2014		<input type="checkbox"/>
92133	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve	Apr 2010	Computerized Scanning Ophthalmology Diagnostic Imaging	23	CPT 2011	September 2014		<input type="checkbox"/>
92134	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina	Apr 2010	Computerized Scanning Ophthalmology Diagnostic Imaging	23	CPT 2011	September 2014		<input type="checkbox"/>
92228	Remote imaging for monitoring and management of active retinal disease (eg, diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral	Apr 2010	Diabetic Retinopathy Imaging	24	CPT 2011	September 2014		<input type="checkbox"/>

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
93279	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead pacemaker system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input type="checkbox"/>
93280	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead pacemaker system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input type="checkbox"/>
93281	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead pacemaker system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input type="checkbox"/>
93282	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead implantable cardioverter-defibrillator system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input type="checkbox"/>

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
93283	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead implantable cardioverter-defibrillator system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input type="checkbox"/>
93284	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead implantable cardioverter-defibrillator system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input type="checkbox"/>
93285	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; implantable loop recorder system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input type="checkbox"/>
93286	Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead pacemaker system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input type="checkbox"/>

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
93287	Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead implantable cardioverter-defibrillator system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input type="checkbox"/>
93288	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead pacemaker system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input type="checkbox"/>
93289	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead implantable cardioverter-defibrillator system, including analysis of heart rhythm derived data elements	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input type="checkbox"/>
93290	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable cardiovascular monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input type="checkbox"/>

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
93291	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable loop recorder system, including heart rhythm derived data analysis	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input type="checkbox"/>
93292	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; wearable defibrillator system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input type="checkbox"/>
93293	Transtelephonic rhythm strip pacemaker evaluation(s) single, dual, or multiple lead pacemaker system, includes recording with and without magnet application with analysis, review and report(s) by a physician or other qualified health care professional, up to 90 days	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input type="checkbox"/>
93294	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input type="checkbox"/>

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
93295	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead implantable cardioverter-defibrillator system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input type="checkbox"/>
93296	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system or implantable cardioverter-defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input type="checkbox"/>
93297	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors, analysis, review(s) and report(s) by a physician or other qualified health care professional	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input type="checkbox"/>
93298	Interrogation device evaluation(s), (remote) up to 30 days; implantable loop recorder system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input type="checkbox"/>

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
93299	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system or implantable loop recorder system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input type="checkbox"/>
93462	Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (List separately in addition to code for primary procedure)	Apr 2010	Diagnostic Cardiac Catheterization	26	CPT 2011	September 2014		<input type="checkbox"/>
93463	Pharmacologic agent administration (eg, inhaled nitric oxide, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent) including assessing hemodynamic measurements before, during, after and repeat pharmacologic agent administration, when performed (List separately in addition to code for primary procedure)	Apr 2010	Diagnostic Cardiac Catheterization	26	CPT 2011	September 2014		<input type="checkbox"/>
93464	Physiologic exercise study (eg, bicycle or arm ergometry) including assessing hemodynamic measurements before and after (List separately in addition to code for primary procedure)	Apr 2010	Diagnostic Cardiac Catheterization	26	CPT 2011	September 2014		<input type="checkbox"/>
9358X1	Percutaneous transcatheter septal reduction therapy (eg, alcohol septal ablation) including temporary pacemaker insertion when performed	January 2013	Percutaneous Alcohol Ablation of Septum	17	CPT 2014	September 2017		<input type="checkbox"/>
93982	Noninvasive physiologic study of implanted wireless pressure sensor in aneurysmal sac following endovascular repair, complete study including recording, analysis of pressure and waveform tracings, interpretation and report	Apr 2007	Wireless Pressure Sensor Implantation	25	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
94011	Measurement of spirometric forced expiratory flows in an infant or child through 2 years of age	Apr 2009	Infant Pulmonary Function Testing	23	CPT 2010	September 2013		<input type="checkbox"/>

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
94012	Measurement of spirometric forced expiratory flows, before and after bronchodilator, in an infant or child through 2 years of age	Apr 2009	Infant Pulmonary Function Testing	23	CPT 2010	September 2013		<input type="checkbox"/>
94013	Measurement of lung volumes (ie, functional residual capacity [FRC], forced vital capacity [FVC], and expiratory reserve volume [ERV]) in an infant or child through 2 years of age	Apr 2009	Infant Pulmonary Function Testing	23	CPT 2010	September 2013		<input type="checkbox"/>
95800	Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time	Apr 2010	Sleep Testing	28	CPT 2011	September 2014		<input type="checkbox"/>
95801	Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (eg, by airflow or peripheral arterial tone)	Apr 2010	Sleep Testing	28	CPT 2011	September 2014		<input type="checkbox"/>
95803	Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)	Apr 2008	Actigraphy Sleep Assessment	25	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
95806	Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow, and respiratory effort (eg, thoracoabdominal movement)	Apr 2010	Sleep Testing	28	CPT 2011	September 2014		<input type="checkbox"/>
95905	Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report	Feb 2009	Nerve Conduction Tests	18	CPT 2010	September 2013		<input type="checkbox"/>



<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
95940	Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure)	Jan 2012	Intraoperative Neurophysiology Monitoring	12	CPT 2013	September 2016	The RUC recommends that these services be reviewed in 3 years to review the number of times this service is reported together by the same physician on the same day once this utilization data is available.	<input type="checkbox"/>
95941	Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code for primary procedure)	Jan 2012	Intraoperative Neurophysiology Monitoring	12	CPT 2013	September 2016	The RUC recommends that these services be reviewed in 3 years to review the number of times this service is reported together by the same physician on the same day once this utilization data is available.	<input type="checkbox"/>
95980	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; intraoperative, with programming	Apr 2007	Electronic Analysis of Implanted Neurostimulator Pulse Generator System	I	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
95981	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, without reprogramming	Apr 2007	Electronic Analysis of Implanted Neurostimulator Pulse Generator System	I	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
95982	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, with reprogramming	Apr 2007	Electronic Analysis of Implanted Neurostimulator Pulse Generator System	I	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
96020	Neurofunctional testing selection and administration during noninvasive imaging functional brain mapping, with test administered entirely by a physician or other qualified health care professional (ie, psychologist), with review of test results and report	Feb 2006	Functional MRI	15	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
96904	Whole body integumentary photography, for monitoring of high risk patients with dysplastic nevus syndrome or a history of dysplastic nevi, or patients with a personal or familial history of melanoma	Feb 2006	Whole Body Integumentary Photography	19	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
98966	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	Apr 2007	Non Face-to-Face Qualified Healthcare Professional Services	U	CPT 2008	September 2011	Remove, not covered by Medicare	☑
98967	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion	Apr 2007	Non Face-to-Face Qualified Healthcare Professional Services	U	CPT 2008	September 2011	Remove, not covered by Medicare	☑

<i>CPT Code</i>	<i>2013 Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>Tab</i>	<i>CPT Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
98968	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion	Apr 2007	Non Face-to-Face Qualified Healthcare Professional Services	U	CPT 2008	September 2011	Remove, not covered by Medicare	<input checked="" type="checkbox"/>
99363	Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; initial 90 days of therapy (must include a minimum of 8 INR measurements)	Apr 2006	Anticoagulant Management Services	I	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
99364	Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; each subsequent 90 days of therapy (must include a minimum of 3 INR measurements)	Apr 2006	Anticoagulant Management Services	I	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	Feb 2007	Non Face-to-Face Services	16	CPT 2008	September 2011	Remove, not covered by Medicare	<input checked="" type="checkbox"/>

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
99442	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion	Feb 2007	Non Face-to-Face Services	16	CPT 2008	September 2011	Remove, not covered by Medicare	<input checked="" type="checkbox"/>
99443	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion	Feb 2007	Non Face-to-Face Services	16	CPT 2008	September 2011	Remove, not covered by Medicare	<input checked="" type="checkbox"/>
99487	Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with no face-to-face visit, per calendar month	Oct 2012	Complex Chronic Care Coordination Services	9	CPT 2013	September 2016		<input type="checkbox"/>
99488	Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with one face-to-face visit, per calendar month	Oct 2012	Complex Chronic Care Coordination Services	09	CPT 2013	September 2016		<input type="checkbox"/>
99489	Complex chronic care coordination services; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)	Oct 2012	Complex Chronic Care Coordination Services	9	CPT 2013	September 2016		<input type="checkbox"/>

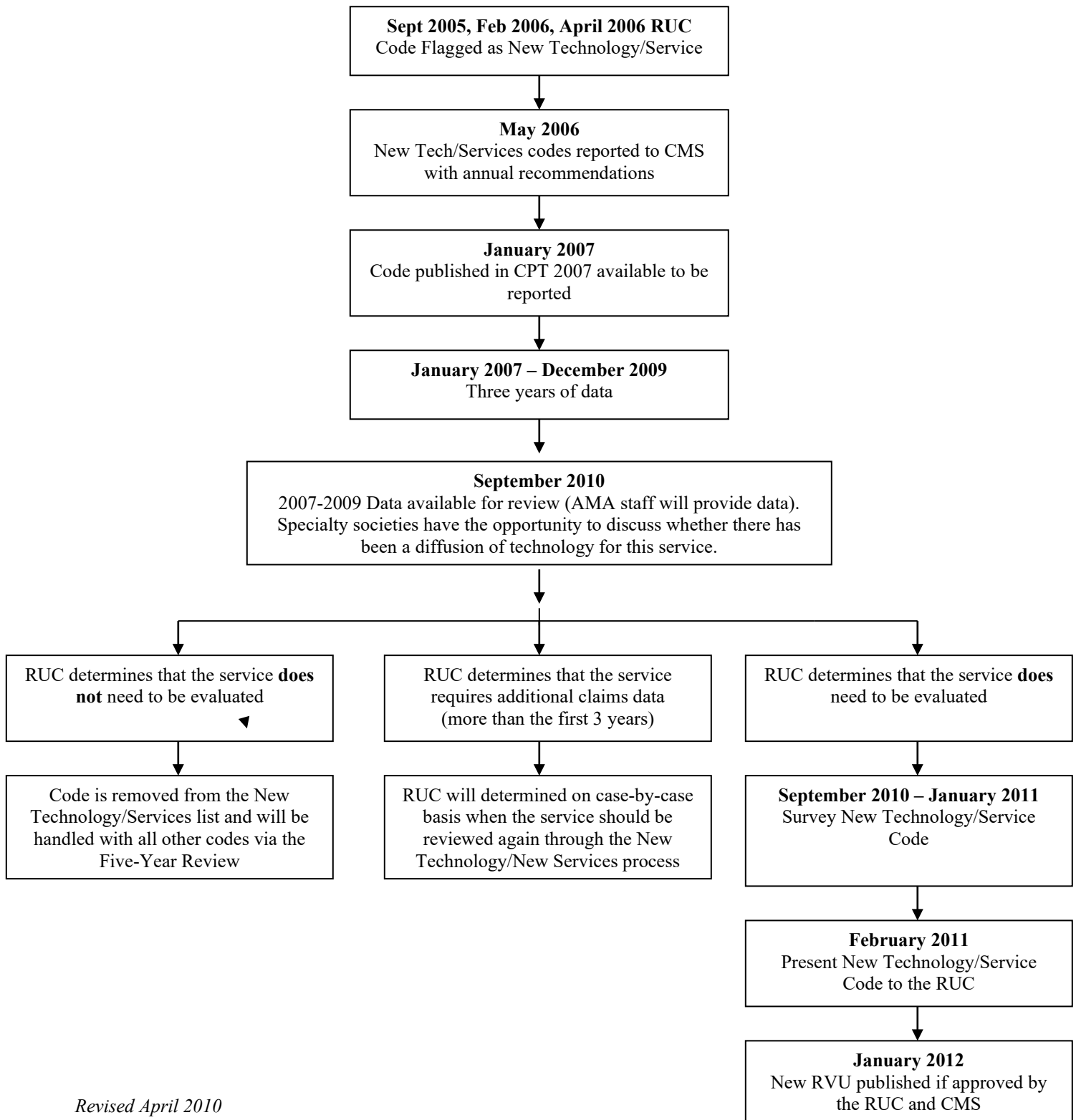
<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
99495	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of at least moderate complexity during the service period Face-to-face visit, within 14 calendar days of discharge	Oct 2012	Transitional Care Management Services	8	CPT 2013	September 2016		<input type="checkbox"/>
99496	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of high complexity during the service period Face-to-face visit, within 7 calendar days of discharge	Oct 2012	Transitional Care Management Services	08	CPT 2013	September 2016		<input type="checkbox"/>
994XX	Interprofessional telephone/internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician/qualified healthcare professional; 5-10 minutes of medical consultative discussion and review	Oct 2012	Interprofessional Telephone Consultative Services	14	CPT 2014	September 2017		<input type="checkbox"/>
994XX	Interprofessional telephone/internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician/qualified healthcare professional; 11-20 minutes of medical consultative discussion and review	Oct 2012	Interprofessional Telephone Consultative Services	14	CPT 2014	September 2017		<input type="checkbox"/>
994XX	Interprofessional telephone/internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician/qualified healthcare professional; 21-30 minutes of medical consultative discussion and review	Oct 2012	Interprofessional Telephone Consultative Services	14	CPT 2014	September 2017		<input type="checkbox"/>

<i><b>CPT Code</b></i>	<i><b>2013 Descriptor</b></i>	<i><b>RUC Meeting</b></i>	<i><b>Issue</b></i>	<i><b>Tab</b></i>	<i><b>CPT Year</b></i>	<i><b>Date to Re-Review</b></i>	<i><b>RUC Rec</b></i>	<i><b>Complete</b></i>
994XX	Interprofessional telephone/internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician/qualified healthcare professional; 31 or more minutes of medical consultative discussion and review	Oct 2012	Interprofessional Telephone Consultative Services	14	CPT 2014	September 2017		<input type="checkbox"/>

## New Technology/Services Timeline

1. Code is identified as a new technology/service at the RUC meeting in which it is initially reviewed.
2. Code is flagged in the next version of the RUC database with date to be reviewed
3. Code will be reviewed in 5 years (depending on what meeting in the CPT/RUC cycle it is initially reviewed) after at least three years of data are available.

### Example



AMA/Specialty Society RVS Update Committee Summary of Recommendations  
*Codes Reported Together 75% or More Screen*

January 2013

**Drainage of Abscess**

In January 2012, several codes describing the percutaneous drainage of abscesses were identified in the Codes reported together 75% or more screen, including 49021 *Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; percutaneous*, 49041 *Drainage of subdiaphragmatic or subphrenic abscess; percutaneous*, and 49061 *Drainage of retroperitoneal abscess; percutaneous* along with CPT code 75989 *Radiological guidance (ie, fluoroscopy, ultrasound, or computed tomography), for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision and interpretation*. In October 2012, the CPT Editorial Panel deleted nine codes and established four bundled codes to describe percutaneous image guided drainage of abscesses.

**10030 Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); soft tissue (eg, extremity, abdominal wall, neck), percutaneous**

The RUC reviewed the survey results from 65 radiologists and determined that a work RVU of 3.00, the survey 25<sup>th</sup> percentile appropriately accounts for the physician work required to perform this service. The committee reviewed CPT code 49083 *Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance* (work RVU=2.00) and determined that physician time and work of 10030 was greater. The RUC also reviewed 62267 *Percutaneous aspiration within the nucleus pulposus, intervertebral disc, or paravertebral tissue for diagnostic purposes* (work RVU=3.00) and determined that physician time and intensity were identical, and therefore, these two services should be valued the same. For additional support, the committee reviewed CPT codes 32557 *Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance* (work RVU=3.12) and agreed that these services were similar in physician work and intensity. In addition, the RUC reviewed 12016 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm* (work RVU=2.68) and MPC 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (work RVU=2.78) and agreed that 10030 required more physician work and complexity. **The RUC recommends a work RVU of 3.00, the survey 25<sup>th</sup> percentile for CPT code 10030.**

**49405 Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); visceral (eg, kidney, liver, spleen, lung/mediastinum), percutaneous**

The RUC reviewed the survey results from 53 radiologists and determined that a work RVU of 4.25, the survey 25<sup>th</sup> percentile appropriately accounts for the physician work and time required to perform this service. The committee noted that this service was previously reported using a combination of the following deleted CPT codes: 32201 *Pneumonostomy; with percutaneous drainage of abscess or cyst* (work RVU=3.99),



47011 *Hepatotomy; for percutaneous drainage of abscess or cyst, 1 or 2 stages* (work RVU=3.69), 48511 *External drainage, pseudocyst of pancreas; percutaneous* (work RVU=3.99), and 50021 *Drainage of perirenal or renal abscess; percutaneous* (work RVU=3.37), along with 75989 *Radiological guidance (ie, fluoroscopy, ultrasound, or computed tomography), for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision and interpretation* (work RVU=1.19). The proposed work RVU of 4.25 is much lower than the previous work RVUs. In addition, the committee noted that patients described by 49405, 49406 and 49407 are sicker and more complex patients with deep abscesses. The committee reviewed CPT code 49418 *Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous* (work RVU=4.21) and MPC codes 11044 *Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less* (work RVU=4.10) and 15004 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children* (work RVU=4.58) and determined that physician work and intensity are similar. **The RUC recommends a work RVU of 4.25, the survey 25<sup>th</sup> percentile for CPT code 49405.**

**49406 *Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, percutaneous***

The RUC reviewed the survey results from 54 radiologists and determined that a work RVU of 4.25, which is slightly below the survey 25<sup>th</sup> percentile appropriately accounts for the physician work and time required to perform this service. The specialty societies confirmed that the physician work and time of 49405 and 49406 is identical and therefore the work RVU should be identical. The committee noted that this service was previously reported using a combination of 49021 *Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; percutaneous* (work RVU=3.37), 49041 *Drainage of subdiaphragmatic or subphrenic abscess; percutaneous* (work RVU=3.99) and 49061 *Drainage of retroperitoneal abscess; percutaneous* (work RVU=3.69) along with 75989 *Radiological guidance (ie, fluoroscopy, ultrasound, or computed tomography), for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision and interpretation* (work RVU=1.19). The proposed work RVU of 4.25 is much lower than the previous work RVUs. In addition, the committee noted that patients described by 49405, 49406 and 49407 are sicker and more complex patients with deep abscesses. The committee reviewed CPT code 49418 *Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous* (work RVU=4.21) and MPC codes 11044 *Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less* (work RVU=4.10) and 15004 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children* (work RVU=4.58) and determined that physician work and intensity are similar. **The RUC recommends a work RVU of 4.25 for CPT code 49406.**

**49407 Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, transvaginal or transrectal**

The RUC reviewed the survey results from 51 radiologists and determined that a work RVU of 4.50, the survey 25<sup>th</sup> percentile appropriately accounts for the physician work and time required to perform this service. There was consensus among the members that this procedure should be valued higher due to the complexity and intensity of transrectal and transvaginal abscesses. The committee noted that this service was previously reported by 58823 *Drainage of pelvic abscess, transvaginal or transrectal approach, percutaneous (eg, ovarian, pericolic)* (Work RVU=3.37), along with 75989 *Radiological guidance (ie, fluoroscopy, ultrasound, or computed tomography), for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision and interpretation* (work RVU=1.19). In addition, the committee noted that patients described by 49405, 49406 and 49407 are sicker and more complex patients with deep abscesses. The committee reviewed CPT code 49418 *Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous* (work RVU=4.21) and MPC codes 11044 *Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less* (work RVU=4.10) and 15004 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children* (work RVU=4.58) and determined that physician work and intensity are similar. **The RUC recommends a work RVU of 4.50 for CPT code 49407.**

**Practice Expense:**

The practice expense (PE) standard for monitoring after moderate sedation is 15 minutes of RN time per 1 hour of monitoring. The specialty societies' recommendation of 60 minutes for this clinical staff activity indicates 4 hours of monitoring. The PE subcommittee determined that 4 hours of monitoring was not appropriate and that the typical time for recovery after moderate sedation for these services is 2 hours. The PE spreadsheet now reflects 30 minutes of RN time for 2 hours of monitoring. The RUC accepted the direct PE inputs for all codes with minor modifications as recommended by the PE Subcommittee.

**Work Neutrality**

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

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
☉● 10030	N1	<p>Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); soft tissue (eg, extremity, abdominal wall, neck), percutaneous</p> <p><u>(Report 10030 for each individual collection drained with a separate catheter)</u></p> <p><u>(Do not report 10030 in conjunction with 75989, 76942, 77002, 77003, 77012, 77021)</u></p> <p><u>(For image-guided fluid collection drainage, percutaneous or transvaginal/transrectal of visceral, peritoneal or retroperitoneal collections see 49405-49407)</u></p>	000	3.00
●☉49405	N2	<p>visceral (eg, kidney, liver, spleen, lung/mediastinum), percutaneous</p> <p><u>(Do not report 49405 in conjunction with 75989, 76942, 77002, 77003, 77012, 77021)</u></p> <p><u>(For percutaneous cholecystostomy, use 47490)</u></p> <p><u>(For pneumonostomy, use 32200)</u></p> <p><u>(For thoracentesis, see 32554, 32555)</u></p> <p><u>(For pleural drainage, see 32556, 32557)</u></p> <p><u>(For open drainage, see 32200, 47010, and 48510)</u></p>	000	4.25

●◎49406	N3	<p>peritoneal or retroperitoneal, percutaneous</p> <p><u>(Do not report 49406 in conjunction with 75989, 76942, 77002, 77003, 77012, 77021)</u></p> <p><u>(For abdominal paracentesis [diagnostic or therapeutic], see 49082, 49083)</u></p> <p><u>(For open drainage see 44900, 49020, 49040, 49060, 50020, 58805, and 58822)</u></p> <p><u>(For peritoneal lavage or paracentesis, see 49082, 49083, and 49084)</u></p> <p><u>(For percutaneous insertion of a tunneled intraperitoneal catheter without subcutaneous port, use 49418)</u></p>	000	4.25
●◎49407	N4	<p>peritoneal or retroperitoneal, transvaginal or transrectal</p> <p><u>(Do not report 49407 in conjunction with 75989, 76942, 77002, 77003, 77012, 77021)</u></p> <p><u>(Report 49405, 49406, 49407 separately for each individual collection drained with a separate catheter)</u></p> <p><u>(For thoracentesis, see 32554, 32555)</u></p> <p><u>(For pleural drainage, see 32556, 32557)</u></p> <p><u>(For open drainage, see 45000, 58800, and 58820)</u></p> <p><u>(For percutaneous image-guided fluid collection drainage by catheter [eg, abscess, hematoma, seroma, lymphocele, cyst] for soft-tissue [eg, extremity, abdominal wall, neck], use 10030)</u></p> <p><u>(For open or percutaneous peritoneal drainage or lavage, see 49020, 49040, 49082, as appropriate)</u></p>	000	4.50

(For percutaneous image-guided fluid collection drainage by catheter of soft-tissue [eg, extremity, abdominal wall, neck], use 10030)

10021            Fine needle aspiration; without imaging guidance

**Surgery**

**Digestive System**

**Rectum**

**Incision**

45000            Transrectal drainage of pelvic abscess

(For percutaneous transrectal image-guided fluid collection drainage by catheter of **pelvic abscess**, use 49407)

**Surgery**

**Urinary System**

**Bladder**

**Incision**

51080            Drainage of perivesical or prevesical space abscess

(For percutaneous image-guided fluid collection drainage by catheter of **perivesicular or perivesicular space abscess**, use 49406)

**Radiology**

**Diagnostic Radiology (Diagnostic Imaging)**

**Vascular Procedures**

**Transcatheter Procedures**

75989            Radiological guidance (ie, fluoroscopy, ultrasound, or computed tomography), for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision and interpretation

(Do not report 75989 in conjunction with 47490, 10030, 49405, 49406, 49407)

<b>Surgery</b> <b>Respiratory System</b> <b>Lungs and Pleura</b> <b>Incision</b> 32200                      Pneumonostomy; with open drainage of abscess or cyst				
D⊙32201		<del>with percutaneous drainage of abscess or cyst</del> (32201 has been deleted) (For percutaneous image-guided drainage of catheter of abscess or cyst of lungs, pleura or mediastinum, use 49405) (For radiological supervision and interpretation, use 75989)	000	N/A
<b>Surgery</b> <b>Digestive System</b> <b>Appendix</b> <b>Incision</b>				
D⊙44901		<del>Incision and drainage of appendiceal abscess; percutaneous</del> (44901 has been deleted) (For percutaneous image-guided <b>drainage by catheter or appendiceal abscess</b> , use 49406) (For radiological supervision and interpretation, use 75989)	000	N/A
<b>Surgery</b> <b>Digestive System</b> <b>Liver</b> <b>Incision</b>				

D⊙47011		<del>Hepatotomy; for percutaneous drainage of abscess or cyst, 1 or 2 stages</del> <del>(47011 has been deleted)</del> <del>(For percutaneous image-guided fluid collection drainage by catheter of hepatic abscess or cyst, use 49405)</del> <del>(For radiological supervision and interpretation, use 75989)</del>	000	N/A
<b>Surgery</b> <b>Digestive System</b> <b>Pancreas</b> <b>Repair</b>				
D⊙48511		<del>External drainage, pseudocyst of pancreas; percutaneous</del> <del>(48511 has been deleted)</del> <del>(For percutaneous image-guided fluid collection drainage by catheter of pancreatic pseudocyst, use 49405)</del> <del>(For radiological supervision and interpretation, use 75989)</del>	000	N/A
<b>Surgery</b> <b>Digestive System</b> <b>Abdomen, Peritoneum, and Omentum</b> <del>Incision</del> <b>Introduction, Revision, Removal</b>				
D⊙49021		<del>Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; percutaneous</del> <del>(49021 has been deleted)</del> <del>(For percutaneous image-guided fluid collection drainage by catheter of peritoneal abscess or localized peritonitis, use 49406)</del> <del>(For radiological supervision and interpretation, use 75989)</del>	000	N/A

D⊙49041		<del>Drainage of subdiaphragmatic or subphrenic abscess; percutaneous</del> <del>(49041 has been deleted)</del> <u>(For percutaneous image-guided fluid collection drainage by catheter of peritoneal abscess or localized peritonitis, use 49406)</u> <del>(For radiological supervision and interpretation, use 75989)</del>	000	N/A
D⊙49061		<del>Drainage of retroperitoneal abscess; percutaneous</del> <del>(49061 has been deleted)</del> <u>(For percutaneous image-guided fluid collection drainage by catheter of peritoneal abscess or localized peritonitis, use 49406)</u> <del>(For laparoscopic drainage, use 49323)</del> <del>(For radiological supervision and interpretation, use 75989)</del>	000	N/A
<b>Surgery</b> <b>Digestive System</b> <b>Abdomen, Peritoneum, and Omentum</b> <b>Laparoscopy</b> 49323 <i>with drainage of lymphocele to peritoneal cavity</i> (For <del>percutaneous</del> or open drainage, <del>see</del> <u>use</u> 4906049061)				



**Introduction, Revision, Removal**

49419      *Insertion of tunneled intraperitoneal catheter, with subcutaneous port (ie, totally implantable)*  
(For removal, use 49422)

(49420 has been deleted. To report open placement of a tunneled intraperitoneal catheter for dialysis, use 49421. To report open or percutaneous peritoneal drainage or lavage, see 49406, 49020, ~~49021~~, 49040, ~~49041~~, 49082-49084, as appropriate. To report percutaneous insertion of a tunneled intraperitoneal catheter without subcutaneous port, use 49418)

**Surgery****Urinary System****Kidney****Incision**

D◎50021		<del>Drainage of perirenal or renal abscess; percutaneous</del> (For radiological supervision and interpretation, use 75989) (50021 has been deleted) (For percutaneous image-guided fluid collection drainage by catheter of perirenal/renal abscess, use 49405)	000	N/A
---------	--	--	-----	-----

**Surgery****Female Genital System****Ovary****Incision**

D◎58823		<del>Drainage of pelvic abscess, transvaginal or transrectal approach, percutaneous (eg, ovarian, pericolic)</del> (58823 has been deleted) (For percutaneous transrectal image-guided fluid collection drainage by catheter of pelvic abscess, use 49407)	000	N/A
---------	--	--	-----	-----

## AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 10030      Tracking Number N1      Original Specialty Recommended RVU: **3.00**  
 Presented Recommended RVU: **3.00**  
 Global Period: 000      RUC Recommended RVU: **3.00**

CPT Descriptor: Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); soft tissue (eg, extremity, abdominal wall, neck), percutaneous

### CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 74-year-old female's status is post abdominal wall hernia repair febrile with an abdominal wall fluid collection on computed tomography. Percutaneous drainage using imaging guidance is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

### Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

### Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 83%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 65%

### Description of Pre-Service Work:

- The medical records and previous imaging and lab studies are reviewed and a decision made on appropriate guidance method(s) and the safest percutaneous route to the collection
- Discuss procedure details, including alternatives and risks with the patient and family and informed consent is reviewed
- Estimate the range of devices that may be required and ensure all are available for use
- Ensure all technical personnel have been familiarized with the procedure and are fully familiar with all required devices
- A brief history and physical examination is performed including suitability for moderate sedation
- Personnel don radiation attire, if required
- Surgical time out performed
- The patient is placed in an appropriate position in the imaging suite
- Patient is given intravenous moderate sedation
- The collection is localized under appropriate imaging guidance (e.g., CT, ultrasound, fluoroscopy or MR). Repositioning may be necessary
- The skin is prepped and draped
- Subcutaneous and deep lidocaine is administered to anesthetize skin and deep structures

### Description of Intra-Service Work:

- The subcutaneous collection is accessed with a needle using appropriate imaging guidance
- Fluid is aspirated and sent for laboratory analysis (e.g., microbiology, chemistry, cell count, etc)
- A small amount of contrast is injected to confirm access into the targeted collection
- A guidewire is passed into the collection and repeat imaging performed
- The tract is serially dilated to the necessary size

- A drainage catheter is advanced into the collection and imaging (which may involve contrast injection) is performed to verify proper position in the collection
- The catheter is secured in place with a suture
- The drainage catheter is connected to a drainage system (e.g., suction, gravity)

Description of Post-Service Work:

- The images are reviewed
- The patient is sent to recovery and patient care orders written
- Education is provided to nursing staff, family members and patient on maintaining and caring for catheter
- Post-procedure vital signs are assessed
- A formal report of the procedure is dictated into the permanent medical record
- The results and further management are discussed with the patient and their family, as well as the requesting physician
- The procedure report is reviewed and signed

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)		01/2013				
Presenter(s):	Zeke Silva, MD; Sean Tutton, MD; Michael Hall, MD; Robert Vogelzang, MD; Jerry Niedzwiecki, MD					
Specialty(s):	American College of Radiology, Society of Interventional Radiology					
CPT Code:	10030					
Sample Size:	925	Resp N:	65	Response: 7.0 %		
Description of Sample:	700 ACR members and 225 SIR members were randomly selected					
		Low	25 <sup>th</sup> pctl	Median*	75 <sup>th</sup> pctl	High
Service Performance Rate		3.00	12.00	25.00	50.00	200.00
Survey RVW:		1.89	3.00	4.00	4.50	6.00
Pre-Service Evaluation Time:				35.00		
Pre-Service Positioning Time:				10.00		
Pre-Service Scrub, Dress, Wait Time:				10.00		
Intra-Service Time:		5.00	20.00	30.00	45.00	60.00
Immediate Post Service-Time:	20.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00				
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00				
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00				
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00				
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00				
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00				

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1b-FAC Straightforw Pat Procedure(w sedate/anes)

CPT Code:	10030	Recommended Physician Work RVU: 3.00			
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:		21.00	19.00	2.00	
Pre-Service Positioning Time:		5.00	1.00	4.00	
Pre-Service Scrub, Dress, Wait Time:		5.00	5.00	0.00	
Intra-Service Time:		30.00			
Immediate Post Service-Time:	20.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	0.00	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	0.00	99224x 0.00	99225x 0.00	99226x 0.00	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
49083	000	2.00	RUC Time

CPT Descriptor Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
31622	000	2.78	RUC Time	83,622

CPT Descriptor 1 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
15002	000	3.65	RUC Time	15,981

CPT Descriptor 2 Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
---------------------------------	---------------	-----------------	--------------------

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 14      % of respondents: 21.5 %

**TIME ESTIMATES (Median)**

	<u>CPT Code:</u> <b>10030</b>	<u>Key Reference CPT Code:</u> <b>49083</b>	<u>Source of Time</u> <b>RUC Time</b>
Median Pre-Service Time	31.00	25.00	
Median Intra-Service Time	30.00	25.00	
Median Immediate Post-service Time	20.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>81.00</b>	<b>60.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.64	2.21
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.64	2.21
--	------	------

Urgency of medical decision making	2.71	2.21
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.71	2.29
--------------------------	------	------

Physical effort required	2.50	2.21
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.57	2.21
---	------	------

Outcome depends on the skill and judgment of physician	2.64	2.21
--	------	------

Estimated risk of malpractice suit with poor outcome	2.36	2.21
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.36	2.14
----------------------------------	------	------

Intra-Service intensity/complexity	2.79	2.36
------------------------------------	------	------

Post-Service intensity/complexity	2.29	2.14
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**

Several codes describing the percutaneous drainage of abscesses were identified by the “Codes reported together 75% or more” RAW screen. This included the following combinations 49021 (*Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; percutaneous*), 49041 (*Drainage of subdiaphragmatic or subphrenic abscess; percutaneous*), and 49061 (*Drainage of retroperitoneal abscess; percutaneous*), along with S&I code 75989 (*Radiological guidance (ie, fluoroscopy, ultrasound, or computed tomography), for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision and interpretation*). To improve the reporting of these procedures, the CPT Editorial Panel created a family of four bundled codes to describe percutaneous image guided drainage of abscesses. The base surgical codes encompassing these new bundled codes will be deleted.

CPT code 10030 (*Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); soft tissue (eg, extremity, abdominal wall, neck), percutaneous*) describes image guided catheter drainage of abscesses or other fluid collections in the subcutaneous and deep tissues. No code is currently available to describe the percutaneous drainage of a superficial fluid collection.

The American College of Radiology and Society of Interventional Radiology surveyed the new family of abscess drainage codes, including CPT code 10030, in November and December 2012, and convened an expert panel of physicians familiar with these services to review the survey data.

### Work RVU Recommendation

The expert panel recommends the 25<sup>th</sup> percentile work RVU of 3.00.

### Pre-Service Time

The panel recommends pre-service package 2B (*Difficult Patient/Straightforward Procedure (With sedation/anesthesia care)*) with the following adjustments: pre-service evaluation time is increased by 2 minutes and pre-service positioning time is increased by 4 minutes to conform to the survey results and account for time prior to skin prep used for US localization of the abscess. Based on the survey instrument, it is reasonable to conclude respondents would consider imaging work prior to skin prep to be pre-service work, and this is consistent with the recently reviewed paracentesis and thoracentesis codes.

### Intra and Post-Service Times

The panel recommends the median intra and post service times for code 10030: 30 minutes and 20 minutes, respectively.

### Comparison to Key Reference Service

The most commonly selected key reference service was CPT code 49083 (*Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance*), which has 2.00 work RVUs and pre, intra, and post service times of 25, 25, and 10 minutes, respectively. CPT code 10030 has longer survey times and greater surveyed complexity (on all 11 measures) than the key reference service. While both of these procedures involve introduction of a catheter using imaging guidance, the greater complexity of the patients and increased skill required for the performance of code 10030 is manifest in the survey responses.

Code	RVU	Pre	Intra	Post	Total	IWPUT
10030	3.00	45	30	20	95	0.054
49083	2.00	25	25	10	60	0.052

### MPC Comparison

The panel recommendation of 3.00 RVUs for 10030 is bracketed by two MPC 0-day global codes: 31622 (*Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)*) and 15002 (*Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children*). 10030 has a higher RVU than 31622, with 30 minutes more total time. 10030 has greater intra-service time than 15002 and slightly less total time.

Code	RVU	Pre	Intra	Post	Total	IWPUT
31622	2.78	20	30	15	65	0.069
10030	3.00	45	30	20	95	0.054
15002	3.65	75	20	20	115	0.087

### Comparison Within Family

Given the lack of a historical standard from which to judge the surveyed values for 10030, comparison with the recommendations for the remainder of the abscess drainage code family provides a context for the current recommendations. The expert panel believes the IWPUT values across the family are appropriate since a superficial drainage would be expected to be less complex than the greater complexity of patients requiring drainage of solid organ (49405) or retroperitoneal (49406) abscesses. Transrectal and transvaginal abscesses should fall closer to solid organ and retroperitoneal abscesses in intensity.

Codes in Family	Recommended RVUs	Pre Time	Intra Time	Post Time	Total Time	IWPUT
10030	3.00	45	30	20	95	0.054
49405	4.28	45	40	20	105	0.072
49406	4.28	45	40	20	105	0.072
49407	4.50	45	45	20	110	0.069

---

### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

---

### FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) N/A



How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
 If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology                      How often? Commonly

Specialty Interventional Radiology                      How often? Commonly

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. An estimate for the number of times this service is performed nationally in a one-year period is unknown.

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. An estimate for the number of times this service is provided to Medicare patients nationally in a one-year period is unknown.

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 37200

## AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 49405	Tracking Number N2	Original Specialty Recommended RVU: <b>4.28</b>
		Presented Recommended RVU: <b>4.28</b>
Global Period: 000		RUC Recommended RVU: <b>4.25</b>

CPT Descriptor: Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); visceral (eg, kidney, liver, spleen, lung/mediastinum), percutaneous

### CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year-old male with history of diverticulitis now intubated and septic in the intensive care unit on pressor support. CT scan shows a low density collection in segment 5 of the liver. Percutaneous drainage using imaging guidance is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

#### Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

#### Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 94%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 76%

#### Description of Pre-Service Work:

- The medical records and previous imaging and lab studies are reviewed and a decision made on appropriate guidance method(s) and the safest percutaneous route to the collection
- Discuss procedure details, including alternatives and risks with the patient and family and informed consent is reviewed
- Estimate the range of devices that may be required and ensure all are available for use
- Ensure all technical personnel have been familiarized with the procedure and are fully familiar with all required devices
- A brief history and physical examination is performed including suitability for moderate sedation
- Personnel don radiation attire, if required
- Surgical time out performed

#### Description of Intra-Service Work:

- The patient is placed in an appropriate position in the imaging suite
- Patient is given intravenous moderate sedation
- The collection is localized under appropriate imaging guidance (e.g., CT, ultrasound, fluoroscopy or MR). Repositioning may be necessary
- The skin is prepped and draped
- Subcutaneous and deep lidocaine is administered to anesthetize skin and deep structures
- The visceral collection is accessed with a needle using appropriate imaging guidance
- Fluid is aspirated and sent for laboratory analysis (e.g., microbiology, chemistry, cell count, etc)
- A small amount of contrast is injected to confirm access into the targeted collection

- A guidewire is passed into the collection and repeat imaging performed
- The tract is serially dilated to the necessary size
- A drainage catheter is advanced into the collection and imaging (which may involve contrast injection) is performed to verify proper position in the collection
- The catheter is secured in place with a suture
- The drainage catheter is connected to a drainage system (e.g., suction, gravity)
- The patient is sent to recovery and patient care orders written

Description of Post-Service Work:

- The images are reviewed
- The patient is sent to recovery and patient care orders written
- Post-procedure vital signs are assessed
- A formal report of the procedure is dictated into the permanent medical record
- The results and further management are discussed with the patient and their family, as well as the requesting physician
- The procedure report is reviewed and signed

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)		01/2013				
Presenter(s):	Zeke Silva, MD; Sean Tutton, MD; Michael Hall, MD; Robert Vogelzang, MD; Jerry Niedzwiecki, MD					
Specialty(s):	American College of Radiology, Society of Interventional Radiology					
CPT Code:	49405					
Sample Size:	925	Resp N:	53	Response: 5.7 %		
Description of Sample:	700 ACR and 225 SIR members were randomly selected.					
		Low	25 <sup>th</sup> pctl	Median*	75 <sup>th</sup> pctl	High
Service Performance Rate		0.00	12.00	25.00	40.00	200.00
Survey RVW:		3.00	4.25	4.80	5.50	9.00
Pre-Service Evaluation Time:				40.00		
Pre-Service Positioning Time:				10.00		
Pre-Service Scrub, Dress, Wait Time:				10.00		
Intra-Service Time:		20.00	30.00	40.00	59.00	90.00
Immediate Post Service-Time:	20.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00		
Discharge Day Mgmt:	0.00	99238x 0.00	99239x 0.00	99217x 0.00		
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00	15x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00	
Sub Obs Care:	0.00	99224x 0.00	99225x 0.00	99226x 0.00		

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	49405	<b>Recommended Physician Work RVU: 4.25</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		35.00	33.00	2.00
<b>Pre-Service Positioning Time:</b>		5.00	1.00	4.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00
<b>Intra-Service Time:</b>		40.00		
<b>Immediate Post Service-Time:</b>	20.00			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	0.00	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	0.00	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	0.00	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	0.00	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	0.00	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	0.00	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
49418	000	4.21	RUC Time

CPT Descriptor Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
11044	000	4.10	RUC Time	53,852

CPT Descriptor 1 Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
15004	000	4.58	RUC Time	19,876

CPT Descriptor 2 Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
---------------------------------	---------------	-----------------	--------------------

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 20      % of respondents: 37.7 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 49405</b>	<b>Key Reference CPT Code: 49418</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	45.00	44.00	
Median Intra-Service Time	40.00	40.00	
Median Immediate Post-service Time	20.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>105.00</b>	<b>104.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.80	3.25
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.85	3.50
--	------	------

Urgency of medical decision making	4.00	3.30
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.80	3.50
--------------------------	------	------

Physical effort required	3.50	3.45
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.00	3.50
---	------	------

Outcome depends on the skill and judgment of physician	4.05	3.55
--	------	------

Estimated risk of malpractice suit with poor outcome	3.75	3.35
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.65	3.50
----------------------------------	------	------

Intra-Service intensity/complexity	3.70	3.55
------------------------------------	------	------

Post-Service intensity/complexity	3.40	3.25
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

## Background

Several codes describing the percutaneous drainage of abscesses were identified by the “Codes reported together 75% or more” RAW screen. This included the following combinations 49021 (*Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; percutaneous*), 49041 (*Drainage of subdiaphragmatic or subphrenic abscess; percutaneous*), and 49061 (*Drainage of retroperitoneal abscess; percutaneous*), along with S&I code 75989 (*Radiological guidance (ie, fluoroscopy, ultrasound, or computed tomography), for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision and interpretation*). To improve the reporting of these procedures, the CPT Editorial Panel created a family of four bundled codes to describe percutaneous image guided drainage of abscesses. The base surgical codes encompassing these new bundled codes will be deleted.

CPT code 49405 (*Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); visceral (eg, kidney, liver, spleen, lung/mediastinum), percutaneous*) describes image guided catheter drainage of abscesses or other fluid collections involving visceral organs such as the liver. This new code replaces several codes previously employed to describe the drainage of a visceral fluid collection, including 50021 (*Drainage of perirenal or renal abscess; percutaneous*), 47011 (*Hepatotomy; for percutaneous drainage of abscess or cyst, 1 or 2 stages*), 48511 (*External drainage, pseudocyst of pancreas; percutaneous*), and 32201 (*Pneumonostomy; with percutaneous drainage of abscess or cyst*). When image guidance is utilized, these codes are reported with code 75989 (*Radiological guidance (ie, fluoroscopy, ultrasound, or computed tomography), for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision and interpretation*).

The American College of Radiology and Society of Interventional Radiology surveyed the new family of abscess drainage codes, including CPT code 49405, in November and December 2012, and convened an expert panel of physicians familiar with these services to review the survey data.

## Work RVU Recommendation

The expert panel recommends a work value of 4.28 RVUs, which is the same as our recommendation for 49406, and very near the 25<sup>th</sup> percentile. This is below the current value.

## Pre-Service Time

The panel recommends pre-service package 2B (*Difficult Patient/Straightforward Procedure (With sedation/anesthesia care)*) with the following adjustments: pre-service evaluation time is increased by 2 minutes and pre-service positioning time is increased by 4 minutes to conform to the survey result and account for time prior to skin prep used for CT localization of the visceral abscess. Based on the survey instrument it is reasonable to conclude respondents would consider imaging work prior to skin prep to be pre-service work and this is consistent with the recently reviewed paracentesis and thoracentesis codes.

## Intra and Post-Service Times

The panel recommends the median intra and post service times for code 49405: 40 minutes and 20 minutes, respectively.

## Comparison to Key Reference Service

The most commonly selected key reference service was CPT code 49418 (*Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous*), which has 4.21 work RVUs and pre, intra, and post service times of 44, 40, and 20 minutes, respectively. 49405 has longer survey times and greater surveyed complexity (on all 11 measures) than the key reference service. Both of these procedures involve introduction of a catheter using imaging guidance, and have nearly identical service period and total times.

The slightly higher RVU for 49405 is justified by the greater complexity of the patients and increased skill required for the performance of code 49405.

Code	RVU	Pre	Intra	Post	Total	IWPUT
49405	4.28	45	40	20	105	0.072
49418	4.21	44	40	20	104	0.071

### MPC Comparison

The panel recommendation of 4.28 RVUs compares favorably to, and is bracketed by, MPC codes 11044 (*Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less*) and 15004 (*Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children*). 49405 has a similar intra-service time to both of these codes and is slightly higher in RVU than 11044 and slightly lower than 15004.

Code	RVU	Pre	Intra	Post	Total	IWPUT
11044	4.10	51	45	20	116	0.061
49405	4.28	45	40	20	105	0.072
15004	4.58	75	45	30	150	0.054

### Building Block Methodology

This is a new CPT code describing an existing service that previously was coded using multiple different codes, including 50021 (*Drainage of perirenal or renal abscess; percutaneous*), 47011 (*Hepatotomy; for percutaneous drainage of abscess or cyst, 1 or 2 stages*), 48511 (*External drainage, pseudocyst of pancreas; percutaneous*), and 32201 (*Pneumonostomy; with percutaneous drainage of abscess or cyst*). The use of these codes with the corresponding radiologic supervision and interpretation code, 75989, allow for direct comparison to the surveyed values. When combined with CPT code 75989 (*Radiological guidance (ie, fluoroscopy, ultrasound, or computed tomography), for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision*), these codes form a range of reference points for consideration of CPT code 49405.

50021 (3.37 RVUs) + 75989 (1.19 RVUs) = 4.56 RVUs.

47011 (3.69 RVUs) + 75989 (1.19 RVUs) = 4.88 RVUs.

48511 (3.99 RVUs) + 75989 (1.19 RVUs) = 5.18 RVUs.

32201 (3.99 RVUs) + 75989 (1.19 RVUs) = 5.18 RVUs.

### Comparison Within Family

The data summarized in the table below demonstrate the accurate relative work involved in the procedures surveyed within the abscess code family. While the survey times increase throughout the code family, the IWPUT across the different codes appropriately reflects the differences in intensity related to treating the varying complexity of patients requiring drainage of superficial (10030), solid organ (49405), retroperitoneal (49406), and deep pelvic abscesses (49407). The expert panel believes the IWPUT values across the family are appropriate since a superficial drainage would be expected to be less complex than the greater complexity of patients requiring drainage of solid organ (49405) or retroperitoneal (49406) abscesses. Transrectal and transvaginal abscesses should fall closer to solid organ and retroperitoneal abscesses in intensity.

Codes in Family	Recommended RVUs	Pre Time	Intra Time	Post Time	Total Time	IWPUT
-----------------	------------------	----------	------------	-----------	------------	-------



10030	3.00	45	30	20	95	0.054
49405	4.28	45	40	20	105	0.072
49406	4.28	45	40	20	105	0.072
49407	4.50	45	45	20	110	0.069

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 32201, 48511, 47011, 50021, 75989

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology                      How often? Commonly

Specialty Interventional Radiology                      How often? Commonly

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 14364

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on the number of times this service might be provided to Medicare patients nationally in a one-year period, it is estimated that 4900X2 might be provided 14,364 times nationally in a one-year period.

Specialty Diagnostic Radiology                      Frequency 11490                      Percentage 79.99 %

Specialty Interventional Radiology                      Frequency 2330                      Percentage 16.22 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 4,788

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The estimated frequency for Medicare patients is 4,788, which is the 2012 Medicare utilization frequency for codes 32201, 48511, 47011, and 50021. Based on past frequency data, we estimated the percent performed by Radiology to be about 79.99%, and by Interventional Radionolgy about 16.22%.

Specialty Diagnostic Radiology	Frequency 3830	Percentage 79.99 %
Specialty Interventional Radiology	Frequency 777	Percentage 16.22 %
Specialty	Frequency 0	Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

### **Professional Liability Insurance Information (PLI)**

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 37200

## AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 49406      Tracking Number N3      Original Specialty Recommended RVU: **4.28**  
 Presented Recommended RVU: **4.28**  
 Global Period: 000      RUC Recommended RVU: **4.25**

CPT Descriptor: Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, percutaneous

### CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 64-year-old female is status-post right colectomy now febrile with an elevated white blood cell count. CT scan shows a low density collection in the lesser sac with an enhancing rim. Percutaneous drainage using imaging guidance is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

### Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

### Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 94%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 78%

### Description of Pre-Service Work:

- The medical records and previous imaging and lab studies are reviewed and a decision made on appropriate guidance method(s) and the safest percutaneous route to the collection
- Discuss procedure details, including alternatives and risks with the patient and family and informed consent is reviewed
- Estimate the range of devices that may be required and ensure all are available for use
- Ensure all technical personnel have been familiarized with the procedure and are fully familiar with all required devices
- A brief history and physical examination is performed including suitability for moderate sedation
- Personnel don radiation attire, if required
- Surgical time out performedThe patient is placed in an appropriate position in the imaging suite
- Patient is given intravenous moderate sedation
- The collection is localized under appropriate imaging guidance (e.g., CT, ultrasound, fluoroscopy or MR). Repositioning may be necessary
- The skin is prepped and draped

### Description of Intra-Service Work:

- Subcutaneous and deep lidocaine is administered to anesthetize skin and deep structures
- The peritoneal or retroperitoneal collection is accessed with a needle using appropriate imaging guidance
- Fluid is aspirated and sent for laboratory analysis (e.g., microbiology, chemistry, cell count, etc)
- A small amount of contrast is injected to confirm access into the targeted collection
- A guidewire is passed into the collection and repeat imaging performed
- The tract is serially dilated to the necessary size

- A drainage catheter is advanced into the collection and imaging (which may involve contrast injection) is performed to verify proper position in the collection
- The catheter is secured in place with a suture
- The drainage catheter is connected to a drainage system (e.g., suction, gravity)
- The patient is sent to recovery and patient care orders written

Description of Post-Service Work:

- The images are reviewed
- The patient is sent to recovery and patient care orders written
- Post-procedure vital signs are assessed
- A formal report of the procedure is dictated into the permanent medical record
- The results and further management are discussed with the patient and their family, as well as the requesting physician
- The procedure report is reviewed and signed

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		01/2013				
<b>Presenter(s):</b>	Zeke Silva, MD; Sean Tutton, MD; Michael Hall, MD; Robert Vogelzang, MD; Jerry Niedzwiecki, MD					
<b>Specialty(s):</b>	American College of Radiology, Society of Interventional Radiology					
<b>CPT Code:</b>	49406					
<b>Sample Size:</b>	925	<b>Resp N:</b>	54	<b>Response:</b> 5.8 %		
<b>Description of Sample:</b>	700 ACR and 225 SIR members were randomly selected					
		<b><u>Low</u></b>	<b><u>25<sup>th</sup> pctl</u></b>	<b><u>Median*</u></b>	<b><u>75<sup>th</sup> pctl</u></b>	<b><u>High</u></b>
<b>Service Performance Rate</b>		0.00	20.00	<b>35.00</b>	50.00	500.00
<b>Survey RVW:</b>		3.00	4.28	<b>4.95</b>	5.50	8.50
<b>Pre-Service Evaluation Time:</b>				<b>40.00</b>		
<b>Pre-Service Positioning Time:</b>				<b>10.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>10.00</b>		
<b>Intra-Service Time:</b>		20.00	30.00	<b>40.00</b>	60.00	90.00
<b>Immediate Post Service-Time:</b>	<b><u>20.00</u></b>					
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>				
<b>Critical Care time/visit(s):</b>	<b><u>0.00</u></b>	99291x 0.00	99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b><u>0.00</u></b>	99231x 0.00	99232x 0.00	99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b><u>0.00</u></b>	99238x 0.00	99239x 0.00	99217x 0.00		
<b>Office time/visit(s):</b>	<b><u>0.00</u></b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00	15x 0.00
<b>Prolonged Services:</b>	<b><u>0.00</u></b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00	
<b>Sub Obs Care:</b>	<b><u>0.00</u></b>	99224x 0.00	99225x 0.00	99226x 0.00		

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

**Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:**

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	49406	Recommended Physician Work RVU: 4.25			
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:		35.00	33.00	2.00	
Pre-Service Positioning Time:		5.00	1.00	4.00	
Pre-Service Scrub, Dress, Wait Time:		5.00	5.00	0.00	
Intra-Service Time:		40.00			
Immediate Post Service-Time:	<u>20.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
49418	000	4.21	RUC Time

CPT Descriptor Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
11044	000	4.10	RUC Time	53,852

CPT Descriptor 1 Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
15004	000	4.58	RUC Time	19,876

CPT Descriptor 2 Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
---------------------------------	---------------	-----------------	--------------------

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 23      % of respondents: 42.5 %

**TIME ESTIMATES (Median)**

	<u>CPT Code:</u> <b>49406</b>	<u>Key Reference CPT Code:</u> <b>49418</b>	<u>Source of Time</u> <b>RUC Time</b>
Median Pre-Service Time	45.00	44.00	
Median Intra-Service Time	40.00	40.00	
Median Immediate Post-service Time	20.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>105.00</b>	<b>104.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.52	3.26
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.78	3.43
--	------	------

Urgency of medical decision making	3.74	3.22
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.70	3.61
--------------------------	------	------

Physical effort required	3.48	3.35
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.74	3.48
---	------	------

Outcome depends on the skill and judgment of physician	3.70	3.52
--	------	------

Estimated risk of malpractice suit with poor outcome	3.65	3.22
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.35	3.26
----------------------------------	------	------

Intra-Service intensity/complexity	3.61	3.52
------------------------------------	------	------

Post-Service intensity/complexity	3.22	3.17
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

## Background

Several codes describing the percutaneous drainage of abscesses were identified by the “Codes reported together 75% or more” RAW screen. This included the following combinations 49021 (*Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; percutaneous*), 49041 (*Drainage of subdiaphragmatic or subphrenic abscess; percutaneous*), and 49061 (*Drainage of retroperitoneal abscess; percutaneous*), along with S&I code 75989 (*Radiological guidance (ie, fluoroscopy, ultrasound, or computed tomography), for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision and interpretation*). To improve the reporting of these procedures, the CPT Editorial Panel created a family of four bundled codes to describe percutaneous image guided drainage of abscesses. The base surgical codes encompassing these new bundled codes will be deleted.

CPT code 49406 (*Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, percutaneous*) describes image guided catheter drainage of abscesses or other fluid collections in the peritoneal and retroperitoneal space. This new code replaces several codes which were previously employed to describe the drainage of peritoneal and retroperitoneal fluid collections: 49021 (*Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; percutaneous*), 49061 (*Drainage of retroperitoneal abscess; percutaneous*), 49041 (*Drainage of subdiaphragmatic or subphrenic abscess; percutaneous*), and 44901 (*Incision and drainage of appendiceal abscess; percutaneous*). When imaging guidance is used, these codes are typically paired with code 75989 (*Radiological guidance (ie, fluoroscopy, ultrasound, or computed tomography), for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision and interpretation*).

The American College of Radiology and Society of Interventional Radiology surveyed the new family of abscess drainage codes, including CPT code 49406, in November and December 2012, and convened an expert panel of physicians familiar with these services to review the survey data.

## Work RVU Recommendation

The expert panel recommends the survey 25<sup>th</sup> percentile work value of 4.28 RVUs, which is the same as our recommendation for 49405. This is below the current value.

## Pre-Service Time

The panel recommends pre-service package 2B (*Difficult Patient/Straightforward Procedure (With sedation/anesthesia care)*) with the following adjustments: pre-service evaluation time is increased by 2 minutes and pre-service positioning time is increased by 4 minutes to conform to the survey result and account for time prior to skin prep used CT localization of the visceral abscess. Based on the survey instrument, it is reasonable to conclude respondents would consider imaging work prior to skin prep to be pre-service work, and this is consistent with the recently reviewed paracentesis and thoracentesis codes.

## Intra and Post-Service Times

The panel recommends the median intra and post service times for code 49406: 40 and 20 minutes, respectively.

## Comparison to Key Reference Service

The most commonly selected key reference service was CPT code 49418 (*Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous*), which has 4.21 work RVUs and pre, intra, and post service times of 44, 40, and 20 minutes, respectively. 49406 has longer survey times and greater surveyed complexity (on all 11 measures) than the key reference service. Both of these procedures involve introduction of a catheter using imaging guidance, and have nearly identical service period and total times.



The slightly higher RVU for 49406 is justified by the greater complexity of the patients and increased skill required for the performance of code 49406.

Code	RVU	Pre	Intra	Post	Total	IWPUT
49406	4.28	45	40	20	105	0.072
49418	4.21	44	40	20	104	0.071

### MPC Comparison

The panel recommendation of 4.28 RVUs compares favorably to, and is bracketed by, MPC codes 11044 (*Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less*) and 15004 (*Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants*). 49406 has a similar intra-service time to both of these codes and is slightly higher in RVU than 11044 and slightly lower than 15004.

Code	RVU	Pre	Intra	Post	Total	IWPUT
11044	4.10	51	45	20	116	0.061
49406	4.28	45	40	20	105	0.072
15004	4.58	75	45	30	150	0.054

### Building Block Methodology

This is a new CPT code describing an existing service that previously was coded using multiple different codes, including 49021, 44901, 49061, and 49041. The use of these codes with the corresponding radiologic supervision and interpretation code, 75989, allow for direct comparison to the surveyed values. When combined with CPT code 75989 (*Radiological guidance (ie, fluoroscopy, ultrasound, or computed tomography), for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision*), these codes form a range of reference points for consideration of CPT code 49406.

49021 (3.37 RVUs) + 75989 (1.19 RVUs) = 4.56 RVUs.

44901 (3.37 RVUs) + 75989 (1.19 RVUs) = 4.56 RVUs.

49061 (3.69 RVUs) + 75989 (1.19 RVUs) = 4.88 RVUs.

49041 (3.99 RVUs) + 75989 (1.19 RVUs) = 5.18 RVUs.

### Comparison Within Family

The data summarized in the table below demonstrate the accurate relative work involved in the procedures surveyed within the abscess code family. While the survey times increase throughout the code family, the IWPUT across the different codes appropriately reflects the differences in intensity related to treating the varying complexity of patients requiring drainage of superficial (10030), solid organ (49405), retroperitoneal (49406), and deep pelvic abscesses (49407). The expert panel believes the IWPUT values across the family are appropriate since a superficial drainage would be expected to be less complex than the greater complexity of patients requiring drainage of solid organ (49405) or retroperitoneal (49406) abscesses. Transrectal and transvaginal abscesses should fall closer to solid organ and retroperitoneal abscesses in intensity.

Codes in Family	Recommended RVUs	Pre Time	Intra Time	Post Time	Total Time	IWPUT
10030	3.00	45	30	20	95	0.054
49405	4.28	45	40	20	105	0.072
49406	4.28	45	40	20	105	0.072
49407	4.50	45	45	20	110	0.069

---

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.
- 

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 49021, 49041, 49061, 75989

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology                      How often? Commonly

Specialty Interventional Radiology                      How often? Commonly

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 90672

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on the number of times this service might be provided to Medicare patients nationally in a one-year period, it is estimated that 49406 might be provided 90,672 times nationally in a one-year period.

Specialty Diagnostic Radiology                      Frequency 71900                      Percentage 79.29 %

Specialty Interventional Radiology                      Frequency 13040                      Percentage 14.38 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

30,224 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The estimated frequency for Medicare is 30,224, which is the 2012 Medicare utilization frequency for codes 44901, 49021, 49041, and 49061. Based on past frequency data, we estimated the percent performed by Radiology to be about 79.29%, and by Interventional Radiology about 14.38%.

Specialty Diagnostic Radiology                      Frequency 23964                      Percentage 79.28 %

Specialty Interventional Radiology

Frequency 4346

Percentage 14.37 %

Specialty

Frequency 0

Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

**Professional Liability Insurance Information (PLI)**

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 37200

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 49407      Tracking Number N4      Original Specialty Recommended RVU: **4.50**  
 Presented Recommended RVU: **4.50**  
 Global Period: 000      RUC Recommended RVU: **4.50**

CPT Descriptor: Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, transvaginal or transrectal

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 58-year-old female is status-post hemicolectomy now febrile with an elevated white blood cell count. CT scan shows a low density collection deep in the pelvis between the vagina and the rectum. Percutaneous transvaginal drainage using imaging guidance is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 96%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 79%

**Description of Pre-Service Work:**

- The medical records and previous imaging and lab studies are reviewed and a decision made on appropriate guidance method(s) and the safest percutaneous route to the collection
- Discuss procedure details, including alternatives and risks with the patient and family and informed consent is reviewed
- Estimate the range of devices that may be required and ensure all are available for use
- Ensure all technical personnel have been familiarized with the procedure and are fully familiar with all required devices
- A brief history and physical examination is performed including suitability for moderate sedation
- Personnel don radiation attire, if required
- Surgical time out performed
- The patient is placed in an appropriate position in the imaging suite
- Patient is given intravenous moderate sedation

**Description of Intra-Service Work:**

- Gently insert transrectal or transvaginal ultrasound probe into rectum or vagina, respectively
- The collection is localized under transvaginal (TV) or transrectal (TR) ultrasound. Repositioning may be necessary
- The entry site is prepped and draped
- Lidocaine is administered to anesthetize entry site and deep structures
- The collection is accessed with a needle using TV or TR ultrasound guidance
- Fluid is aspirated and sent for laboratory analysis (e.g., microbiology, chemistry, cell count, etc)
- A small amount of contrast is injected to confirm access into the targeted collection
- A guidewire is passed into the collection and repeat imaging performed

- The tract is serially dilated to the necessary size
- A drainage catheter is advanced into the collection and imaging (which may involve contrast injection) is performed to verify proper position in the collection
- The catheter is secured in place with a suture
- The drainage catheter is connected to a drainage system (e.g., suction, gravity)
- The patient is sent to recovery and patient care orders written

Description of Post-Service Work:

- The images are reviewed
- The patient is sent to recovery and patient care orders written
- Post-procedure vital signs are assessed
- A formal report of the procedure is dictated into the permanent medical record
- The results and further management are discussed with the patient and their family, as well as the requesting physician
- The procedure report is reviewed and signed

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)		01/2013				
Presenter(s):	Zeke Silva, MD; Sean Tutton, MD; Michael Hall, MD; Robert Vogelzang, MD; Jerry Niedzwiecki, MD					
Specialty(s):	American College of Radiology, Society of Interventional Radiology					
CPT Code:	49407					
Sample Size:	925	Resp N:	51	Response: 5.5 %		
Description of Sample:	700 ACR and 225 SIR members were randomly selected					
		Low	25 <sup>th</sup> pctl	Median*	75 <sup>th</sup> pctl	High
Service Performance Rate		0.00	0.00	7.00	25.00	80.00
Survey RVW:		3.00	4.50	5.30	5.95	8.00
Pre-Service Evaluation Time:				40.00		
Pre-Service Positioning Time:				10.00		
Pre-Service Scrub, Dress, Wait Time:				10.00		
Intra-Service Time:		20.00	30.00	45.00	60.00	80.00
Immediate Post Service-Time:	20.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00		
Discharge Day Mgmt:	0.00	99238x 0.00	99239x 0.00	99217x 0.00		
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00	15x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00	
Sub Obs Care:	0.00	99224x 0.00	99225x 0.00	99226x 0.00		

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

**Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:**

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	49407	<b>Recommended Physician Work RVU: 4.50</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		35.00	33.00	2.00
<b>Pre-Service Positioning Time:</b>		5.00	1.00	4.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00
<b>Intra-Service Time:</b>		45.00		
<b>Immediate Post Service-Time:</b>	<b>20.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
49418	000	4.21	RUC Time

CPT Descriptor Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
11044	000	4.10	RUC Time	53,852

CPT Descriptor 1 Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
15004	000	4.56	RUC Time	19,876

CPT Descriptor 2 Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
---------------------------------	---------------	-----------------	--------------------

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 19      % of respondents: 37.2 %**

**TIME ESTIMATES (Median)**

	<b>CPT Code: 49407</b>	<b>Key Reference CPT Code: 49418</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	45.00	44.00	
Median Intra-Service Time	45.00	40.00	
Median Immediate Post-service Time	20.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>110.00</b>	<b>104.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.37	3.26
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.53	3.37
--	------	------

Urgency of medical decision making	3.63	3.05
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.00	3.42
--------------------------	------	------

Physical effort required	3.74	3.47
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.89	3.47
---	------	------

Outcome depends on the skill and judgment of physician	4.05	3.47
--	------	------

Estimated risk of malpractice suit with poor outcome	3.74	3.42
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.58	3.21
----------------------------------	------	------

Intra-Service intensity/complexity	3.79	3.47
------------------------------------	------	------

Post-Service intensity/complexity	3.47	3.26
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*



## Background

Several codes describing the percutaneous drainage of abscesses were identified by the “Codes reported together 75% or more” RAW screen. This included the following combinations 49021 (*Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; percutaneous*), 49041 (*Drainage of subdiaphragmatic or subphrenic abscess; percutaneous*), and 49061 (*Drainage of retroperitoneal abscess; percutaneous*), along with S&I code 75989 (*Radiological guidance (ie, fluoroscopy, ultrasound, or computed tomography), for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision and interpretation*). To improve the reporting of these procedures, the CPT Editorial Panel created a family of four bundled codes to describe percutaneous image guided drainage of abscesses. The base surgical codes encompassing these new bundled codes will be deleted.

CPT code 49407 (*Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, transvaginal or transrectal*) describes image guided catheter drainage of abscesses or other fluid collections in the peritoneal or retroperitoneal space using a transvaginal or transrectal technique. The new code replaces the code previously used to describe the drainage of a deep pelvic fluid collection, 58823 (*Drainage of pelvic abscess, transvaginal or transrectal approach, percutaneous (eg, ovarian, pericolic)*). When imaging guidance is used, this code is typically paired with code 75989 (*Radiological guidance (ie, fluoroscopy, ultrasound, or computed tomography), for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision and interpretation*).

The American College of Radiology and Society of Interventional Radiology surveyed the new family of abscess drainage codes, including CPT code 49407, in November and December 2012, and convened an expert panel of physicians familiar with these services to review the survey data.

## Work RVU Recommendation

The expert panel recommends the survey 25<sup>th</sup> percentile survey value of 4.50 RVUs, which is below the current value.

## Pre-Service Time

The panel recommends pre-service package 2B (*Difficult Patient/Straightforward Procedure (With sedation/anesthesia care)*) with the following adjustments: pre-service evaluation time is increased by 2 minutes and pre-service positioning time is increased by 4 minutes to conform to the survey result and account for time prior to skin prep used for US localization of the abscess. Based on the survey instrument, it is reasonable to conclude respondents would consider imaging work prior to skin prep to be pre-service work, and this is consistent with the recently reviewed paracentesis and thoracentesis codes.

## Intra and Post-Service Times

The panel recommends the median intra and post service times for code 49407, with 45 minutes and 20 minutes, respectively.

## Comparison to Key Reference Service

The most commonly selected key reference service was CPT code 49418 (*Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous*), which has 4.21 work RVUs and pre, intra, and post service times of 44, 40, and 20 minutes, respectively. 49407 has longer survey times and significantly greater surveyed complexity (on all 11 measures) than the key reference service. While both of these procedures involve introduction of a catheter using imaging guidance, the greater complexity of the patients and increased skill required for the performance of code 49407 is manifest in the survey responses.

Code	RVU	Pre	Intra	Post	Total	IWPUT
49407	4.50	45	45	20	110	0.069
49418	4.21	44	40	20	104	0.071

### MPC Comparison

The panel recommendation of 4.50 RVUs compares favorably to, and is bracketed by, MPC codes 11044 (*Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less*) and 15004 (*Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children*). 49407 has a similar intra-service time to both of these codes and is slightly higher in RVU than 11044 and slightly lower than 15004.

Code	RVU	Pre	Intra	Post	Total	IWPUT
11044	4.10	51	45	20	116	0.061
49407	4.50	45	45	20	110	0.069
15004	4.58	75	45	30	150	0.054

### Building Block Methodology

This is a new CPT code describing an existing service that previously was coded using codes 58823 (*Drainage of pelvic abscess, transvaginal or transrectal approach, percutaneous (eg, ovarian, pericolic)*) and 75989 (*Radiological guidance (ie, fluoroscopy, ultrasound, or computed tomography), for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision*).

58823 (3.37 RVUs) + 75989 (1.19 RVUs) = 4.56 RVUs.

### Comparison Within Family

The data summarized in the table below demonstrate the accurate relative work involved in the procedures surveyed within the abscess code family. While the survey times increase throughout the code family, the IWPUT across the different codes appropriately reflects the differences in intensity related to treating the varying complexity of patients requiring drainage of superficial (10030), solid organ (49405), retroperitoneal (49406), and deep pelvic abscesses (49407). The expert panel believes the IWPUT values across the family are appropriate since a superficial drainage would be expected to be less complex than the greater complexity of patients requiring drainage of solid organ (49405) or retroperitoneal (49406) abscesses. Transrectal and transvaginal abscesses should fall closer to solid organ and retroperitoneal abscesses in intensity.

Codes in Family	Recommended RVUs	Pre Time	Intra Time	Post Time	Total Time	IWPUT
10030	3.00	45	30	20	95	0.054
49405	4.28	45	40	20	105	0.072
49406	4.28	45	40	20	105	0.072
49407	4.50	45	45	20	110	0.069

---

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 58823, 75989

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology                      How often? Commonly

Specialty Interventional Radiology                      How often? Commonly

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 876

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The overall number of services described by 49407 provided nationally in a one-year period is estimated to be 876.

Specialty Diagnostic Radiology                      Frequency 541                      Percentage 61.75 %

Specialty Interventional Radiology                      Frequency 154                      Percentage 17.57 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 292

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The estimated frequency for Medicare is 292 which is the 2012 Medicare utilization frequency for CPT code 58823. Based on past frequency data, we estimated the percent performed by Radiology to be about 61.78%, and by Interventional Radiology about 17.59%.

Specialty Diagnostic Radiology                      Frequency 180                      Percentage 61.64 %

Specialty Interventional Radiology                      Frequency 51                      Percentage 17.46 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

### **Professional Liability Insurance Information (PLI)**

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 37200

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	AF	AG	AH	AI	AJ
12	ISSUE: Drainage of Abscess																								
13	TAB: 4																								
14						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	Office				
15	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	15	14	13	12	11
16	REF	49083	Abdominal paracentesis	14	0.052			2.00			60	15	5	5			25			10					
17	CURRENT	75989	Radiological guidance (ie, fluo	#DIV/0!				1.19			23														
18	CURRENT	10140	Incision and drainage of hema		0.026			1.58			66	17	3	5			15			10				1	
19	SVY	10030	Image-guided fluid colle	65	0.082	1.89	3.00	4.00	4.50	6.00	105	35	10	10	5	20	30	45	60	20					
20	REC	10030			0.064	3.00					81	21	5	5			30			20					
21																									
22						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	Office				
23	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	15	14	13	12	11
24	REF	49418	Insertion of tunneled int	20	0.071			4.21			104	33	6	5			40			20					
25	CURRENT	75989	Radiological guidance (ie, fluo	#DIV/0!				1.19			23														
26	CURRENT	32201	Pneumonostomy; with percuta		0.043			3.99			122	38					60			24					
27	CURRENT	48511	External drainage, pseudocyst		0.041			3.99			127	40					62			25					
28	CURRENT	47011	Hepatotomy; for percutaneous		0.038			3.69			123	38					60			25					
29	CURRENT	50021	Drainage of perirenal or renal		0.029			3.37			131	38					68			25					
30	SVY	49405	Image-guided fluid colle	53	0.079	3.00	4.25	4.80	5.50	9.00	120	40	10	10	20	30	40	59	90	20					
31	REC	49405			0.072	4.25					105	35	5	5			40			20					
32																									
33						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	Office				
34	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	15	14	13	12	11
35	REF	49418	Insertion of tunneled int	23	0.071			4.21			104	33	6	5			40			20					
36	CURRENT	75989	Radiological guidance (ie, fluo	#DIV/0!				1.19			23														
37	CURRENT	44901	Incision and drainage of apper		0.035			3.37			118	38					60			20					
38	CURRENT	49021	Drainage of peritoneal abscess		0.032			3.37			124	38					60			26					
39	CURRENT	49041	Drainage of subdiaphragmatic		0.041			3.99			128	38					60			30					
40	CURRENT	49061	Drainage of retroperitoneal ab		0.037			3.69			126	38					60			28					
41	SVY	49406	Image-guided fluid colle	54	0.083	3.00	4.28	4.95	5.50	8.50	120	40	10	10	20	30	40	60	90	20					
42	REC	49406			0.072	4.25					105	35	5	5			40			20					
43																									
44						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	Office				
45	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	15	14	13	12	11
46	REF	49418	Insertion of tunneled int	19	0.071			4.21			104	33	6	5			40			20					
47	CURRENT	75989	Radiological guidance (ie, fluo	#DIV/0!				1.19			23														
48	CURRENT	58823	Drainage of pelvic abscess, tra		0.028			3.37			135	45					60			30					
49	SVY	49407	Image-guided fluid collection c		0.081	3.00	4.50	5.30	5.95	8.00	125	40	10	10	20	30	45	60	80	20					
50	REC	49407			0.069	4.50					110	35	5	5			45			20					

**AMA/Specialty Society Update Process**  
**Practice Expense Summary of Recommendation**  
**Non Facility Direct Inputs**

CPT Long Descriptor:

**10030** - Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); soft tissue (eg, extremity, abdominal wall, neck), percutaneous

**49405** - Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); visceral (eg, kidney, liver, spleen, lung/mediastinum), percutaneous

**49406** - Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, percutaneous

**49407** - Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, transvaginal or transrectal

Global Period: 000 Meeting Date: 01/2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The American College of Radiology and the Society of Interventional Radiology convened a consensus panel to finalize the practice expense data for CPT codes 10030, 49405, 49406, and 49407.

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

The existing codes, 50021, 49021, and 58823, are being replaced by the abscess drainage codes, 49405-49407, and the practice expense inputs for these codes are similar to the practice expense inputs for the new codes. For 10030, because there is no existing code that represents the described procedure, the ACR and SIR crosswalked it to the other abscess codes.

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:

The additional time for pre-service activities represents staff activities which typically occur following the decision for the procedure

4. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic & referral forms
- Coordinate pre-surgery services
- Provide pre-service education/obtain consent
- Other Clinical Activity - Retrieve prior imaging exams, hang for MD review, verify orders, review chart to incorporate relevant clinical information, confirm contrast protocol with interpreting MD

Intra-Service Clinical Labor Activities:

- Greet patient, provide gowning, ensure appropriate medical records are available
- Obtain vital signs
- Provide pre-service education/obtain consent
- Prepare room, equipment, supplies
- Prepare and position patient/ monitor patient/ set up IV
- Sedate/apply anesthesia
- Assist physician in performing procedure
- Assist physician in performing procedure (CS)
- Image Acquisition (75%)
- Circulating throughout procedure (25%)
- Monitor pt. following service/check tubes, monitors, drains
- Clean room/equipment by physician staff
- Complete diagnostic forms, lab & X-ray requisitions
- Check dressings & wound/ home care instructions /coordinate office visits /prescriptions
- Other Clinical Activity: Process and hang films

Post-Service Clinical Labor Activities:

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
1	<b>REVISED AT RUC 1/26/13</b>																
2	<b>Note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.</b>			<b>10030</b>	<b>10030</b>			<b>49405</b>	<b>49405</b>			<b>49406</b>	<b>49406</b>			<b>49407</b>	<b>49407</b>
4	<b>LOCATION</b>			<b>Non Fac</b>	<b>Fac</b>			<b>Non Fac</b>	<b>Fac</b>			<b>Non Fac</b>	<b>Fac</b>			<b>Non Fac</b>	<b>Fac</b>
5	<b>GLOBAL PERIOD</b>			<b>000</b>	<b>000</b>			<b>000</b>	<b>000</b>			<b>000</b>	<b>000</b>			<b>000</b>	<b>000</b>
6	<b>TOTAL CLINICAL LABOR TIME</b>			<b>155.0</b>	<b>6.0</b>			<b>185.0</b>	<b>6.0</b>			<b>185.0</b>	<b>6.0</b>			<b>200.0</b>	<b>6.0</b>
7		L051B	stic Medical Sc	<b>67.0</b>	<b>0.0</b>	L046A	CT Tech	<b>84.0</b>	<b>0.0</b>	L046A	CT Tech	<b>84.0</b>	<b>0.0</b>	L051B	stic Medical Sc	<b>93.0</b>	<b>0.0</b>
8		L037D	RN/LPN/MTA	<b>26.0</b>	<b>6.0</b>	L037D	RN/LPN/MTA	<b>29.0</b>	<b>6.0</b>	L037D	RN/LPN/MTA	<b>29.0</b>	<b>6.0</b>	L037D	RN/LPN/MTA	<b>30.0</b>	<b>6.0</b>
9		L051A	RN	<b>62.0</b>	<b>0.0</b>	L051A	RN	<b>72.0</b>	<b>0.0</b>	L051A	RN	<b>72.0</b>	<b>0.0</b>	L051A	RN	<b>77.0</b>	<b>0.0</b>
10	<b>TOTAL PRE-SERV CLINICAL LABOR TIME</b>	L051B	stic Medical Sc	<b>5.0</b>		L046A	CT Tech	<b>5.0</b>	<b>0.0</b>	L046A	CT Tech	<b>5.0</b>	<b>0.0</b>	L051B	stic Medical Sc	<b>5.0</b>	<b>0.0</b>
11		L037D	RN/LPN/MTA	<b>4.0</b>	<b>6.0</b>	L037D	RN/LPN/MTA	<b>4.0</b>	<b>6.0</b>	L037D	RN/LPN/MTA	<b>4.0</b>	<b>6.0</b>	L037D	RN/LPN/MTA	<b>4.0</b>	<b>6.0</b>
12	<b>TOTAL SERVICE PERIOD CLINICAL LABOR TIME</b>	L051B	stic Medical Sc	<b>62.0</b>	<b>0.0</b>	L046A	CT Tech	<b>79.0</b>	<b>0.0</b>	L046A	CT Tech	<b>79.0</b>	<b>0.0</b>	L051B	stic Medical Sc	<b>88.0</b>	<b>0.0</b>
13		L037D	RN/LPN/MTA	<b>22.0</b>	<b>0.0</b>	L037D	RN/LPN/MTA	<b>25.0</b>	<b>0.0</b>	L037D	RN/LPN/MTA	<b>25.0</b>	<b>0.0</b>	L037D	RN/LPN/MTA	<b>26.0</b>	<b>0.0</b>
14		L051A	RN	<b>62.0</b>	<b>0.0</b>	L051A	RN	<b>72.0</b>	<b>0.0</b>	L051A	RN	<b>72.0</b>	<b>0.0</b>	L051A	RN	<b>77.0</b>	<b>0.0</b>
15	<b>TOTAL POST-SERV CLINICAL LABOR TIME</b>	L037D	RN/LPN/MTA			L037D	RN/LPN/MTA			L037D	RN/LPN/MTA			L037D	RN/LPN/MTA		
16	<b>PRE-SERVICE</b>																
17	<b>Start: Following visit when decision for surgery or procedure made</b>																
18	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	<b>3</b>	<b>3</b>	L037D	RN/LPN/MTA	<b>3</b>	<b>3</b>	L037D	RN/LPN/MTA	<b>3</b>	<b>3</b>	L037D	RN/LPN/MTA	<b>3</b>	<b>3</b>
19	Coordinate pre-surgery services	L037D	RN/LPN/MTA	<b>1</b>		L037D	RN/LPN/MTA	<b>1</b>		L037D	RN/LPN/MTA	<b>1</b>		L037D	RN/LPN/MTA	<b>1</b>	
20	Schedule space and equipment in facility	L037D	RN/LPN/MTA		<b>3</b>	L037D	RN/LPN/MTA		<b>3</b>	L037D			<b>3</b>	L037D	RN/LPN/MTA		<b>3</b>
21	Provide pre-service education/obtain consent																
22	Provide pre-service education/obtain consent																
23	Follow-up phone calls & prescriptions																
24	Other Clinical Activity - <i>specify: Retrieve prior imaging exams, hang for MD review, verify orders, review chart to incorporate relevant clinical information, confirm contrast protocol with interpreting MD</i>	L051B	RN/Diagnostic Medical Sonographer	<b>5</b>		L046A	CT Tech	<b>5</b>		L046A	CT Tech	<b>5</b>		L051B	RN/Diagnostic Medical Sonographer	<b>5</b>	
25	<b>End: When patient enters office/facility for surgery/procedure</b>																
26	<b>SERVICE PERIOD</b>																
27	<b>Start: When patient enters office/facility for surgery/procedure:</b>																
28	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	<b>3</b>		L037D	RN/LPN/MTA	<b>3</b>		L037D	RN/LPN/MTA	<b>3</b>		L037D	RN/LPN/MTA	<b>3</b>	
29	Obtain vital signs	L037D	RN/LPN/MTA	<b>3</b>		L037D	RN/LPN/MTA	<b>3</b>		L037D	RN/LPN/MTA	<b>3</b>		L037D	RN/LPN/MTA	<b>3</b>	
30	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	<b>3</b>		L037D	RN/LPN/MTA	<b>3</b>		L037D	RN/LPN/MTA	<b>3</b>		L037D	RN/LPN/MTA	<b>3</b>	
31	Prepare room, equipment, supplies	L051B	RN/Diagnostic Medical Sonographer	<b>2</b>		L046A	CT Tech	<b>2</b>		L046A	CT Tech	<b>2</b>		L051B	RN/Diagnostic Medical Sonographer	<b>2</b>	
32	Setup scope (non facility setting only)																
33	Prepare and position patient/ monitor patient/ set up IV	L051B	RN/Diagnostic Medical Sonographer	<b>2</b>		L046A	CT Tech	<b>2</b>		L046A	CT Tech	<b>2</b>		L051B	RN/Diagnostic Medical Sonographer	<b>2</b>	
34	Sedate/apply anesthesia	L051A	RN	<b>2</b>		L051A	RN	<b>2</b>		L051A	RN	<b>2</b>		L051A	RN	<b>2</b>	
35	<b>Intra-service</b>																
36	Assist physician in performing procedure	L051B	RN/Diagnostic Medical Sonographer	<b>30</b>		L046A	CT Tech	<b>40</b>		L046A	CT Tech	<b>40</b>		L051B	RN/Diagnostic Medical Sonographer	<b>45</b>	
37	<i>Assist physician in performing procedure (CS)</i>	L051A	RN	<b>30</b>		L051A	RN	<b>40</b>		L051A	RN	<b>40</b>		L051A	RN	<b>45</b>	
38	<i>Image Acquisition (75%)</i>	L051B	RN/Diagnostic Medical Sonographer	<b>23</b>		L046A	CT Tech	<b>30</b>		L046A	CT Tech	<b>30</b>		L051B	RN/Diagnostic Medical Sonographer	<b>34</b>	
39	<i>Circulating throughout procedure (25%)</i>	L037D	RN/LPN/MTA	<b>7</b>		L037D	RN/LPN/MTA	<b>10</b>		L037D	RN/LPN/MTA	<b>10</b>		L037D	RN/LPN/MTA	<b>11</b>	



	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
1	<b>REVISED AT RUC 1/26/13</b>																
2	<b>Note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.</b>			<b>10030</b>	<b>10030</b>			<b>49405</b>	<b>49405</b>			<b>49406</b>	<b>49406</b>			<b>49407</b>	<b>49407</b>
4	<b>LOCATION</b>			<b>Non Fac</b>	<b>Fac</b>			<b>Non Fac</b>	<b>Fac</b>			<b>Non Fac</b>	<b>Fac</b>			<b>Non Fac</b>	<b>Fac</b>
5	<b>GLOBAL PERIOD</b>			<b>000</b>	<b>000</b>			<b>000</b>	<b>000</b>			<b>000</b>	<b>000</b>			<b>000</b>	<b>000</b>
40	<b>Post-Service</b>																
41	Monitor pt. following service/check tubes, monitors, drains	L051A	RN	<b>30</b>		L051A	RN	<b>30</b>		L051A	RN	<b>30</b>		L051A	RN	<b>30</b>	
42	Clean room/equipment by physician staff	L051B	RN/Diagnostic Medical Sonographer	<b>3</b>		L046A	CT Tech	<b>3</b>		L046A	CT Tech	<b>3</b>		L051B	RN/Diagnostic Medical Sonographer	<b>3</b>	
43	Clean Scope																
44	Clean Surgical Instrument Package																
45	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA	<b>3</b>		L037D	RN/LPN/MTA	<b>3</b>		L037D	RN/LPN/MTA	<b>3</b>		L037D	RN/LPN/MTA	<b>3</b>	
46	Review/read X-ray, lab, and pathology reports																
47	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	<b>3</b>		L037D	RN/LPN/MTA	<b>3</b>		L037D	RN/LPN/MTA	<b>3</b>		L037D	RN/LPN/MTA	<b>3</b>	
48	Other Clinical Activity - <i>specify: <b>Process and hang films</b></i>	L051B	RN/Diagnostic Medical Sonographer	<b>2</b>		L046A	CT Tech	<b>2</b>		L046A	CT Tech	<b>2</b>		L051B	RN/Diagnostic Medical Sonographer	<b>2</b>	
49	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			<b>n/a</b>	<b>n/a</b>			<b>n/a</b>	<b>n/a</b>			<b>n/a</b>				<b>n/a</b>	<b>n/a</b>
50	Dischrg mgmt (1.0 x 99238) (enter 12 min)			<b>n/a</b>	<b>n/a</b>			<b>n/a</b>	<b>n/a</b>			<b>n/a</b>				<b>n/a</b>	<b>n/a</b>
51	Dischrg mgmt (1.0 x 99239) (enter 15 min)			<b>n/a</b>	<b>n/a</b>			<b>n/a</b>	<b>n/a</b>			<b>n/a</b>				<b>n/a</b>	<b>n/a</b>
52	<b>End: Patient leaves office</b>																
53	<b>POST-SERVICE Period</b>																
54	<b>Start: Patient leaves office/facility</b>																
55	Conduct phone calls/call in prescriptions																
56	Coordinate home or outpatient care																
	<b>Office visits: List Number and Level of Office Visits</b>			<b># visits</b>	<b># visits</b>			<b># visits</b>	<b># visits</b>			<b># visits</b>				<b># visits</b>	<b># visits</b>
57																	
58	99211 16 minutes		16				16				16				16		
59	99212 27 minutes		27				27				27				27		
60	99213 36 minutes		36				36				36				36		
61	99214 53 minutes		53				53				53				53		
62	99215 63 minutes		63				63				63				63		
63	<b>Total Office Visit Time</b>			<b>0.0</b>	<b>0.0</b>			<b>0.0</b>	<b>0.0</b>			<b>0.0</b>	<b>0.0</b>			<b>0.0</b>	<b>0.0</b>
64	Other Clinical Activity - <i>specify:</i>																
65	<b>End: with last office visit before end of global period</b>																

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
1	<b>REVISED AT RUC 1/26/13</b>																
2	<b>Note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.</b>			<b>10030</b>	<b>10030</b>			<b>49405</b>	<b>49405</b>			<b>49406</b>	<b>49406</b>			<b>49407</b>	<b>49407</b>
4	<b>LOCATION</b>			<b>Non Fac</b>	<b>Fac</b>			<b>Non Fac</b>	<b>Fac</b>			<b>Non Fac</b>	<b>Fac</b>			<b>Non Fac</b>	<b>Fac</b>
5	<b>GLOBAL PERIOD</b>			<b>000</b>	<b>000</b>			<b>000</b>	<b>000</b>			<b>000</b>	<b>000</b>			<b>000</b>	<b>000</b>
66	<b>MEDICAL SUPPLIES</b>	<b>CODE</b>	<b>UNIT</b>			<b>CODE</b>	<b>UNIT</b>			<b>CODE</b>	<b>UNIT</b>			<b>CODE</b>	<b>UNIT</b>		
67	pack, moderate sedation	SA044	pack	<b>1</b>		SA044	pack	<b>1</b>		SA044	pack	<b>1</b>		SA044	pack	<b>1</b>	
68	tape, surgical paper 1in (Micropore)	SG079	in			SG079	in			SG079	in			SG079	in		
69	gown, surgical, sterile	SB028	gds			SB028	gds			SB028	gds			SB028	gds		
70	gauze, sterile 4in x 4in	SG055	item	<b>2</b>		SG055	item	<b>2</b>		SG055	item	<b>2</b>		SG055	item	<b>2</b>	
71	stop cock, 3-way	SC049	item			SC049	item			SC049	item			SC049	item		
72	gloves, sterile	SB024	pair			SB024	pair			SB024	pair			SB024	pair		
73	swab-pad, alcohol	SJ053	item			SJ053	item			SJ053	item			SJ053	item		
74	computer media, dvd	SK013	item	<b>1</b>		SK013	item	<b>1</b>		SK013	item	<b>1</b>		SK013	item	<b>1</b>	
75	film, x-ray, laser print	SK098	item	<b>1</b>		SK098	item	<b>1</b>		SK098	item	<b>1</b>		SK098	item	<b>1</b>	
76	x-ray envelope	SK091	item			SK091	item			SK091	item			SK091	item		
77	x-ray ID card (flashcard)	SK093	item			SK093	item			SK093	item			SK093	item		
78	disinfectant, surface (Envirocide, Sanizide)	SM013	oz	<b>1</b>		SM013	oz	<b>1</b>		SM013	oz	<b>1</b>		SM013	oz	<b>1</b>	
79	gloves, non-sterile	SB022	pair	<b>1</b>		SB022	pair	<b>1</b>		SB022	pair	<b>1</b>		SB022	pair	<b>1</b>	
80	drape, sterile, fenestrated 16in x 29in	SB011	item	<b>1</b>		SB011	item	<b>1</b>		SB011	item	<b>1</b>		SB011	item	<b>1</b>	
81	syringe w-needle, OSHA compliant (SafetyGlide)	SC058	item	<b>2</b>		SC058	item	<b>2</b>		SC058	item	<b>2</b>		SC058	item	<b>2</b>	
82	povidone soln (Betadine)	SJ041	ml	<b>60</b>		SJ041	ml	<b>60</b>		SJ041	ml	<b>60</b>		SJ041	ml	<b>60</b>	
83	sodium chloride 0.9% flush syringe	SH065	item	<b>1</b>		SH065	item	<b>1</b>		SH065	item	<b>1</b>		SH065	item	<b>1</b>	
84	cup, sterile, 12-16 oz	SL156	item	<b>1</b>		SL156	item	<b>1</b>		SL156	item	<b>1</b>		SL156	item	<b>1</b>	
85	cup, sterile, 8 oz	SL157	item	<b>1</b>		SL157	item	<b>1</b>		SL157	item	<b>1</b>		SL157	item	<b>1</b>	
86	cup, biopsy-specimen sterile 4oz	SL036	item	<b>1</b>		SL036	item	<b>1</b>		SL036	item	<b>1</b>		SL036	item	<b>1</b>	
87	shoe covers, surgical	SB039	item	<b>2</b>		SB039	item	<b>2</b>		SB039	item	<b>2</b>		SB039	item	<b>2</b>	
88	applicator, sponge-tipped	SG009	item	<b>4</b>		SG009	item	<b>4</b>		SG009	item	<b>4</b>		SG009	item	<b>4</b>	
89	blade, surgical (Bard-Parker)	SF007	item	<b>1</b>		SF007	item	<b>1</b>		SF007	item	<b>1</b>		SF007	item	<b>1</b>	
90	cap, surgical	SB001	item	<b>2</b>		SB001	item	<b>2</b>		SB001	item	<b>2</b>		SB001	item	<b>2</b>	
91	lidocaine 1%-2% inj (Xylocaine)	SH047	ml	<b>10</b>		SH047	ml	<b>10</b>		SH047	ml	<b>10</b>		SH047	ml	<b>10</b>	
92	underpad 2ft x 3ft (Chux)	SB044	item	<b>1</b>		SB044	item	<b>1</b>		SB044	item	<b>1</b>		SB044	item	<b>1</b>	
93	drainage catheter, all purpose	SD161	item	<b>1</b>		SD161	item	<b>1</b>		SD161	item	<b>1</b>		SD161	item	<b>1</b>	
94	kit, AccuStick II Introducer System with RO Marker	SA071	kit	<b>1</b>		SA071	kit	<b>1</b>		SA071	kit	<b>1</b>		SA071	kit	<b>1</b>	
95	drainage pouch, nephrostomy-biliary	SD163	item	<b>1</b>		SD163	item	<b>1</b>		SD163	item	<b>1</b>		SD163	item	<b>1</b>	
96	catheter percutaneous fastener (Percu-Stay)	SD146	item	<b>1</b>		SD146	item	<b>1</b>		SD146	item	<b>1</b>		SD146	item	<b>1</b>	
97	closed flush system, angiography	SC010	item	<b>1</b>		SC010	item	<b>1</b>		SC010	item	<b>1</b>		SC010	item	<b>1</b>	
98	guidewire	SD088	item	<b>1</b>		SD088	item	<b>1</b>		SD088	item	<b>1</b>		SD088	item	<b>1</b>	
99	dilator, vessel, angiographic	SD043	item	<b>1</b>		SD043	item	<b>1</b>		SD043	item	<b>1</b>		SD043	item	<b>1</b>	
100	drape, sterile, three-quarter sheet	SB014	item	<b>1</b>		SB014	item	<b>1</b>		SB014	item	<b>1</b>		SB014	item	<b>1</b>	
101	mask, surgical, with face shield	SB034	item	<b>2</b>		SB034	item	<b>2</b>		SB034	item	<b>2</b>		SB034	item	<b>2</b>	
102	sodium chloride 0.9% irrigation (500-1000ml uou)	SH069	item	<b>1</b>		SH069	item	<b>1</b>		SH069	item	<b>1</b>		SH069	item	<b>1</b>	
103	tray, shave prep	SA067	tray	<b>1</b>		SA067	tray	<b>1</b>		SA067	tray	<b>1</b>		SA067	tray	<b>1</b>	
104	syringe 50-60ml	SC056	item	<b>2</b>		SC056	item	<b>2</b>		SC056	item	<b>2</b>		SC056	item	<b>2</b>	
105	drape-towel, sterile 18in x 26in	SB019	item	<b>4</b>		SB019	item	<b>4</b>		SB019	item	<b>4</b>		SB019	item	<b>4</b>	
106	<b>EQUIPMENT</b>	<b>CODE</b>				<b>CODE</b>				<b>CODE</b>				<b>CODE</b>			
107	room, CT							<b>49</b>				<b>49</b>					
108	room, ultrasound, general	EL015		<b>39</b>										EL015		<b>54</b>	
109	film processor, dry, laser	ED024		<b>3</b>		ED024		<b>3</b>		ED024		<b>3</b>		ED024		<b>3</b>	
110	film alternator (motorized film viewbox)	ER029		<b>3</b>		ER029		<b>3</b>		ER029		<b>3</b>		ER029		<b>3</b>	
111	light, exam	EQ168		<b>30</b>		EQ168		<b>40</b>		EQ168		<b>40</b>		EQ168		<b>45</b>	
112	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011		<b>152</b>		EQ011		<b>162</b>		EQ011		<b>162</b>		EQ011		<b>167</b>	
113	IV infusion pump	EQ032		<b>152</b>		EQ032		<b>162</b>		EQ032		<b>162</b>		EQ032		<b>167</b>	
114	table, instrument, mobile	EF027		<b>152</b>		EF027		<b>162</b>		EF027		<b>162</b>		EF027		<b>167</b>	
115	Stretcher	EF018		<b>0</b>		EF018		<b>0</b>		EF018		<b>0</b>		EF018		<b>0</b>	

	A	B	C	R	S	T	U	V
1	<b>REVISED AT RUC 1/26/13</b>				<b>REFERENCE CODE REFERENCE CODE REFERENCE CODE REFERENCE CODE</b>			
2	Note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.				50021	49021	58823	75989
4	LOCATION				Non Fac	Non Fac	Non Fac	Non Fac
5	GLOBAL PERIOD				000	000	000	XXX
6	TOTAL CLINICAL LABOR TIME				157.0	143.0	144.0	21.0
7		L051B	stic Medical Sc		61.0	55.0	56.0	21.0
8		L037D	RN/LPN/MTA		11.0	11.0	11.0	
9		L051A	RN		85.0	77.0	77.0	
10	TOTAL PRE-SERV CLINICAL LABOR TIME	L051B	stic Medical Sc					5.0
11		L037D	RN/LPN/MTA					
12	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L051B	stic Medical Sc		61.0	55.0	56.0	16.0
13		L037D	RN/LPN/MTA		11.0	11.0	11.0	
14		L051A	RN		85.0	77.0	77.0	
15	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA					
16	PRE-SERVICE							
17	Start: Following visit when decision for surgery or procedure made							
18	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA					
19	Coordinate pre-surgery services	L037D	RN/LPN/MTA					
20	Schedule space and equipment in facility	L037D	RN/LPN/MTA					
21	Provide pre-service education/obtain consent							
22	Provide pre-service education/obtain consent							
23	Follow-up phone calls & prescriptions							
24	Other Clinical Activity - specify: <i>Retrieve prior imaging exams, hang for MD review, verify orders, review chart to incorporate relevant clinical information, confirm contrast protocol with interpreting MD</i>	L051B	RN/Diagnostic Medical Sonographer					5
25	End: When patient enters office/facility for surgery/procedure							
26	SERVICE PERIOD							
27	Start: When patient enters office/facility for surgery/procedure:							
28	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA					
29	Obtain vital signs	L037D	RN/LPN/MTA					
30	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5	5	5	
31	Prepare room, equipment, supplies	L051B	RN/Diagnostic Medical Sonographer		3	3	3	1
32	Setup scope (non facility setting only)							
33	Prepare and position patient/ monitor patient/ set up IV	L051B	RN/Diagnostic Medical Sonographer		2	2	3	1
34	Sedate/apply anesthesia	L051A	RN		2	2	2	
35	Intra-service							
36	Assist physician in performing procedure	L051B	RN/Diagnostic Medical Sonographer		54	48	48	9
37	Assist physician in performing procedure (CS)	L051A	RN		68	60	60	
38	Image Acquisition (75%)	L051B	RN/Diagnostic Medical Sonographer					
39	Circulating throughout procedure (25%)	L037D	RN/LPN/MTA					

	A	B	C	R	S	T	U	V
1	<b>REVISED AT RUC 1/26/13</b>				<b>REFERENCE CODE REFERENCE CODE REFERENCE CODE REFERENCE CODE</b>			
2	<b>Note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.</b>				<b>50021</b>	<b>49021</b>	<b>58823</b>	<b>75989</b>
4	<b>LOCATION</b>				<b>Non Fac</b>	<b>Non Fac</b>	<b>Non Fac</b>	<b>Non Fac</b>
5	<b>GLOBAL PERIOD</b>				<b>000</b>	<b>000</b>	<b>000</b>	<b>XXX</b>
40	<b>Post-Service</b>							
41	Monitor pt. following service/check tubes, monitors, drains	L051A	RN		<b>15</b>	<b>15</b>	<b>15</b>	
42	Clean room/equipment by physician staff	L051B	RN/Diagnostic Medical Sonographer		<b>2</b>	<b>2</b>	<b>2</b>	<b>3</b>
43	Clean Scope							
44	Clean Surgical Instrument Package							
45	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA		<b>3</b>	<b>3</b>	<b>3</b>	
46	Review/read X-ray, lab, and pathology reports							
47	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA		<b>3</b>	<b>3</b>	<b>3</b>	
48	Other Clinical Activity - specify: <i>Process and hang films</i>	L051B	RN/Diagnostic Medical Sonographer					<b>2</b>
49	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)				<b>n/a</b>	<b>n/a</b>	<b>n/a</b>	<b>n/a</b>
50	Dischrg mgmt (1.0 x 99238) (enter 12 min)				<b>n/a</b>	<b>n/a</b>	<b>n/a</b>	<b>n/a</b>
51	Dischrg mgmt (1.0 x 99239) (enter 15 min)				<b>n/a</b>	<b>n/a</b>	<b>n/a</b>	<b>n/a</b>
52	<b>End: Patient leaves office</b>							
53	<b>POST-SERVICE Period</b>							
54	<b>Start: Patient leaves office/facility</b>							
55	Conduct phone calls/call in prescriptions							
56	Coordinate home or outpatient care							
57	<b>Office visits: List Number and Level of Office Visits</b>				<b># visits</b>	<b># visits</b>	<b># visits</b>	<b># visits</b>
58	99211 16 minutes		16					
59	99212 27 minutes		27					
60	99213 36 minutes		36					
61	99214 53 minutes		53					
62	99215 63 minutes		63					
63	<b>Total Office Visit Time</b>				<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>
64	Other Clinical Activity - specify:							
65	<b>End: with last office visit before end of global period</b>							

	A	B	C	R	S	T	U	V
1	<b>REVISED AT RUC 1/26/13</b>				<b>REFERENCE CODE</b>			
2	<b>Note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.</b>				<b>50021</b>	<b>49021</b>	<b>58823</b>	<b>75989</b>
4	<b>LOCATION</b>				<b>Non Fac</b>	<b>Non Fac</b>	<b>Non Fac</b>	<b>Non Fac</b>
5	<b>GLOBAL PERIOD</b>				<b>000</b>	<b>000</b>	<b>000</b>	<b>XXX</b>
66	<b>MEDICAL SUPPLIES</b>	<b>CODE</b>	<b>UNIT</b>					
67	pack, moderate sedation	SA044	pack		<b>1</b>	<b>1</b>	<b>1</b>	
68	tape, surgical paper 1in (Micropore)	SG079	in		<b>12</b>	<b>12</b>	<b>12</b>	
69	gown, surgical, sterile	SB028	gds		<b>1</b>	<b>1</b>	<b>1</b>	
70	gauze, sterile 4in x 4in	SG055	item		<b>6</b>	<b>6</b>	<b>6</b>	
71	stop cock, 3-way	SC049	item		<b>1</b>	<b>1</b>	<b>1</b>	
72	gloves, sterile	SB024	pair		<b>1</b>	<b>1</b>	<b>1</b>	
73	swab-pad, alcohol	SJ053	item					
74	computer media, dvd	SK013	item					<b>1</b>
75	film, x-ray, laser print	SK098	item					<b>1</b>
76	x-ray envelope	SK091	item					<b>1</b>
77	x-ray ID card (flashcard)	SK093	item					<b>1</b>
78	disinfectant, surface (Envirocide, Sanizide)	SM013	oz					<b>1</b>
79	gloves, non-sterile	SB022	pair					<b>1</b>
80	drape, sterile, fenestrated 16in x 29in	SB011	item		<b>1</b>	<b>1</b>	<b>1</b>	
81	syringe w-needle, OSHA compliant (SafetyGlide)	SC058	item		<b>2</b>	<b>2</b>	<b>2</b>	
82	povidone soln (Betadine)	SJ041	ml		<b>60</b>	<b>60</b>	<b>60</b>	
83	sodium chloride 0.9% flush syringe	SH065	item		<b>1</b>	<b>1</b>	<b>1</b>	
84	cup, sterile, 12-16 oz	SL156	item		<b>1</b>	<b>1</b>	<b>1</b>	
85	cup, sterile, 8 oz	SL157	item		<b>1</b>	<b>1</b>	<b>1</b>	
86	cup, biopsy-specimen sterile 4oz	SL036	item		<b>1</b>	<b>1</b>	<b>1</b>	
87	shoe covers, surgical	SB039	item		<b>2</b>	<b>2</b>	<b>2</b>	
88	applicator, sponge-tipped	SG009	item		<b>4</b>	<b>4</b>	<b>4</b>	
89	blade, surgical (Bard-Parker)	SF007	item		<b>1</b>	<b>1</b>	<b>1</b>	
90	cap, surgical	SB001	item		<b>2</b>	<b>2</b>	<b>2</b>	
91	lidocaine 1%-2% inj (Xylocaine)	SH047	ml		<b>10</b>	<b>10</b>	<b>10</b>	
92	underpad 2ft x 3ft (Chux)	SB044	item		<b>1</b>	<b>1</b>	<b>1</b>	
93	drainage catheter, all purpose	SD161	item		<b>1</b>	<b>1</b>	<b>1</b>	
94	kit, AccuStick II Introducer System with RO Marker	SA071	kit		<b>1</b>	<b>1</b>	<b>1</b>	
95	drainage pouch, nephrostomy-biliary	SD163	item		<b>1</b>	<b>1</b>	<b>1</b>	
96	catheter percutaneous fastener (Percu-Stay)	SD146	item		<b>1</b>	<b>1</b>	<b>1</b>	
97	closed flush system, angiography	SC010	item		<b>1</b>	<b>1</b>	<b>1</b>	
98	guidewire	SD088	item		<b>1</b>	<b>1</b>	<b>1</b>	
99	dilator, vessel, angiographic	SD043	item		<b>1</b>	<b>1</b>	<b>1</b>	
100	drape, sterile, three-quarter sheet	SB014	item		<b>1</b>	<b>1</b>	<b>1</b>	
101	mask, surgical, with face shield	SB034	item		<b>2</b>	<b>2</b>	<b>2</b>	
102	sodium chloride 0.9% irrigation (500-1000ml uou)	SH069	item		<b>1</b>	<b>1</b>	<b>1</b>	
103	tray, shave prep	SA067	tray		<b>1</b>	<b>1</b>	<b>1</b>	
104	syringe 50-60ml	SC056	item		<b>2</b>	<b>2</b>	<b>2</b>	
105	drape-towel, sterile 18in x 26in	SB019	item		<b>4</b>	<b>4</b>	<b>4</b>	
106	<b>EQUIPMENT</b>	<b>CODE</b>						
107	room, CT				<b>70</b>	<b>62</b>	<b>62</b>	<b>9</b>
108	room, ultrasound, general	EL015						
109	film processor, dry, laser	ED024						<b>3</b>
110	film alternator (motorized film viewbox)	ER029						<b>3</b>
111	light, exam	EQ168			<b>60</b>	<b>60</b>	<b>60</b>	
112	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011			<b>130</b>	<b>122</b>	<b>122</b>	
113	IV infusion pump	EQ032			<b>130</b>	<b>122</b>	<b>122</b>	
114	table, instrument, mobile	EF027			<b>130</b>	<b>122</b>	<b>122</b>	
115	Stretcher	EF018						



AMA/Specialty Society RVS Update Committee Summary of Recommendations  
*Codes Reported Together 75% or More Screen*

April 2013

**Breast Biopsy**

In January 2012, the RUC identified codes 77031 *Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation*, 19103 *Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance*, 77032 *Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation* and 19290 *Preoperative placement of needle localization wire, breast* through the Codes Reported Together 75% or More screen. In October 2012, the CPT Editorial Panel established six new bundled codes to report breast biopsy with imaging guidance and established eight new bundled codes to report placement of breast location devices with imaging guidance. The six breast lesion biopsy codes include marker placement and specimen radiography if performed and are categorized by stereotactic guidance, ultrasound guidance and MRI guidance, each with an add-on code to describe additional lesions subject to biopsy. The eight breast marker placement codes are reported in the absence of breast biopsy and are categorized by mammographic guidance, stereotactic guidance, ultrasound guidance and MRI guidance, each with an add-one code to describe additional lesions localized.

The RUC noted that the recommendations for these two families of services, breast lesion biopsy and breast marker placement, maintain the proper rank order relative to one another in regards to physician work as follows: (1) magnetic resonance guidance; (2) stereotactic guidance; (3) mammographic guidance; and (4) ultrasound guidance.

**Breast Lesion Biopsy**

The specialty society indicated and the RUC agreed that for the breast lesion biopsy family of services, imaging of the biopsy specimen is bundled into these services when performed. For example, the physician would use radiography for a specimen from the patient to identify calcification and confirm it is in the specimen prior to sending it to the pathologist for further analysis.

**19081 Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance**

The RUC reviewed the survey results from 99 physicians for CPT code 19081 and determined that the survey respondents slightly overestimated the work required to perform this service. The respondents indicated CPT code 37191 *Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed* (work RVU = 4.71) as the key reference service which is more intense and complex and may have caused the respondents to overestimate the work for 19081. Additionally, the RUC determined that the 25<sup>th</sup> percentile work RVU was

too low for this service and would cause a rank order anomaly within this family and other similar services. Therefore, the RUC recommended a direct crosswalk to CPT code 31296 *Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation)* (work RVU = 3.29 and 30 minutes intra-service time). The RUC determined that for stereotactic guidance service, the patient is typically in the prone position, therefore 2 additional minutes for positioning time is warranted. The RUC agreed that the pre-service package 1A *Facility straightforward patient/procedure (no sedation/anesthesia)* with the positioning adjustment for 13 minutes evaluation, 3 minute positioning and 6 minutes scrub, dress and wait pre-service time is appropriate. The RUC determined the physician time of 22 minutes pre-service, 30 minutes intra-service and 15 minutes immediate post-service time were appropriate to perform this procedure. For additional support the RUC compared 19081 to 50386 *Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation* (work RVU = 3.30) and determined that each require similar physician work and the same intra-service time of 30 minutes. **The RUC recommends a work RVU of 3.29 for CPT code 19081.**

**19082 Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)**

The RUC reviewed the survey results from 52 physicians for CPT code 19082 and determined that the physician work may have been overestimated in relation to the base code 19081. The RUC discussed the pre-service time associated with this add-on code and determined that 1 minute positioning and 4 minutes scrub, dress and wait of pre-service time are appropriate. The patient must come off of the table to be re-positioned, re-draped and additional anesthesia must be administered for each subsequent lesion biopsied. The specialty society indicated and the RUC agreed that the physician work required to biopsy each additional lesion is half that of the primary code. Therefore, the RUC determined a work value of 1.65 appropriately values this procedure. For support the RUC referenced similar service 76812 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)* (work RVU = 1.78), which requires similar physician work and time. **The RUC recommends a work RVU of 1.65 for CPT code 19082.**

**19083 Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance**

The RUC reviewed the survey results from 97 physicians for CPT code 19083 and determined that the median work RVU of 3.10 appropriately accounts for the work required to perform this service and is appropriate in relation to this code family. The RUC determined that for this ultrasound guided service, the patient is typically in the supine position; therefore, no additional positioning time is warranted. The RUC agreed that the pre-service package 1A *Facility straightforward patient/procedure (no sedation/anesthesia)* with an adjustment in the scrub, dress and wait time to match the survey respondents for 13 minutes evaluation, 1 minute positioning and 5 minutes scrub, dress and wait pre-service time is appropriate. The RUC recommends 19 minutes of pre-service, 25 minutes of intra-service and 15 minutes of immediate post-service time for this service. The RUC compared 19083 to key reference service 37191 *Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intra-procedural*

*roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed* (work RVU = 4.71) and agreed that the key reference service is more intense and complex and requires 5 more minutes intra-service to perform. For additional support the RUC reviewed MPC codes 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (work RVU = 2.78); 15002 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children* (work RVU = 3.65) and similar service 32557 *Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance* (work RVU = 3.12) and determined that the median work RVU of 3.10 appropriately places this service relative to other similar services. **The RUC recommends a work RVU of 3.10 for CPT code 19083.**

**19084 Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)**

The RUC reviewed the survey results from 52 physicians for CPT code 19084 and determined that the physician work may have been overestimated in relation to the survey responses related to the base code 19083. The RUC discussed the pre-service time associated with this add-on code and determined that 1 minute positioning and 4 minutes scrub, dress and wait of pre-service time are appropriate. The patient must come off of the table to be re-positioned, re-draped and additional anesthesia must be administered for each subsequent lesion biopsied. The specialty society indicated and the RUC agreed that the physician work required to biopsy each additional lesion is half of that of the primary code. Therefore, the RUC determined a work value of 1.55 appropriately values this procedure. For support, the RUC referenced similar service 49412 *Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), open, intra-abdominal, intrapelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple (List separately in addition to code for primary procedure)* (work RVU = 1.50), which requires similar physician work and time. **The RUC recommends a work RVU of 1.55 for CPT code 19084.**

**19085 Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including magnetic resonance guidance**

The RUC reviewed the survey results from 64 physicians for CPT code 19085 and determined that the median work RVU of 3.64 accounts for the work required to perform this service and maintains appropriate relativity within this family. The RUC determined that for MRI guidance service, the patient is typically in the prone position, therefore 2 additional minutes for positioning time is warranted. The RUC agreed that the pre-service package 1A *Facility straightforward patient/procedure (no sedation/anesthesia)* with the positioning adjustment for 13 minutes evaluation, 3 minute positioning and 6 minutes scrub, dress and wait pre-service time is appropriate. The RUC recommends 22 minutes of pre-service, 45 minutes of intra-service and 15 minutes of immediate post-service time for this service. The RUC compared 19085 to key reference service 49411 *Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum, single or multiple* (work RVU = 3.82) and noted that the respondents indicated variation in the intensity and complexity measures for both of these services, which reflects the unique nature of breast interventions.



Although reference code 49411 requires 5 minutes less intra-service than 19085, 40 and 45 minutes, respectively, it is a more intense service. For additional support the RUC reviewed MPC codes 15002 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children* (work RVU = 3.65) and 31628 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe* (work RVU = 3.80) and determined that the median work RVU of 3.64 appropriately places this service relative to other similar services. **The RUC recommends a work RVU of 3.64 for CPT code 19085.**

**19086 Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)**

The RUC reviewed the survey results from 40 physicians for CPT code 19086 and determined that the survey 25<sup>th</sup> percentile work RVU of 1.80 was appropriate. The RUC discussed the pre-service time associated with this add-on code and determined that 1 minute positioning and 4 minutes scrub, dress and wait of pre-service time are appropriate. The patient must come off of the table to be re-positioned, re-draped and additional anesthesia must be administered for each subsequent lesion. The specialty society indicated and the RUC agreed that the physician work required to biopsy each additional lesion is half of that of the primary code. Therefore, the RUC determined a work value of 1.82 appropriately values this procedure. For support, the RUC referenced similar service 13133 *Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (List separately in addition to code for primary procedure)* (work RVU = 2.19), which has slightly higher total time and, hence, a slightly higher RVU. **The RUC recommends a work RVU of 1.82 for CPT code 19086.**

**Breast Marker Placement**

**19281 Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including mammographic guidance**

The RUC reviewed the survey results from 62 physicians and determined that the median work RVU of 2.00 appropriately accounts for the work required to perform this service and maintains appropriate relativity within this code family. The RUC agreed that the pre-service package 1A *Facility straightforward patient/procedure (no sedation/anesthesia)* for 13 minutes evaluation, 1 minute positioning and 6 minutes scrub, dress and wait pre-service time is appropriate. The RUC agreed that 20 minutes of pre-service, 30 minutes of intra-service and 15 minutes of immediate post-service time are appropriate for this service. The RUC compared 19281 to key reference service 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older* (work RVU = 2.50) and noted that the respondents indicated higher intensity and complexity for the surveyed service, however, 36556 requires 15 minutes of intra-service time compared to 30 minutes. The RUC agreed that this reflects the unique nature of breast interventions. The breast marker placement services are associated with very high patient and family anxiety, which tend to increase the psychological stress of the physician. Although the reference code requires less time, the physician work is higher, rendering it a more intense service. For additional support, the RUC reviewed MPC codes 64483 *Injection(s)*,

*anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level (work RVU = 1.90) and 90937 Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription (work RVU = 2.11) and determined that the median work RVU of 2.00 appropriately places this service relative to other similar services. **The RUC recommends a work RVU of 2.00 for CPT code 19281.***

**19282 Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including mammographic guidance (List separately in addition to code for primary procedure)**

The RUC reviewed the survey results from 37 physicians for CPT code 19282 and determined that the physician work may have been overestimated in relation to the survey responses related to the base code 19281. The RUC discussed the pre-service time associated with this add-on code and determined that 1 minute positioning and 4 minutes scrub, dress and wait of pre-service time are appropriate. The patient must come off of the table to be re-positioned, re-draped and additional anesthesia must be administered for each subsequent lesion. The specialty society indicated and the RUC agreed that the physician work required for each additional lesion is half of that of the primary code. Therefore, the RUC determined a work value of 1.00 appropriately values this procedure. For further support the RUC referenced similar service 11046 *Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 1.03), which requires similar physician work and time. **The RUC recommends a work RVU of 1.00 for CPT code 19282.**

**19283 Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance**

The RUC reviewed the survey results from 93 physicians and determined that the survey 25<sup>th</sup> percentile work RVU of 2.00 appropriately accounts for the work required to perform this service and maintains appropriate relativity within this code family. The RUC determined that for this stereotactic guidance service, the patient is typically in the prone position, therefore 2 additional minutes for positioning time is warranted. The RUC agreed that the pre-service package 1A *Facility straightforward patient/procedure (no sedation/anesthesia)* with the positioning adjustment for 13 minutes evaluation, 3 minute positioning and 6 minutes scrub, dress and wait pre-service time is appropriate. The RUC agreed that 22 minutes of pre-service, 20 minutes of intra-service and 15 minutes of immediate post-service time are appropriate for this service. The survey respondents indicated that the intra-service time is 10 minutes less for 19283 compared to 19281. The RUC noted that the survey respondents may have only assumed one wire for 19283 as it is not specified as a dual-wire service in the vignette as it is for 19281, thus causing the time variation. The specialty societies indicated and the RUC agreed that two wires are typical to perform 19283, the same as 19281, therefore it is appropriate that the work RVU for these services to be the same. The RUC compared 19283 to key reference service 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older* (work RVU = 2.50) and noted that the respondents indicated higher intensity and complexity for the surveyed service, however, 36556 requires 15 minutes of intra-service time compared to 20 minutes. The RUC agreed that this reflects the unique nature of breast interventions. The breast marker placement services are associated with very high patient and family anxiety, which tend to increase the psychological stress of the physician. Although the reference code requires less time, the physician work is higher, rendering it a more intense service. For additional support, the RUC reviewed MPC

codes 64483 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level* (work RVU = 1.90) and 90937 *Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription* (work RVU = 2.11) and determined that the 25<sup>th</sup> percentile work RVU of 2.00 appropriately places this service relative to other similar services. **The RUC recommends a work RVU of 2.00 for CPT code 19283.**

**19284 Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)**

The RUC reviewed the survey results from 48 physicians for CPT code 19284 and determined that the physician work may have been overestimated in relation to the survey responses related to the base code 19283. The RUC discussed the pre-service time associated with this add-on code and determined that 1 minute positioning and 4 minutes scrub, dress and wait of pre-service time are appropriate. The patient must come off of the table to be re-positioned, re-draped and additional anesthesia must be administered for each subsequent lesion. The specialty society indicated and the RUC agreed that the physician work required for each additional lesion is half that of the primary code. Therefore, the RUC determined a work value of 1.00 appropriately values this procedure. Additionally, the RUC determined that this service requires the same physician work and time as 19282 and therefore should be valued the same. For further support the RUC referenced similar service 11046 *Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 1.03), which requires similar physician work and time. **The RUC recommends a work RVU of 1.00 for CPT code 19284.**

**19285 Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including ultrasound guidance**

The RUC reviewed the survey results from 101 physicians and determined that the survey 25<sup>th</sup> percentile work RVU of 1.70 appropriately accounts for the work required to perform this service and maintains appropriate relativity within this code family. The RUC determined that for this ultrasound guidance service, the patient is typically in the supine position; therefore no additional positioning time is warranted. The RUC agreed that the pre-service package 1A *Facility straightforward patient/procedure (no sedation/anesthesia)* for 13 minutes evaluation, 1 minute positioning and 6 minutes scrub, dress and wait pre-service time is appropriate. The RUC agreed that 20 minutes of pre-service, 15 minutes of intra-service and 15 minutes of immediate post-service time are appropriate for this service. The RUC noted that 19285 typically requires one wire and less intra-service time than 19281 and 19283 and therefore should be valued lower. The RUC compared 19285 to key reference service 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older* (work RVU = 2.50) and noted that the respondents indicated higher intensity and complexity for the surveyed service, however, both services require 15 minutes of intra-service time. The RUC agreed that this reflects the unique nature of breast interventions. The breast marker placement services are associated with very high patient and family anxiety, which tend to increase the psychological stress of the physician. Although the reference code has the same intra-service time, the physician work is higher, rendering it a more intense service. For additional support, the RUC reviewed MPC code 64483 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT);*

*lumbar or sacral, single level* (work RVU = 1.90) and determined that the 25<sup>th</sup> percentile work RVU of 1.70 appropriately places this service relative to other similar services. **The RUC recommends a work RVU of 1.70 for CPT code 19285.**

**19286 Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)**

The RUC reviewed the survey results from 48 physicians for CPT code 19286 and determined that the physician work may have been overestimated in relation to the survey responses related to the base code 19285. The RUC discussed the pre-service time associated with this add-on code and determined that 1 minute positioning and 4 minutes scrub, dress and wait of pre-service time are appropriate. The patient must come off of the table to be re-positioned, re-draped and additional anesthesia must be administered for each subsequent lesion. The specialty society indicated and the RUC agreed that the physician work required for each additional lesion is half of that of the primary code. Therefore, the RUC determined a work value of 0.85 appropriately values this procedure. For further support the RUC referenced similar service 93565 *Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective left ventricular or left atrial angiography (List separately in addition to code for primary procedure)* (work RVU = 0.86), which requires similar physician work and time. **The RUC recommends a work RVU of 0.85 for CPT code 19286.**

**19287 Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including magnetic resonance guidance**

The RUC reviewed the survey results from 64 physicians for CPT code 19287 and determined that the median work RVU of 3.02 appropriately accounts for the work required to perform this service and maintains appropriate relativity within this code family. The RUC determined that for this magnetic resonance guidance service, the patient is typically in the prone position; therefore 2 additional minutes for positioning time is warranted. The RUC agreed that the pre-service package 1A *Facility straightforward patient/procedure (no sedation/anesthesia)* with the positioning adjustment for 13 minutes evaluation, 3 minute positioning and 6 minutes scrub, dress and wait pre-service time is appropriate. The RUC recommends 22 minutes of pre-service, 37 minutes of intra-service and 15 minutes of immediate post-service time for this service. The RUC noted that 19287 is for the primary lesion with multiple clips, typically 3 clips. The RUC compared 19287 to key reference service 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older* (work RVU = 2.50 and 15 minutes intra-service time) and determined that the physician work is more intense and complex and requires an additional 22 minutes of intra-service time to complete than the key reference service. For additional support, the RUC reviewed MPC code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (work RVU = 2.78 and 30 minutes intra-service time) and determined that the median work RVU of 3.02 appropriately places this service relative to other similar services. **The RUC recommends a work RVU of 3.02 for CPT code 19287.**

**19288 Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)**

The RUC reviewed the survey results from 40 physicians for CPT code 19288 and determined that the physician work may have been overestimated in relation to the survey responses related to the base code 19287. The RUC discussed the pre-service time associated with this add-on code and determined that 1 minute positioning and 4 minutes scrub, dress and wait of pre-service time are appropriate. The patient must come off of the table to be re-positioned, re-draped and additional anesthesia must be administered for each subsequent lesion. The specialty society indicated and the RUC agreed that the physician work required for each additional lesion is half of that of the primary code. Therefore, the RUC determined a work value of 1.51 appropriately values this procedure. For further support the RUC referenced similar service 31637 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; each additional major bronchus stented (List separately in addition to code for primary procedure)* (work RVU = 1.58), which requires similar physician work and time. **The RUC recommends a work RVU of 1.51 for CPT code 19288.**

### **Practice Expense**

The RUC requested that the specialties clarify the contents of the stereotactic imaging system included as an equipment input in the practice expense. According to the CMS direct PE inputs the *breast biopsy imaging system, stereotactic (imager, table, software)* (EQ075) includes a table used for stereotactic services. The RUC noted a separate input, *table, power* (EF031) is also included in the equipment items and should be removed if a separate table is not necessary to perform the service. Following the meeting, the specialty confirmed that a separate table is not needed and subsequently the *table, power* (EF031) has been removed from the stereotactic services codes. The RUC noted that a *table, exam* (EF023) is included in the equipment inputs for the mammography codes because a table is not included in the *room, mammography* (EL013). The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

### **Work Neutrality**

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

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<b>General</b>				
10022		<p>Fine needle aspiration, with imaging guidance</p> <p>(For placement of percutaneous localization <u>device[s]</u> [eg, clip, metallic pellet, during breast biopsy], <del>use 19295, see 19081-19086</del>)</p> <p>(For radiological supervision and interpretation, see 76942, 77002, 77012, 77021)</p> <p>(For percutaneous needle biopsy other than fine needle aspiration, see <del>20206 19081-19086 19081, 19083, 19085</del>, for breast, <u>20206</u>, for muscle, 32400 for pleura, 32405 for lung or mediastinum, 42400 for salivary gland, 47000 for liver, 48102 for pancreas, 49180 for abdominal or retroperitoneal mass, 50200 for kidney, 54500 for testis, 54800 for epididymis, 60100 for thyroid, 62267 for nucleus pulposus, intervertebral disc, or paravertebral tissue, 62269 for spinal cord)</p> <p>(For evaluation of fine needle aspirate, see 88172, 88173)</p>		
<b>Surgery Integumentary Breast Incision</b>				
19000		Puncture aspiration of cyst of breast;		
19001		<p>each additional cyst (List separately in addition to code for primary procedure)</p> <p>(Use 19001 in conjunction with 19000)</p> <p>(If imaging guidance is performed, see 76942, 77021, <del>77031, 77032</del>)</p>		

**Integumentary**  
**Breast**  
**Excision**  
**Surgery**

Excisional breast surgery includes certain biopsy procedures, the removal of cysts or other benign or malignant tumors or lesions, and the surgical treatment of breast and chest wall malignancies. Biopsy procedures may be percutaneous or open, and they involve the removal of differing amounts of tissue for diagnosis.

Breast biopsies, without image guidance are reported with 19100 and 19101. Image-guided breast biopsies including the placement of localization devices when performed are reported using codes 19081-19086. The image-guided placement of localization devices without image-guided biopsy are reported with 19100-19103, 19281-19288. When more than one biopsy or localization device placement is performed using the same imaging modality, use an add-on code. If additional biopsies are performed using different imaging modalities, report another primary code for each additional modality. When an open incisional biopsy is performed after image-guided placement of a localization device, 19101 is reported and the appropriate image-guided localization device placement code is reported. The open excision of breast lesions (eg, lesions of the breast ducts, cysts, benign or malignant tumors), without specific attention to adequate surgical margins, with or without the preoperative placement of radiological markers, is reported using codes 19110-19126. Partial mastectomy procedures (eg, lumpectomy, tylectomy, quadrantectomy, or segmentectomy) describe open excisions of breast tissue with specific attention to adequate surgical margins

Partial mastectomy procedures are reported using codes 19301 or 19302 as appropriate. Documentation for partial mastectomy procedures includes attention to the removal of adequate surgical margins surrounding the breast mass or lesion.

Total mastectomy procedures include simple mastectomy, complete mastectomy, subcutaneous mastectomy, modified radical mastectomy, radical mastectomy, and more extended procedures (eg, Urban type operation). Total mastectomy procedures are reported using codes 19303-19307 as appropriate.

Excisions or resections of chest wall tumors including ribs, with or without reconstruction, with or without mediastinal lymphadenectomy, are reported using codes 19260, 19271, or 19272. Codes 19260-19272 are not restricted to breast tumors and are used to report resections of chest wall tumors originating from any chest wall component. (For excision of lung or pleura, see 32310 et seq)

(To report bilateral procedure, report modifier 50 with the procedure code)

●19081	O1	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance	000	3.29
●+19082	O2	each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure) <u>(Use 19082 in conjunction with 19081)</u>	ZZZ	1.65
●19083	O3	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance	000	3.10
+●19084	O4	each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure) <u>(Use 19084 in conjunction with 19083)</u>	ZZZ	1.55
●19085	O5	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including magnetic resonance guidance	000	3.64
●+19086	O6	each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure) <u>(Use 19086 in conjunction with 19085)</u> <u>(Do not report 19081-19086 in conjunction with 19281-19288, 76098, 76942, 77002, 77021 for same lesion)</u>	ZZZ	1.82



19100            Biopsy of breast; percutaneous, needle core, not using imaging guidance (separate procedure) (For fine needle aspiration, use 10021) <del>(For image-guided breast biopsy, see 10022, 19081-19086)</del>				
19101            open, incisional (For placement of percutaneous localization clip with imaging guidance, see 19281-19288)				
D19102		percutaneous, needle core, using imaging guidance	000	N/A
D19103		percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance (19102, 19103 have been deleted. To report, see 19081-19086) <del>(For imaging guidance performed in conjunction with 19102, 19103, see 76942, 77012, 77021, 77031, 77032)</del> (For placement of percutaneous localization clip, use 19295)	000	N/A
<b>Category I</b> <b>Surgery</b> <b>Integumentary System</b> <b>Breast</b> <b>Introduction</b> Breast biopsies without image-guidance are reported with 19100 and 19101. Image-guided breast biopsies, including the placement of localization devices when performed are reported using codes 19081-19086. The image guided placement of localization devices without image guided biopsy are reported with 19281-19288. When more than one biopsy or localization device placement is performed using the same imaging modality use an add-on code. If additional biopsies are performed using different imaging modalities, report another primary code for each additional modality. When an open incisional biopsy is performed after image guided placement of a localization device, 19101 is reported and the appropriate image guided localization device placement code is reported.				

●19281	O7	Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including mammographic guidance	000	2.00
✚●19282	O8	each additional lesion, including mammographic guidance (List separately in addition to code for primary procedure)  (Use 19282 in conjunction with 19281)	ZZZ	1.00
●19283	O9	Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance	000	2.00
✚●19284	O10	each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)  (Use 19284 in conjunction with 19283)	ZZZ	1.00
●19285	O11	Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including ultrasound guidance	000	1.70
✚●19286	O12	each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)  (Use 19286 in conjunction with 19285)	ZZZ	0.85
●19287	O13	Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including magnetic resonance guidance	000	3.02

✚●19288	O14	<p>each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)</p> <p><u>(Use 19288 in conjunction with 19287)</u></p> <p><u>(Do not report 19281-19288 in conjunction with 19081-19086, 76942, 77002, 77021 for same lesion)</u></p> <p><u>(For surgical specimen radiography, use 76098)</u></p>	ZZZ	1.51
D19290		<del>Preoperative placement of needle localization wire, breast;</del>	000	N/A
D19291		<p><del>each additional lesion (List separately in addition to code for primary procedure)</del></p> <p><del>(Use 19291 in conjunction with 19290)</del></p> <p><del>(For radiological supervision and interpretation, see 76942, 77031, 77032)</del></p> <p><del>(19290, 19291 have been deleted).</del></p> <p><u>(To report image guided placement of breast localization devices during image guided biopsy, see 19081-19086. To report image guided placement of breast localization device without image guided biopsy, see 19281-19288)</u></p>	ZZZ	N/A

D+19295		<p><del>Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure); (Use 19295 in conjunction with 10022, 19102, 19103)</del></p> <p><u>(19295 has been deleted)</u></p> <p><u>(To report placement of breast localization device during biopsy, see 19081-19086. To report placement of breast localization device without biopsy, see 19281-19288)</u></p> <p><del>(Use 19295 in conjunction with 10022, 19102, 19103)</del></p>	ZZZ	N/A
<b>Radiology</b> <b>Diagnostic Ultrasound</b> <b>Other Procedures</b>  76098              Radiological examination, surgical specimen  <u>(Do not report 76098 in conjunction with 19081-19086)</u>				
<b>Radiology</b> <b>Diagnostic Ultrasound</b> <b>Ultrasonic Guidance Procedures</b>  76942              Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation  (Do not report 76942 in conjunction with <u>19083, 19285</u> , 27096, 32554, 32555, 32556, 32557, 37760, 37761, 43232, 43237, 43242, 45341, 45342, 64479-64484, 64490-64495, 76975, 0213T-0218T, 0228T-0231T, 0232T, 0249T, 0301T)  (For injection(s) of platelet rich plasma, use 0232T)				

<b>Radiology</b> <b>Radiologic Guidance</b> <b>Fluoroscopic Guidance</b>	
77002	<p>Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)</p> <p>(See appropriate surgical code for procedure and anatomic location)</p> <p>(77002 includes all radiographic arthrography with the exception of supervision and interpretation for CT and MR arthrography)</p> <p>(Do not report 77002 in conjunction with <u>19081-19086, 19281-19288, 32554, 32555, 32556, 32557, 70332, 73040, 73085, 73115, 73525, 73580, 73615, 0232T</u>)</p> <p>(For injection(s) of platelet rich plasma, use 0232T)</p> <p>(77002 is included in the organ/anatomic specific radiological supervision and interpretation procedures 49440, 74320, 74355, 74445, 74470, 74475, 75809, 75810, 75885, 75887, 75980, 75982, 75989)</p>
<b>Magnetic Resonance Guidance</b>	
77021	<p>Magnetic resonance guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation</p> <p>(For procedure, see appropriate organ or site)</p> <p>(Do not report 77021 in conjunction with <u>19085, 19287, 32554, 32555, 32556, 32557, 0232T</u>)</p> <p>(For injection(s) of platelet rich plasma, use 0232T)</p>
<b>Radiology</b> <b>Radiologic Guidance</b> <b>Other Radiologic Guidance</b>	

D77031		<p><del>Stereotactic localization guidance for breast biopsy or needle placement(eg, for wire localization or for injection), each lesion, radiological supervision and interpretation</del></p> <p><del>(For procedure, see 10022, 19000-19103, 19290, 19291)</del></p> <p><del>(For injection for sentinel node localization without lymphoscintigraphy, use 38792)</del></p> <p><del>(77031 has been deleted)</del></p> <p><u>(To report stereotactic localization guidance for breast biopsy or for placement of breast localization device(s), see 19081, 19283)</u></p>	XXX	N/A
D77032		<p><del>Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation</del></p> <p><del>(For procedure, see 10022, 19000, 19102, 19103, 19290, 19291)</del></p> <p><del>(For injection for sentinel node localization without lymphoscintigraphy, use 38792)</del></p> <p><del>(For mammographic guidance for needle placement of breast lesion, use 77032)</del></p> <p><del>(77032 has been deleted)</del></p> <p><u>(To report mammographic guidance for placement of breast localization device(s), see 19281)</u></p>	XXX	N/A

**Radiology****Breast, Mammography**

~~(For mammographic guidance for needle placement of breast lesion, use 77032)~~

- ✚77051 Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further review for interpretation, with or without digitization of film radiographic images; diagnostic mammography (List separately in addition to code for primary procedure)

(Use 77051 in conjunction with 77055, 77056)

AMA/Specialty Society RVS Update Committee Summary of Recommendations  
*Codes Reported Together 75% or More Screen*

April 2013

**Breast Biopsy**

In January 2012, the RUC identified codes 77031 *Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation*, 19103 *Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance*, 77032 *Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation* and 19290 *Preoperative placement of needle localization wire, breast* through the Codes Reported Together 75% or More screen. In October 2012, the CPT Editorial Panel established six new bundled codes to report breast biopsy with imaging guidance and established eight new bundled codes to report placement of breast location devices with imaging guidance. The six breast lesion biopsy codes include marker placement and specimen radiography if performed and are categorized by stereotactic guidance, ultrasound guidance and MRI guidance, each with an add-on code to describe additional lesions subject to biopsy. The eight breast marker placement codes are reported in the absence of breast biopsy and are categorized by mammographic guidance, stereotactic guidance, ultrasound guidance and MRI guidance, each with an add-one code to describe additional lesions localized.

The RUC noted that the recommendations for these two families of services, breast lesion biopsy and breast marker placement, maintain the proper rank order relative to one another in regards to physician work as follows: (1) magnetic resonance guidance; (2) stereotactic guidance; (3) mammographic guidance; and (4) ultrasound guidance.

**Breast Lesion Biopsy**

The specialty society indicated and the RUC agreed that for the breast lesion biopsy family of services, imaging of the biopsy specimen is bundled into these services when performed. For example, the physician would use radiography for a specimen from the patient to identify calcification and confirm it is in the specimen prior to sending it to the pathologist for further analysis.

**19081 Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance**

The RUC reviewed the survey results from 99 physicians for CPT code 19081 and determined that the survey respondents slightly overestimated the work required to perform this service. The respondents indicated CPT code 37191 *Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed* (work RVU = 4.71) as the key reference service which is more intense and complex and may have caused the respondents to overestimate the work for 19081. Additionally, the RUC determined that the 25<sup>th</sup> percentile work RVU was



too low for this service and would cause a rank order anomaly within this family and other similar services. Therefore, the RUC recommended a direct crosswalk to CPT code 31296 *Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation)* (work RVU = 3.29 and 30 minutes intra-service time). The RUC determined that for stereotactic guidance service, the patient is typically in the prone position, therefore 2 additional minutes for positioning time is warranted. The RUC agreed that the pre-service package 1A *Facility straightforward patient/procedure (no sedation/anesthesia)* with the positioning adjustment for 13 minutes evaluation, 3 minute positioning and 6 minutes scrub, dress and wait pre-service time is appropriate. The RUC determined the physician time of 22 minutes pre-service, 30 minutes intra-service and 15 minutes immediate post-service time were appropriate to perform this procedure. For additional support the RUC compared 19081 to 50386 *Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation* (work RVU = 3.30) and determined that each require similar physician work and the same intra-service time of 30 minutes. **The RUC recommends a work RVU of 3.29 for CPT code 19081.**

**19082 Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)**

The RUC reviewed the survey results from 52 physicians for CPT code 19082 and determined that the physician work may have been overestimated in relation to the base code 19081. The RUC discussed the pre-service time associated with this add-on code and determined that 1 minute positioning and 4 minutes scrub, dress and wait of pre-service time are appropriate. The patient must come off of the table to be re-positioned, re-draped and additional anesthesia must be administered for each subsequent lesion biopsied. The specialty society indicated and the RUC agreed that the physician work required to biopsy each additional lesion is half that of the primary code. Therefore, the RUC determined a work value of 1.65 appropriately values this procedure. For support the RUC referenced similar service 76812 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)* (work RVU = 1.78), which requires similar physician work and time. **The RUC recommends a work RVU of 1.65 for CPT code 19082.**

**19083 Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance**

The RUC reviewed the survey results from 97 physicians for CPT code 19083 and determined that the median work RVU of 3.10 appropriately accounts for the work required to perform this service and is appropriate in relation to this code family. The RUC determined that for this ultrasound guided service, the patient is typically in the supine position; therefore, no additional positioning time is warranted. The RUC agreed that the pre-service package 1A *Facility straightforward patient/procedure (no sedation/anesthesia)* with an adjustment in the scrub, dress and wait time to match the survey respondents for 13 minutes evaluation, 1 minute positioning and 5 minutes scrub, dress and wait pre-service time is appropriate. The RUC recommends 19 minutes of pre-service, 25 minutes of intra-service and 15 minutes of immediate post-service time for this service. The RUC compared 19083 to key reference service 37191 *Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intra-procedural*

*roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed* (work RVU = 4.71) and agreed that the key reference service is more intense and complex and requires 5 more minutes intra-service to perform. For additional support the RUC reviewed MPC codes 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (work RVU = 2.78); 15002 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children* (work RVU = 3.65) and similar service 32557 *Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance* (work RVU = 3.12) and determined that the median work RVU of 3.10 appropriately places this service relative to other similar services. **The RUC recommends a work RVU of 3.10 for CPT code 19083.**

**19084 Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)**

The RUC reviewed the survey results from 52 physicians for CPT code 19084 and determined that the physician work may have been overestimated in relation to the survey responses related to the base code 19083. The RUC discussed the pre-service time associated with this add-on code and determined that 1 minute positioning and 4 minutes scrub, dress and wait of pre-service time are appropriate. The patient must come off of the table to be re-positioned, re-draped and additional anesthesia must be administered for each subsequent lesion biopsied. The specialty society indicated and the RUC agreed that the physician work required to biopsy each additional lesion is half of that of the primary code. Therefore, the RUC determined a work value of 1.55 appropriately values this procedure. For support, the RUC referenced similar service 49412 *Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), open, intra-abdominal, intrapelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple (List separately in addition to code for primary procedure)* (work RVU = 1.50), which requires similar physician work and time. **The RUC recommends a work RVU of 1.55 for CPT code 19084.**

**19085 Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including magnetic resonance guidance**

The RUC reviewed the survey results from 64 physicians for CPT code 19085 and determined that the median work RVU of 3.64 accounts for the work required to perform this service and maintains appropriate relativity within this family. The RUC determined that for MRI guidance service, the patient is typically in the prone position, therefore 2 additional minutes for positioning time is warranted. The RUC agreed that the pre-service package 1A *Facility straightforward patient/procedure (no sedation/anesthesia)* with the positioning adjustment for 13 minutes evaluation, 3 minute positioning and 6 minutes scrub, dress and wait pre-service time is appropriate. The RUC recommends 22 minutes of pre-service, 45 minutes of intra-service and 15 minutes of immediate post-service time for this service. The RUC compared 19085 to key reference service 49411 *Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum, single or multiple* (work RVU = 3.82) and noted that the respondents indicated variation in the intensity and complexity measures for both of these services, which reflects the unique nature of breast interventions.

Although reference code 49411 requires 5 minutes less intra-service than 19085, 40 and 45 minutes, respectively, it is a more intense service. For additional support the RUC reviewed MPC codes 15002 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children* (work RVU = 3.65) and 31628 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe* (work RVU = 3.80) and determined that the median work RVU of 3.64 appropriately places this service relative to other similar services. **The RUC recommends a work RVU of 3.64 for CPT code 19085.**

**19086 Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)**

The RUC reviewed the survey results from 40 physicians for CPT code 19086 and determined that the survey 25<sup>th</sup> percentile work RVU of 1.80 was appropriate. The RUC discussed the pre-service time associated with this add-on code and determined that 1 minute positioning and 4 minutes scrub, dress and wait of pre-service time are appropriate. The patient must come off of the table to be re-positioned, re-draped and additional anesthesia must be administered for each subsequent lesion. The specialty society indicated and the RUC agreed that the physician work required to biopsy each additional lesion is half of that of the primary code. Therefore, the RUC determined a work value of 1.82 appropriately values this procedure. For support, the RUC referenced similar service 13133 *Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (List separately in addition to code for primary procedure)* (work RVU = 2.19), which has slightly higher total time and, hence, a slightly higher RVU. **The RUC recommends a work RVU of 1.82 for CPT code 19086.**

**Breast Marker Placement**

**19281 Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including mammographic guidance**

The RUC reviewed the survey results from 62 physicians and determined that the median work RVU of 2.00 appropriately accounts for the work required to perform this service and maintains appropriate relativity within this code family. The RUC agreed that the pre-service package 1A *Facility straightforward patient/procedure (no sedation/anesthesia)* for 13 minutes evaluation, 1 minute positioning and 6 minutes scrub, dress and wait pre-service time is appropriate. The RUC agreed that 20 minutes of pre-service, 30 minutes of intra-service and 15 minutes of immediate post-service time are appropriate for this service. The RUC compared 19281 to key reference service 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older* (work RVU = 2.50) and noted that the respondents indicated higher intensity and complexity for the surveyed service, however, 36556 requires 15 minutes of intra-service time compared to 30 minutes. The RUC agreed that this reflects the unique nature of breast interventions. The breast marker placement services are associated with very high patient and family anxiety, which tend to increase the psychological stress of the physician. Although the reference code requires less time, the physician work is higher, rendering it a more intense service. For additional support, the RUC reviewed MPC codes 64483 *Injection(s)*,

*anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level (work RVU = 1.90) and 90937 Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription (work RVU = 2.11) and determined that the median work RVU of 2.00 appropriately places this service relative to other similar services. **The RUC recommends a work RVU of 2.00 for CPT code 19281.***

**19282 Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including mammographic guidance (List separately in addition to code for primary procedure)**

The RUC reviewed the survey results from 37 physicians for CPT code 19282 and determined that the physician work may have been overestimated in relation to the survey responses related to the base code 19281. The RUC discussed the pre-service time associated with this add-on code and determined that 1 minute positioning and 4 minutes scrub, dress and wait of pre-service time are appropriate. The patient must come off of the table to be re-positioned, re-draped and additional anesthesia must be administered for each subsequent lesion. The specialty society indicated and the RUC agreed that the physician work required for each additional lesion is half of that of the primary code. Therefore, the RUC determined a work value of 1.00 appropriately values this procedure. For further support the RUC referenced similar service 11046 *Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 1.03), which requires similar physician work and time. **The RUC recommends a work RVU of 1.00 for CPT code 19282.**

**19283 Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance**

The RUC reviewed the survey results from 93 physicians and determined that the survey 25<sup>th</sup> percentile work RVU of 2.00 appropriately accounts for the work required to perform this service and maintains appropriate relativity within this code family. The RUC determined that for this stereotactic guidance service, the patient is typically in the prone position, therefore 2 additional minutes for positioning time is warranted. The RUC agreed that the pre-service package 1A *Facility straightforward patient/procedure (no sedation/anesthesia)* with the positioning adjustment for 13 minutes evaluation, 3 minute positioning and 6 minutes scrub, dress and wait pre-service time is appropriate. The RUC agreed that 22 minutes of pre-service, 20 minutes of intra-service and 15 minutes of immediate post-service time are appropriate for this service. The survey respondents indicated that the intra-service time is 10 minutes less for 19283 compared to 19281. The RUC noted that the survey respondents may have only assumed one wire for 19283 as it is not specified as a dual-wire service in the vignette as it is for 19281, thus causing the time variation. The specialty societies indicated and the RUC agreed that two wires are typical to perform 19283, the same as 19281, therefore it is appropriate that the work RVU for these services to be the same. The RUC compared 19283 to key reference service 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older* (work RVU = 2.50) and noted that the respondents indicated higher intensity and complexity for the surveyed service, however, 36556 requires 15 minutes of intra-service time compared to 20 minutes. The RUC agreed that this reflects the unique nature of breast interventions. The breast marker placement services are associated with very high patient and family anxiety, which tend to increase the psychological stress of the physician. Although the reference code requires less time, the physician work is higher, rendering it a more intense service. For additional support, the RUC reviewed MPC

codes 64483 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level* (work RVU = 1.90) and 90937 *Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription* (work RVU = 2.11) and determined that the 25<sup>th</sup> percentile work RVU of 2.00 appropriately places this service relative to other similar services. **The RUC recommends a work RVU of 2.00 for CPT code 19283.**

**19284 Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)**

The RUC reviewed the survey results from 48 physicians for CPT code 19284 and determined that the physician work may have been overestimated in relation to the survey responses related to the base code 19283. The RUC discussed the pre-service time associated with this add-on code and determined that 1 minute positioning and 4 minutes scrub, dress and wait of pre-service time are appropriate. The patient must come off of the table to be re-positioned, re-draped and additional anesthesia must be administered for each subsequent lesion. The specialty society indicated and the RUC agreed that the physician work required for each additional lesion is half that of the primary code. Therefore, the RUC determined a work value of 1.00 appropriately values this procedure. Additionally, the RUC determined that this service requires the same physician work and time as 19282 and therefore should be valued the same. For further support the RUC referenced similar service 11046 *Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 1.03), which requires similar physician work and time. **The RUC recommends a work RVU of 1.00 for CPT code 19284.**

**19285 Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including ultrasound guidance**

The RUC reviewed the survey results from 101 physicians and determined that the survey 25<sup>th</sup> percentile work RVU of 1.70 appropriately accounts for the work required to perform this service and maintains appropriate relativity within this code family. The RUC determined that for this ultrasound guidance service, the patient is typically in the supine position; therefore no additional positioning time is warranted. The RUC agreed that the pre-service package 1A *Facility straightforward patient/procedure (no sedation/anesthesia)* for 13 minutes evaluation, 1 minute positioning and 6 minutes scrub, dress and wait pre-service time is appropriate. The RUC agreed that 20 minutes of pre-service, 15 minutes of intra-service and 15 minutes of immediate post-service time are appropriate for this service. The RUC noted that 19285 typically requires one wire and less intra-service time than 19281 and 19283 and therefore should be valued lower. The RUC compared 19285 to key reference service 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older* (work RVU = 2.50) and noted that the respondents indicated higher intensity and complexity for the surveyed service, however, both services require 15 minutes of intra-service time. The RUC agreed that this reflects the unique nature of breast interventions. The breast marker placement services are associated with very high patient and family anxiety, which tend to increase the psychological stress of the physician. Although the reference code has the same intra-service time, the physician work is higher, rendering it a more intense service. For additional support, the RUC reviewed MPC code 64483 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT);*

*lumbar or sacral, single level* (work RVU = 1.90) and determined that the 25<sup>th</sup> percentile work RVU of 1.70 appropriately places this service relative to other similar services. **The RUC recommends a work RVU of 1.70 for CPT code 19285.**

**19286 Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)**

The RUC reviewed the survey results from 48 physicians for CPT code 19286 and determined that the physician work may have been overestimated in relation to the survey responses related to the base code 19285. The RUC discussed the pre-service time associated with this add-on code and determined that 1 minute positioning and 4 minutes scrub, dress and wait of pre-service time are appropriate. The patient must come off of the table to be re-positioned, re-draped and additional anesthesia must be administered for each subsequent lesion. The specialty society indicated and the RUC agreed that the physician work required for each additional lesion is half of that of the primary code. Therefore, the RUC determined a work value of 0.85 appropriately values this procedure. For further support the RUC referenced similar service 93565 *Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective left ventricular or left atrial angiography (List separately in addition to code for primary procedure)* (work RVU = 0.86), which requires similar physician work and time. **The RUC recommends a work RVU of 0.85 for CPT code 19286.**

**19287 Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including magnetic resonance guidance**

The RUC reviewed the survey results from 64 physicians for CPT code 19287 and determined that the median work RVU of 3.02 appropriately accounts for the work required to perform this service and maintains appropriate relativity within this code family. The RUC determined that for this magnetic resonance guidance service, the patient is typically in the prone position; therefore 2 additional minutes for positioning time is warranted. The RUC agreed that the pre-service package 1A *Facility straightforward patient/procedure (no sedation/anesthesia)* with the positioning adjustment for 13 minutes evaluation, 3 minute positioning and 6 minutes scrub, dress and wait pre-service time is appropriate. The RUC recommends 22 minutes of pre-service, 37 minutes of intra-service and 15 minutes of immediate post-service time for this service. The RUC noted that 19287 is for the primary lesion with multiple clips, typically 3 clips. The RUC compared 19287 to key reference service 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older* (work RVU = 2.50 and 15 minutes intra-service time) and determined that the physician work is more intense and complex and requires an additional 22 minutes of intra-service time to complete than the key reference service. For additional support, the RUC reviewed MPC code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (work RVU = 2.78 and 30 minutes intra-service time) and determined that the median work RVU of 3.02 appropriately places this service relative to other similar services. **The RUC recommends a work RVU of 3.02 for CPT code 19287.**

**19288 Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)**

The RUC reviewed the survey results from 40 physicians for CPT code 19288 and determined that the physician work may have been overestimated in relation to the survey responses related to the base code 19287. The RUC discussed the pre-service time associated with this add-on code and determined that 1 minute positioning and 4 minutes scrub, dress and wait of pre-service time are appropriate. The patient must come off of the table to be re-positioned, re-draped and additional anesthesia must be administered for each subsequent lesion. The specialty society indicated and the RUC agreed that the physician work required for each additional lesion is half of that of the primary code. Therefore, the RUC determined a work value of 1.51 appropriately values this procedure. For further support the RUC referenced similar service 31637 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; each additional major bronchus stented (List separately in addition to code for primary procedure)* (work RVU = 1.58), which requires similar physician work and time. **The RUC recommends a work RVU of 1.51 for CPT code 19288.**

### **Practice Expense**

The RUC requested that the specialties clarify the contents of the stereotactic imaging system included as an equipment input in the practice expense. According to the CMS direct PE inputs the *breast biopsy imaging system, stereotactic (imager, table, software)* (EQ075) includes a table used for stereotactic services. The RUC noted a separate input, *table, power* (EF031) is also included in the equipment items and should be removed if a separate table is not necessary to perform the service. Following the meeting, the specialty confirmed that a separate table is not needed and subsequently the *table, power* (EF031) has been removed from the stereotactic services codes. The RUC noted that a *table, exam* (EF023) is included in the equipment inputs for the mammography codes because a table is not included in the *room, mammography* (EL013). The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

### **Work Neutrality**

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

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<b>General</b>				
10022		Fine needle aspiration, with imaging guidance  (For placement of percutaneous localization <u>device[s]</u> [eg, clip, metallic pellet, during breast biopsy], <del>use 19295, see 19081-19086</del> )  (For radiological supervision and interpretation, see 76942, 77002, 77012, 77021)  (For percutaneous needle biopsy other than fine needle aspiration, see <del>20206</del> <u>19081-19086</u> <del>19081, 19083, 19085</del> , for breast, <u>20206</u> , for muscle, 32400 for pleura, 32405 for lung or mediastinum, 42400 for salivary gland, 47000 for liver, 48102 for pancreas, 49180 for abdominal or retroperitoneal mass, 50200 for kidney, 54500 for testis, 54800 for epididymis, 60100 for thyroid, 62267 for nucleus pulposus, intervertebral disc, or paravertebral tissue, 62269 for spinal cord)  (For evaluation of fine needle aspirate, see 88172, 88173)		
<b>Surgery Integumentary Breast Incision</b>				
19000		Puncture aspiration of cyst of breast;		
19001		each additional cyst (List separately in addition to code for primary procedure)  (Use 19001 in conjunction with 19000)  (If imaging guidance is performed, see 76942, 77021, <del>77031, 77032</del> )		



**Integumentary**  
**Breast**  
**Excision**  
**Surgery**

Excisional breast surgery includes certain biopsy procedures, the removal of cysts or other benign or malignant tumors or lesions, and the surgical treatment of breast and chest wall malignancies. Biopsy procedures may be percutaneous or open, and they involve the removal of differing amounts of tissue for diagnosis.

Breast biopsies, without image guidance are reported with 19100 and 19101. Image-guided breast biopsies including the placement of localization devices when performed are reported using codes 19081-19086. The image-guided placement of localization devices without image-guided biopsy are reported with ~~19100-19103~~19281-19288. When more than one biopsy or localization device placement is performed using the same imaging modality, use an add-on code. If additional biopsies are performed using different imaging modalities, report another primary code for each additional modality. When an open incisional biopsy is performed after image-guided placement of a localization device, 19101 is reported and the appropriate image-guided localization device placement code is reported. The open excision of breast lesions (eg, lesions of the breast ducts, cysts, benign or malignant tumors), without specific attention to adequate surgical margins, with or without the preoperative placement of radiological markers, is reported using codes 19110-19126. Partial mastectomy procedures (eg, lumpectomy, tylectomy, quadrantectomy, or segmentectomy) describe open excisions of breast tissue with specific attention to adequate surgical margins

Partial mastectomy procedures are reported using codes 19301 or 19302 as appropriate. Documentation for partial mastectomy procedures includes attention to the removal of adequate surgical margins surrounding the breast mass or lesion.

Total mastectomy procedures include simple mastectomy, complete mastectomy, subcutaneous mastectomy, modified radical mastectomy, radical mastectomy, and more extended procedures (eg, Urban type operation). Total mastectomy procedures are reported using codes 19303-19307 as appropriate.

Excisions or resections of chest wall tumors including ribs, with or without reconstruction, with or without mediastinal lymphadenectomy, are reported using codes 19260, 19271, or 19272. Codes 19260-19272 are not restricted to breast tumors and are used to report resections of chest wall tumors originating from any chest wall component. (For excision of lung or pleura, see 32310 et seq)

(To report bilateral procedure, report modifier 50 with the procedure code)

●19081	O1	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance	000	3.29
●+19082	O2	each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure) <u>(Use 19082 in conjunction with 19081)</u>	ZZZ	1.65
●19083	O3	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance	000	3.10
+●19084	O4	each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure) <u>(Use 19084 in conjunction with 19083)</u>	ZZZ	1.55
●19085	O5	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including magnetic resonance guidance	000	3.64
●+19086	O6	each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure) <u>(Use 19086 in conjunction with 19085)</u> <u>(Do not report 19081-19086 in conjunction with 19281-19288, 76098, 76942, 77002, 77021 for same lesion)</u>	ZZZ	1.82

19100            Biopsy of breast; percutaneous, needle core, not using imaging guidance (separate procedure) (For fine needle aspiration, use 10021) <del>(For image-guided breast biopsy, see 10022, 19081-19086)</del>				
19101            open, incisional (For placement of percutaneous localization clip with imaging guidance, see 19281-19288)				
D19102		percutaneous, needle core, using imaging guidance	000	N/A
D19103		percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance (19102, 19103 have been deleted. To report, see 19081-19086) <del>(For imaging guidance performed in conjunction with 19102, 19103, see 76942, 77012, 77021, 77031, 77032)</del> (For placement of percutaneous localization clip, use 19295)	000	N/A
<b>Category I</b> <b>Surgery</b> <b>Integumentary System</b> <b>Breast</b> <b>Introduction</b> Breast biopsies without image-guidance are reported with 19100 and 19101. Image-guided breast biopsies, including the placement of localization devices when performed are reported using codes 19081-19086. The image guided placement of localization devices without image guided biopsy are reported with 19281-19288. When more than one biopsy or localization device placement is performed using the same imaging modality use an add-on code. If additional biopsies are performed using different imaging modalities, report another primary code for each additional modality. When an open incisional biopsy is performed after image guided placement of a localization device, 19101 is reported and the appropriate image guided localization device placement code is reported.				

●19281	O7	Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including mammographic guidance	000	2.00
✚●19282	O8	each additional lesion, including mammographic guidance (List separately in addition to code for primary procedure)  (Use 19282 in conjunction with 19281)	ZZZ	1.00
●19283	O9	Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance	000	2.00
✚●19284	O10	each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)  (Use 19284 in conjunction with 19283)	ZZZ	1.00
●19285	O11	Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including ultrasound guidance	000	1.70
✚●19286	O12	each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)  (Use 19286 in conjunction with 19285)	ZZZ	0.85
●19287	O13	Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including magnetic resonance guidance	000	3.02

✚●19288	O14	<p>each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)</p> <p><u>(Use 19288 in conjunction with 19287)</u></p> <p><u>(Do not report 19281-19288 in conjunction with 19081-19086, 76942, 77002, 77021 for same lesion)</u></p> <p><u>(For surgical specimen radiography, use 76098)</u></p>	ZZZ	1.51
D19290		<del>Preoperative placement of needle localization wire, breast;</del>	000	N/A
D19291		<p><del>each additional lesion (List separately in addition to code for primary procedure)</del></p> <p><del>(Use 19291 in conjunction with 19290)</del></p> <p><del>(For radiological supervision and interpretation, see 76942, 77031, 77032)</del></p> <p><del>(19290, 19291 have been deleted).</del></p> <p><u>(To report image guided placement of breast localization devices during image guided biopsy, see 19081-19086. To report image guided placement of breast localization device without image guided biopsy, see 19281-19288)</u></p>	ZZZ	N/A

D+19295		<p><del>Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure); (Use 19295 in conjunction with 10022, 19102, 19103)</del></p> <p><u>(19295 has been deleted)</u></p> <p><u>(To report placement of breast localization device during biopsy, see 19081-19086. To report placement of breast localization device without biopsy, see 19281-19288)</u></p> <p><del>(Use 19295 in conjunction with 10022, 19102, 19103)</del></p>	ZZZ	N/A
<b>Radiology</b> <b>Diagnostic Ultrasound</b> <b>Other Procedures</b>  76098              Radiological examination, surgical specimen  <u>(Do not report 76098 in conjunction with 19081-19086)</u>				
<b>Radiology</b> <b>Diagnostic Ultrasound</b> <b>Ultrasonic Guidance Procedures</b>  76942              Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation  (Do not report 76942 in conjunction with <u>19083, 19285</u> , 27096, 32554, 32555, 32556, 32557, 37760, 37761, 43232, 43237, 43242, 45341, 45342, 64479-64484, 64490-64495, 76975, 0213T-0218T, 0228T-0231T, 0232T, 0249T, 0301T)  (For injection(s) of platelet rich plasma, use 0232T)				

<b>Radiology</b> <b>Radiologic Guidance</b> <b>Fluoroscopic Guidance</b>	
77002	<p>Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)</p> <p>(See appropriate surgical code for procedure and anatomic location)</p> <p>(77002 includes all radiographic arthrography with the exception of supervision and interpretation for CT and MR arthrography)</p> <p>(Do not report 77002 in conjunction with <u>19081-19086, 19281-19288, 32554, 32555, 32556, 32557, 70332, 73040, 73085, 73115, 73525, 73580, 73615, 0232T</u>)</p> <p>(For injection(s) of platelet rich plasma, use 0232T)</p> <p>(77002 is included in the organ/anatomic specific radiological supervision and interpretation procedures 49440, 74320, 74355, 74445, 74470, 74475, 75809, 75810, 75885, 75887, 75980, 75982, 75989)</p>
<b>Magnetic Resonance Guidance</b>	
77021	<p>Magnetic resonance guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation</p> <p>(For procedure, see appropriate organ or site)</p> <p>(Do not report 77021 in conjunction with <u>19085, 19287, 32554, 32555, 32556, 32557, 0232T</u>)</p> <p>(For injection(s) of platelet rich plasma, use 0232T)</p>
<b>Radiology</b> <b>Radiologic Guidance</b> <b>Other Radiologic Guidance</b>	

D77031		<p><del>Stereotactic localization guidance for breast biopsy or needle placement(eg, for wire localization or for injection), each lesion, radiological supervision and interpretation</del></p> <p><del>(For procedure, see 10022, 19000-19103, 19290, 19291)</del></p> <p><del>(For injection for sentinel node localization without lymphoscintigraphy, use 38792)</del></p> <p><del>(77031 has been deleted)</del></p> <p><u>(To report stereotactic localization guidance for breast biopsy or for placement of breast localization device(s), see 19081, 19283)</u></p>	XXX	N/A
D77032		<p><del>Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation</del></p> <p><del>(For procedure, see 10022, 19000, 19102, 19103, 19290, 19291)</del></p> <p><del>(For injection for sentinel node localization without lymphoscintigraphy, use 38792)</del></p> <p><del>(For mammographic guidance for needle placement of breast lesion, use 77032)</del></p> <p><del>(77032 has been deleted)</del></p> <p><u>(To report mammographic guidance for placement of breast localization device(s), see 19281)</u></p>	XXX	N/A



**Radiology****Breast, Mammography**

~~(For mammographic guidance for needle placement of breast lesion, use 77032)~~

- ✚77051 Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further review for interpretation, with or without digitization of film radiographic images; diagnostic mammography (List separately in addition to code for primary procedure)

(Use 77051 in conjunction with 77055, 77056)

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 19081      Tracking Number 01      Original Specialty Recommended RVU: **3.80**  
 Presented Recommended RVU: **3.50**  
 Global Period: 000      RUC Recommended RVU: **3.29**

CPT Descriptor: Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 63-year-old asymptomatic female has new indeterminate microcalcifications in the upper-outer quadrant of the right breast. A biopsy is performed using stereotactic guidance.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 10%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 10%

**Description of Pre-Service Work:**

- Review medical records and previous imaging and decide on appropriate guidance method and initial approach based on prior imaging.
- Discuss procedure details, including alternatives and risks with the patient and family and obtain informed consent.
- Review set up in the biopsy suite. Perform stereo calibration of the equipment. Supervise initial positioning and preparation of the patient.
- Surgical time out performed.
- Supervise and review initial scout image and stereotactic pair of images. Target the lesion to be biopsied. Transmit coordinates to the biopsy device. If the lesion is not adequately visualized, change patient position and repeat the localizing process.
- Move the needle into appropriate position on the machine. Confirm that coordinates have transmitted correctly.
- Prepare the skin with an appropriate surgical antiseptic solution and administer local anesthesia.

**Description of Intra-Service Work:**

- Make a small incision with a scalpel.
- Obtain and review periodic imaging to assure that the biopsy device is accurately positioned. Once needle position is verified, "fire" the needle; verify needle position with an additional stereotactic pair of images.
- Activate vacuum system; remove multiple samples of tissue. Once the tissue is removed, partially withdraw the biopsy device; stereotactically image the biopsy bed to evaluate for sample adequacy.
- Obtain a radiograph of the specimen samples to confirm sampling adequacy.

- If additional tissue is deemed necessary, retarget the lesion, re-advance the needle to the lesion, and obtain additional tissue. Obtain an additional radiograph of the new specimen samples and an additional stereotactic set of images of the biopsy bed. Repeat until the physician is convinced that an adequate sample has been obtained for the pathologist.
- Once adequate sampling has been determined, place a marker into the breast through the stereotactic needle system to mark the site of biopsy.
- Obtain stereotactic images after marker deployment.
- Review post-marker placement stereotactic images for successful deployment.
- Withdraw the needle and obtain hemostasis with manual compression over the biopsy site.
- Close the skin incision with steri-strips.

Description of Post-Service Work:

- Apply dressing.
- Monitor the patient's condition prior to discharge including wound check.
- Review post-procedure wound care and activity level instructions with the patient and her family.
- A formal report of the procedure is dictated into the permanent medical record.
- The results and further management are discussed with the patient and their family, as well as the requesting physician.
- Review and sign procedure report.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Zeke Silva, MD; Kurt Schoppe, MD; Mark Alson, MD; Jan Jeske, MD; Eric Whitacre, MD FACS; Christopher Senkowski, MD FACS; Charles Mabry, MD FACS				
<b>Specialty(s):</b>	American College of Radiology, American College of Surgeons, American Society of Breast Surgeons				
<b>CPT Code:</b>	19081				
<b>Sample Size:</b>	2600	<b>Resp N:</b>	99	<b>Response:</b> 3.8 %	
<b>Description of Sample:</b> Random Sample					
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	32.00	80.00	120.00	700.00
<b>Survey RVW:</b>	1.25	2.62	3.80	4.80	5.68
<b>Pre-Service Evaluation Time:</b>			35.00		
<b>Pre-Service Positioning Time:</b>			10.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			6.00		
<b>Intra-Service Time:</b>	5.00	20.00	30.00	50.00	70.00
<b>Immediate Post Service-Time:</b>	<u>15.00</u>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1a-FAC Straightforw Pat/Procedure(no sedate/anesth

<b>CPT Code:</b>	19081	<b>Recommended Physician Work RVU: 3.29</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		13.00	13.00	0.00
<b>Pre-Service Positioning Time:</b>		3.00	1.00	2.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		6.00	6.00	0.00
<b>Intra-Service Time:</b>		30.00		
<b>Immediate Post Service-Time:</b>	<u>15.00</u>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00		

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
37191	000	4.71	RUC Time

CPT Descriptor Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
15002	000	3.65	RUC Time	16,473

CPT Descriptor 1 Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
31628	000	3.80	RUC Time	38,792

CPT Descriptor 2 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
---------------------------------	---------------	-----------------	--------------------

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 20      % of respondents: 20.2 %

**TIME ESTIMATES (Median)**

	<u>CPT Code:</u> <b>19081</b>	<u>Key Reference CPT Code:</u> <u>37191</u>	<u>Source of Time</u> <b>RUC Time</b>
Median Pre-Service Time	22.00	38.00	
Median Intra-Service Time	30.00	30.00	
Median Immediate Post-service Time	15.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>67.00</b>	<b>83.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.85	3.95
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	4.00
--	------	------

Urgency of medical decision making	3.95	3.90
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.75	3.60
--------------------------	------	------

Physical effort required	3.65	3.65
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.60	3.40
---	------	------

Outcome depends on the skill and judgment of physician	3.85	3.55
--	------	------

Estimated risk of malpractice suit with poor outcome	4.30	3.60
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.65	3.70
----------------------------------	------	------

Intra-Service intensity/complexity	3.85	3.90
------------------------------------	------	------

Post-Service intensity/complexity	3.55	3.60
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**

Several breast intervention codes were identified by the 75% screen including the following:

Code	Descriptor
<b>19103</b>	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance
<b>19295</b>	Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)
<b>19290</b>	Preoperative placement of needle localization wire, breast;
<b>77031</b>	Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation
<b>76098</b>	Radiological examination, surgical specimen
<b>77032</b>	Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation

To improve the reporting of breast interventions, the entire family of existing breast intervention codes was sent to the CPT Editorial Panel who created a new family of 14 bundled codes to describe image-guided breast interventions. This new family consists of two main groups: (1) 6 codes to describe breast biopsy (19081-19086) differentiated by the imaging modality used, either stereotactic, ultrasound, or MR guidance, with each guidance method then divided into a base code for the 1<sup>st</sup> lesion and an add-on code for each additional lesion biopsied; (2) 8 new codes (19281-19288) to describe the placement of breast localization device(s) also differentiated by the imaging guidance used with base and add-on codes created.

The American College of Radiology, American College of Surgeons, and the American Society of Breast Surgeons randomly surveyed their respective members, and an expert panel was convened to review the survey results. The MR guidance codes (19085, 19085, 19287, and 19288) and the mammo guided localization codes (19281 and 19282) were only surveyed by the ACR.

### Biopsy Codes (19081-19086)

#### Compelling Evidence

The Society recommendations detailed below satisfy budget neutrality requirements, so compelling evidence arguments are not required. However, the societies would like to point out that since the original breast biopsy codes were developed, advances in imaging guidance have made it possible to target and sample progressively smaller and more subtle lesions. Lesions that previously were impossible to biopsy by stereotactic guidance are now routinely performed. Similar advancements in ultrasound and MRI technology have allowed sampling of lesions that previously needed open surgical biopsy for diagnosis.

CPT code 19081 (*Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance*) describes image guided breast biopsy of a first lesion utilizing stereotactic imaging guidance including the placement of a breast localizing device(s) and imaging of the biopsy specimen, when performed. This service is currently reported using the following codes:

Code	Descriptor	Work RVU
<b>19103</b>	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance	3.69
<b>77031</b>	Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation	1.59
<b>76098</b>	Radiological examination, surgical specimen	0.16
<b>19295</b>	Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)	0.00

#### Work RVU Recommendation

The expert panel recommends the median RVU of 3.80 RVUs which is below the RVUs for the combination of codes currently used to report this service.

#### Pre-Service Time

The expert panel recommends pre-service package 1a (Straightforward Patient/Straightforward Procedure (No sedation/anesthesia care)) with the following adjustments:

(1) Increase the total pre-service evaluation time by 5 minutes to 18 minutes total to accommodate an extra 3 minutes necessary for "history and exam (Performance and review of appropriate pre-tests) and an additional 2 minutes for "Communicate with patient and/or family (Discuss procedure / obtain consent)". Patients undergoing stereotactic breast biopsy typically have a large number of prior examinations which must be reviewed in detail including prior screening mammography, diagnostic mammography, diagnostic ultrasound, prior biopsies and clip placements. Moreover, a careful review of the prior pathology, previous medical and surgical treatment and planned therapy is performed. It is incumbent on the performing physician to review the entire breast imaging record prior to the biopsy being performed including imaging of the opposite breast. These patients are often well informed women appropriately requiring and expecting detailed discussion of the expected course and outcome. Unlike other biopsies performed elsewhere in the body, there is high anxiety, both because the biopsy is often unanticipated and because it involves the breast. For these reasons, breast biopsy patients have more anxiety, have more questions, and frequently bring multiple family members to the consent, which increases time to address all of their needs as well.

(2) Increase the positioning time by 2 minutes to 3 minutes to accommodate the additional time necessary to optimally position these patients on the stereotactic table and ensure that operator and imaging equipment are likewise well positioned relative to the patient. Further, it is reasonable to conclude that survey respondents would consider imaging to localize the mass and guide skin prep prior to biopsy to be considered pre-service work.

### Intra and Post Service Times

We are recommending the median intra and post-service times of 30 and 15 minutes, respectively.

### Comparison to Key Reference Service

The panel would like to point out that many of our survey respondents practice nearly 100% breast imaging. Since the surveyed code family essentially includes all of the 0 day global services this survey population performs, respondents may have struggled to find a 0 day global reference service they commonly perform. Nonetheless, the most commonly chosen KRS is 37191 (*Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed*) which has the same intra-service time of 30 minutes but higher RVUs of 4.71. Both of these procedures include imaging guidance, and while 37191 scored higher or equal to 19081 on most complexity measures, 19081 scored higher on all 3 measures assessing psychological stress, including the estimated risk of a malpractice suit with a poor outcome. This reflects the unique nature of breast interventions. These procedures are associated with very high patient and family anxiety, which tends to increase the psychological stress of the physician performing the exam. Additionally, these types of exams have a higher frequency to be associated with malpractice suits, which adds to the stress as well.

Our recommendation yields an IWPUT of 0.0982, reflecting the intensity of this procedure in this subset of patients. Indeed, the patient is laying prone with her breast in compression throughout the intra service period of this procedure. The stereotactic table is inherently uncomfortable leading to frequent complaints of neck and shoulder pain during the procedure as time passes. Due to the need for the patient to remain fully aware and not move even a few millimeters, the atmosphere in the room can become quite tense. Calcifications which are readily visible on a high resolution digital mammogram are often poorly seen on the much lower resolution screen of the stereotactic machine. In addition, surrounding landmarks are often not visible in the much smaller field of view. This can lead to multiple changes of patient position which can be very unsettling for the patient and increase pressure on the physician thus increasing the intensity of the procedure.

Code	RVU	Pre Eval	Pre Positioning	Pre S/D/W	Total Pre	Intra	Post	Total	IWPUT
<b>19081</b>	<b>3.29</b>	<b>13</b>	<b>3</b>	<b>6</b>	<b>23</b>	<b>30</b>	<b>15</b>		
37191	4.71	30	3	5	38	30	15	83	0.1198

### MPC Comparison

Our recommendation is bracketed in both RVUs and intra-service time by two MPC codes, 15002 (*Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children*) and 31628 (*Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe*).



Code	RVU	Pre Eval	Pre Positioning	Pre S/D/W	Total Pre	Intra	Post	Total	IWPUT
15002	3.65	45	15	15	75	20	20	115	0.0868
<b>19081</b>	<b>3.29</b>	<b>13</b>	<b>3</b>	<b>6</b>	<b>23</b>	<b>30</b>	<b>15</b>		
31628	3.80	10	10	10	30	40	20	90	0.0706

### Comparison Within the Family

The recommendations maintain appropriate rank order across the entire family of breast biopsy codes as summarized in the table below. As discussed above, the inherent level of patient discomfort throughout this examination and the variability of visualization of the biopsy target, procedures performed under stereotactic guidance are, by definition, more intense than other breast biopsies. The MRI guided biopsies have similar proposed RVU values yet significantly longer intra service times due to the much longer acquisition times to obtain MRI sequences to verify lesion location and needle placement than the acquisition times for stereotactic procedures. Similarly ultrasound guided procedures require less intra service time due to the use of real-time imaging.

### Conclusion

In summary, the panel recommends the median survey value of 3.80 RVU. We believe this relative value is appropriate based on comparisons to the KRS, the two MPC codes provided, and within the larger family of breast intervention codes.

### SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

### FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 19103, 77031, 76098, 19295

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology                      How often? Commonly

Specialty General Surgery                              How often? Commonly

Specialty    How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We are unable to accurately estimate the number of times this service might be provided nationally in a one year period.

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?  
46,069 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.  
Please explain the rationale for this estimate. see work neutrality estimates.

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 32553

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 19082	Tracking Number O2	Original Specialty Recommended RVU: <b>1.90</b>
		Presented Recommended RVU: <b>1.90</b>
Global Period: ZZZ		RUC Recommended RVU: <b>1.65</b>

CPT Descriptor: Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 72-year-old asymptomatic female has new segmental coarse heterogenous microcalcifications in the upper outer quadrant of the right breast, and a separate cluster of linear pleomorphic microcalcifications in the lower outer quadrant of the right breast. Stereotactic-guided biopsy of the second cluster of calcifications in the lower outer breast is performed after initial stereotactic biopsy of the calcifications in the upper outer breast. (Initial biopsy reported separately, using 19081)

Percentage of Survey Respondents who found Vignette to be Typical: 98%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 16%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 17%

**Description of Pre-Service Work:**

- Reposition patient back into the stereotactic biopsy system.
- Target second separate lesion. Supervise and review scout image and stereotactic pair of images. Transmit coordinates to the biopsy device. If the lesion is not adequately visualized, change patient position and repeat the localizing process.
- Move the needle into appropriate position on the machine.
- Prepare the skin with an appropriate surgical antiseptic solution and administer local anesthesia.

**Description of Intra-Service Work:**

- Make a small incision with a scalpel.
- Obtain and review periodic imaging to assure accurate positioning of the biopsy device. Once needle position is verified, "fire" the needle; verify its position with a stereotactic pair of images.
- Activate vacuum system. Remove multiple samples of tissue. Once the tissue is removed, partially withdraw the biopsy device; stereotactically image the biopsy bed to evaluate for sample adequacy.
- Obtain a radiograph of the specimen samples to determine sampling adequacy.
- If additional tissue is deemed necessary, retarget the lesion, re-advance the needle to the lesion, and obtain additional tissue. Obtain an additional radiograph of the new specimen samples and an additional stereotactic set of images of the biopsy bed. This is repeated until the physician is convinced that an adequate sample has been obtained for the pathologist.

- Once adequate sampling has been determined, place a marker into the breast through the stereotactic needle system to mark the site of biopsy.
- Obtain stereotactic images after marker deployment.
- Review post-marker placement stereotactic images for successful deployment.
- Withdraw the needle and obtain hemostasis with manual compression over the biopsy site.
- Close the skin incision with steri-strips.

Description of Post-Service Work:

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Zeke Silva, MD; Kurt Schoppe, MD; Mark Alson, MD; Jan Jeske, MD; Eric Whitacre, MD FACS; Christopher Senkowski, MD FACS; Charles Mabry, MD FACS				
<b>Specialty(s):</b>	American College of Radiology, American College of Surgeons, American Society of Breast Surgeons				
<b>CPT Code:</b>	19082				
<b>Sample Size:</b>	2600	<b>Resp N:</b>	52	<b>Response:</b> 2.0 %	
<b>Description of Sample:</b>	Random Sample				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	19.00	<b>40.00</b>	60.00	150.00
<b>Survey RVW:</b>	0.50	2.28	<b>2.90</b>	3.50	4.75
<b>Pre-Service Evaluation Time:</b>			<b>5.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>0.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>0.00</b>		
<b>Intra-Service Time:</b>	5.00	18.00	<b>25.00</b>	40.00	60.00
<b>Immediate Post Service-Time:</b>	<b>5.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: ZZZ Global Code

<b>CPT Code:</b>	19082	<b>Recommended Physician Work RVU: 1.65</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>1.00</b>	<b>0.00</b>	<b>1.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>4.00</b>	<b>0.00</b>	<b>4.00</b>
<b>Intra-Service Time:</b>		<b>25.00</b>		
<b>Immediate Post Service-Time:</b>	<b>0.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00		

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
36479	ZZZ	3.38	RUC Time

CPT Descriptor Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; second and subsequent veins treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
64480	ZZZ	1.20	RUC Time	30,408

CPT Descriptor 1 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level (List separately in addition to code for primary procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99292	ZZZ	2.25	RUC Time	434,114

CPT Descriptor 2 Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
---------------------------------	---------------	-----------------	--------------------

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 19      % of respondents: 36.5 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 19082</b>	<b>Key Reference CPT Code: 36479</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	5.00	0.00	
Median Intra-Service Time	25.00	45.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>30.00</b>	<b>45.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.42	3.74
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.21	3.63
--	------	------

Urgency of medical decision making	3.32	3.74
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.42	3.26
--------------------------	------	------

Physical effort required	3.21	3.42
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.32	3.42
---	------	------

Outcome depends on the skill and judgment of physician	3.37	3.37
--	------	------

Estimated risk of malpractice suit with poor outcome	3.37	3.58
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.39	3.78
----------------------------------	------	------

Intra-Service intensity/complexity	3.42	3.89
------------------------------------	------	------

Post-Service intensity/complexity	3.39	3.72
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**

Several breast intervention codes were identified by the 75% screen including the following:

Code	Descriptor
<b>19103</b>	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance
<b>19295</b>	Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)
<b>19290</b>	Preoperative placement of needle localization wire, breast;
<b>77031</b>	Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation
<b>76098</b>	Radiological examination, surgical specimen
<b>77032</b>	Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation

To improve the reporting of breast interventions, the entire family of existing breast intervention codes was sent to the CPT Editorial Panel who created a new family of 14 bundled codes to describe image-guided breast interventions. This new family consists of two main groups: (1) 6 codes to describe breast biopsy (19081-19086) differentiated by the imaging modality used, either stereotactic, ultrasound, or MR guidance, with each guidance method then divided into a base code for the 1<sup>st</sup> lesion and an add-on code for each additional lesion biopsied; (2) 8 new codes (19281-19288) to describe the placement of breast localization device(s) also differentiated by the imaging guidance used with base and add-on codes created.

The American College of Radiology, American College of Surgeons, and the American Society of Breast Surgeons randomly surveyed their respective members, and an expert panel was convened to review the survey results. The MR guidance codes (19085, 19085, 19287, and 19288) and the mammo guided localization codes (19281 and 19282) were only surveyed by the ACR.

### Biopsy Codes (19081-19086)

### Compelling Evidence

The Society recommendations detailed below satisfy budget neutrality requirements, so compelling evidence arguments are not required. However, the societies would like to point out that since the original breast biopsy codes were developed, advances in imaging guidance have made it possible to target and sample progressively smaller and more subtle lesions. Lesions that previously were impossible to biopsy by stereotactic guidance are now routinely performed. Similar advancements in ultrasound and MRI technology have allowed sampling of lesions that previously needed open surgical biopsy for diagnosis.

CPT code 19082 (*Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)*) describes image guided breast biopsy of each additional lesion utilizing stereotactic imaging guidance including the placement of a breast localizing device and imaging of the biopsy specimen, when performed. Currently, these are typically performed using multiple localization wires to “bracket” the lesion. Depending on lesion morphology, this procedure can involve placement of 1-4 wires, with 2 being most typical. This CPT code was designed to utilize a single CPT code, reported only once, regardless of the number or type of markers placed in or around a second separate lesion under stereotactic guidance. This service is currently reported using the following codes:

Code	Descriptor	Work RVU
<b>19103-51</b>	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance	1.85
<b>77031</b>	Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation	1.59
<b>76098</b>	Radiological examination, surgical specimen	0.16
<b>19295</b>	Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)	0.00

### Work RVU Recommendation

The expert panel recommends a work RVU of 1.90 RVUs which is of half the recommended value of 19081, the base code with which add on code 19082 will be reported. The intra-service time for these 2 codes is nearly identical (30 vs. 25 minutes)



suggesting the application of the surgical MPPR to reach our recommendation is appropriate. Our recommendation is below the 25th percentile of our survey and below the existing value of the four codes currently used to describe this service.

### Pre and Post-Service Time

The respondents indicated 5 minutes of pre service time and 5 minutes of post service time for this ZZZ add-on code. The expert panel attributes this time to the following activities which occur after and in addition to similar activities involved in treating the 1<sup>st</sup> lesion

pre-service activities:

- Target second separate lesion. Supervise and review scout image and stereotactic pair of images. Transmit coordinates to the biopsy device. If the lesion is not adequately visualized, change patient position and repeat the localizing process.
- Move the needle into appropriate position on the machine.
- Prepare the skin with an appropriate surgical antiseptic solution and administer local anesthesia.

and post-service activities:

- Apply dressing.

### Intra Service Time

We are recommending the median intra service time of 25 minutes which is slightly less than the 30 minutes of intra-service time for the base code, 191081, with which this ZZZ code is reported. The panel again points out that treating the second lesion involves completely new skin preparation, lesion localization, biopsy, wound dressing and recovery. If it is concluded that our recommended pre and post times are not appropriate for this ZZZ code, we suggest adding those minutes to the intra-service work since survey respondents could have easily shifted what is otherwise intra-service time to the pre and post service periods.

### Comparison to Key Reference Service

The panel would like to point out that many of our survey respondents practice nearly 100% breast imaging. Since the surveyed code family essentially includes all of the services this survey population performs, respondents may have struggled to find a ZZZ day global KRS they commonly perform. Nonetheless, the most commonly chosen KRS is 36479 (*Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; second and subsequent veins treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)*) which has a higher RVU of 3.38 and a longer intra service time of 45 minutes and, hence, a higher RVU.

Code	RVU	Pre Eval	Pre Positioning	Pre S/D/W	Total Pre	Intra	Post	Total	IWPUT
<b>19082</b>	<b>1.65</b>	<b>0</b>	<b>1</b>	<b>4</b>	<b>5</b>	<b>25</b>	<b>0</b>	<b>30</b>	
36479	3.38					45		45	0.0750

### MPC Comparison

Our recommendation is bracketed in both RVUs and intra-service time by two ZZZ MPC codes, 64480 (*Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level (List separately in addition to code for primary procedure)*) and 99292 (*Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)*).

Code	RVU	Pre Eval	Pre Positioning	Pre S/D/W	Total Pre	Intra	Post	Total	IWPUT
64480	1.20					15		15	0.0800
<b>19082</b>	<b>1.65</b>	<b>0</b>	<b>1</b>	<b>4</b>	<b>5</b>	<b>25</b>	<b>0</b>	<b>30</b>	
99292	2.25					30		30	0.0750

### Comparison Within the Family

The recommendations maintain appropriate rank order across the entire family of breast biopsy codes as summarized in the table below. As discussed above, the inherent level of patient discomfort throughout this examination and the variability of visualization of the biopsy target, procedures performed under stereotactic guidance are, by definition, more intense than other breast biopsies. The MRI guided biopsies have similar proposed RVU values yet significantly longer intra service times due to the much longer acquisition times to obtain MRI sequences to verify lesion location and needle placement than the acquisition times for stereotactic procedures. Similarly ultrasound guided procedures require less intra service time due to the use of real-time imaging.

**Conclusion**

In summary, the panel recommends an RVU of 1.90, half the value of the base code with which this code will be reported. We believe this relative value is appropriate based on comparisons to the KRS, the two MPC codes provided and within the larger family of breast biopsy codes.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 19103-51, 76098, 19295, 77031

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology                      How often? Commonly

Specialty General Surgery                              How often? Commonly

Specialty    How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We are unable to accurately estimate the number of times this service might be provided nationally in a one year period.

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,835

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. see work neutrality estimates

Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 64480

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 19083      Tracking Number 03      Original Specialty Recommended RVU: **3.10**  
 Presented Recommended RVU: **3.10**  
 Global Period: 000      RUC Recommended RVU: **3.10**

CPT Descriptor: Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 58-year-old asymptomatic female has an indeterminate hypo-echoic mass demonstrated on ultrasound in the left breast with irregular margins and posterior acoustic shadowing. A biopsy is performed using ultrasound guidance.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 10%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 10%

**Description of Pre-Service Work:**

- Review medical records and previous imaging and decide on appropriate guidance method and initial approach based on prior imaging.
- Discuss procedure details, including alternatives and risks with the patient and family and obtain informed consent.
- Review set up in the biopsy suite. Ensure accurate calibration of the equipment. Supervise positioning and preparation of the patient.
- Surgical time out performed.
- Position patient on the ultrasound table to best localize the lesion. Reimage sonographically to confirm adequate lesion visualization and approach to lesion.
- Prepare the skin with an appropriate surgical antiseptic solution and administer local anesthesia.

**Description of Intra-Service Work:**

- Make a small incision with a scalpel.
- Under ultrasound visualization, move the tip of the biopsy needle to the edge of the lesion. Once needle position is verified, “fire” the needle. Obtain pre-fire and post-fire images.
- Activate vacuum system. While watching with ultrasound, obtain a series of samples through the lesion until the lesion is determined to be adequately sampled by the physician.
- Once adequate sampling has been determined, place a marker into the breast utilizing ultrasound guidance to mark the site of biopsy. Document marker deployment with an ultrasound image.
- Withdraw the needle and obtain hemostasis with manual compression over the biopsy site.
- Close the skin incision with steri-strips

Description of Post-Service Work:

- Apply dressing.
- Monitor the patient's condition prior to discharge including wound check.
- Review post-procedure wound care and activity level instructions with the patient and her family.
- A formal report of the procedure is dictated into the permanent medical record.
- The results and further management are discussed with the patient and their family, as well as the requesting physician.
- Review and sign procedure report.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Zeke Silva, MD; Kurt Schoppe, MD; Mark Alson, MD; Jan Jeske, MD; Eric Whitacre, MD FACS; Christopher Senkowski, MD FACS; Charles Mabry, MD FACS				
<b>Specialty(s):</b>	American College of Radiology, American College of Surgeons, American Society of Breast Surgeons				
<b>CPT Code:</b>	19083				
<b>Sample Size:</b>	2600	<b>Resp N:</b>	97	<b>Response:</b> 3.7 %	
<b>Description of Sample:</b>	Random Sample				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	40.00	100.00	180.00	900.00
<b>Survey RVW:</b>	1.50	2.50	3.10	4.30	5.60
<b>Pre-Service Evaluation Time:</b>			38.00		
<b>Pre-Service Positioning Time:</b>			10.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			5.00		
<b>Intra-Service Time:</b>	5.00	15.00	25.00	36.00	60.00
<b>Immediate Post Service-Time:</b>	<u>15.00</u>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1a-FAC Straightforw Pat/Procedure(no sedate/anesth

<b>CPT Code:</b>	19083	<b>Recommended Physician Work RVU: 3.10</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		13.00	13.00	0.00
<b>Pre-Service Positioning Time:</b>		1.00	1.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	6.00	-1.00
<b>Intra-Service Time:</b>		25.00		
<b>Immediate Post Service-Time:</b>	<u>15.00</u>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
37191	000	4.71	RUC Time

CPT Descriptor Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
31622	000	2.78	RUC Time	83,969

CPT Descriptor 1 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
15002	000	3.65	RUC Time	16,473

CPT Descriptor 2 Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
---------------------------------	---------------	-----------------	--------------------

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 16      % of respondents: 16.4 %

**TIME ESTIMATES (Median)**

	CPT Code: 19083	Key Reference CPT Code: 37191	Source of Time RUC Time
Median Pre-Service Time	19.00	38.00	
Median Intra-Service Time	25.00	30.00	
Median Immediate Post-service Time	15.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>59.00</b>	<b>83.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.75	3.94
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	4.13
--	------	------

Urgency of medical decision making	3.44	3.81
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.13	4.00
--------------------------	------	------

Physical effort required	3.63	3.75
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.38	3.69
---	------	------

Outcome depends on the skill and judgment of physician	3.88	3.81
--	------	------

Estimated risk of malpractice suit with poor outcome	4.06	3.94
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.56	3.75
----------------------------------	------	------

Intra-Service intensity/complexity	3.75	4.06
------------------------------------	------	------

Post-Service intensity/complexity	3.06	3.44
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**



Several breast intervention codes were identified by the 75% screen including the following:

Code	Descriptor
<b>19103</b>	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance
<b>19295</b>	Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)
<b>19290</b>	Preoperative placement of needle localization wire, breast;
<b>77031</b>	Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation
<b>76098</b>	Radiological examination, surgical specimen
<b>77032</b>	Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation

To improve the reporting of breast interventions, the entire family of existing breast intervention codes was sent to the CPT Editorial Panel who created a new family of 14 bundled codes to describe image-guided breast interventions. This new family consists of two main groups: (1) 6 codes to describe breast biopsy (19081-19086) differentiated by the imaging modality used, either stereotactic, ultrasound, or MR guidance, with each guidance method then divided into a base code for the 1<sup>st</sup> lesion and an add-on code for each additional lesion biopsied; (2) 8 new codes (19281-19288) to describe the placement of breast localization device(s) also differentiated by the imaging guidance used with base and add-on codes created.

The American College of Radiology, American College of Surgeons, and the American Society of Breast Surgeons randomly surveyed their respective members, and an expert panel was convened to review the survey results. The MR guidance codes (19085, 19085, 19287, and 19288) and the mammo guided localization codes (19281 and 19282) were only surveyed by the ACR.

### Biopsy Codes (19081-19086)

#### Compelling Evidence

The Society recommendations detailed below satisfy budget neutrality requirements, so compelling evidence arguments are not required. However, the societies would like to point out that since the original breast biopsy codes were developed, advances in imaging guidance have made it possible to target and sample progressively smaller and more subtle lesions. Lesions that previously were impossible to biopsy by stereotactic guidance are now routinely performed. Similar advancements in ultrasound and MRI technology have allowed sampling of lesions that previously needed open surgical biopsy for diagnosis.

CPT code 19083 (*Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance*) describes image guided breast biopsy of a first lesion utilizing ultrasound imaging guidance including the placement of a breast localizing device(s) and imaging of the biopsy specimen, when performed.

This service is currently reported using the following codes:

Code	Descriptor	Work RVU
<b>19103</b>	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance	3.69
<b>76942</b>	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	0.67
<b>19295</b>	Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)	0.00

#### Work RVU Recommendation

The expert panel recommends the median survey RVU of 3.10. This is below the existing value of the three codes currently used to describe this service.

#### Pre-Service Time

The expert panel recommends pre-service package 1a (Straightforward Patient/Straightforward Procedure (No sedation/anesthesia care)) with the following adjustments:

(1) Increase the total pre-service evaluation time by 5 minutes to 18 minutes total to accommodate an extra 3 minutes necessary for "history and exam (Performance and review of appropriate pre-tests) and an additional 2 minutes for "Communicate with patient and/or family (Discuss procedure / obtain consent)". Patients undergoing ultrasound breast biopsy typically have a number of prior examinations which must be reviewed in detail including prior screening mammography, diagnostic mammography, diagnostic ultrasound, prior biopsies and clip placements. Moreover, a careful review of the prior pathology, previous medical and surgical treatment and planned therapy is performed. It is incumbent on the performing physician to review the entire breast imaging record prior to the biopsy being performed including imaging of the opposite breast. These patients are often well informed women appropriately requiring and expecting detailed discussion of the expected course and outcome. Unlike other biopsies performed elsewhere in the body, there is high anxiety, both because the biopsy is often unanticipated and because it involves the breast. For these reasons, breast biopsy patients have more anxiety, have more questions, and frequently bring multiple family members to the consent, which increases time to address all of their needs as well.

(2) Increase the positioning time by 2 minutes to 3 minutes to accommodate the additional time necessary to optimally position these patients on the ultrasound table and ensure that operator and imaging equipment are likewise well positioned relative to the patient. Further, it is reasonable to conclude that survey respondents would consider imaging to localize the mass and guide skin prep prior to biopsy to be considered pre-service work.

### Intra and Post Service Times

We are recommending the median intra and post-service times of 25 and 15 minutes, respectively.

### Comparison to Key Reference Service

The panel would like to point out that many of our survey respondents practice nearly 100% breast imaging. Since the surveyed code family essentially includes all of the 0 day global services this survey population performs, respondents may have struggled to find a 0 day global reference service they commonly perform. Nonetheless, the most commonly chosen KRS is 37191 (*Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed*), which has slightly higher intra-service time of 30 minutes but also higher RVUs of 4.71. 37191 also scored higher than 19083 on most complexity measures. This reflects the unique nature of breast interventions. These procedures are associated with very high patient and family anxiety, which tends to increase the psychological stress of the physician performing the exam. Additionally, these types of exams have a higher frequency to be associated with malpractice suits, which adds to the stress as well.

Our recommendation yields an IWP/UT of 0.0898, reflecting the intensity of this procedure in this subset of patients. Due to the need for the patient to remain fully aware and not move even a few millimeters, the atmosphere in the room can become quite tense. The patient is typically able to view the, large biopsy device entering her breast which makes many patients very anxious. Some lesions can be quite mobile both initially and after local anesthesia administration leading to difficulty localizing the lesion which can add to the anxiety.

Code	RVU	Pre Eval	Pre Positioning	Pre S/D/W	Total Pre	Intra	Post	Total	IWP/UT
<b>19083</b>	<b>3.10</b>	<b>13</b>	<b>1</b>	<b>5</b>	<b>19</b>	<b>25</b>	<b>15</b>		
37191	4.71	30	3	5	38	30	15	83	0.1198

### MPC Comparison

Our recommendation is bracketed in both RVUs and intra-service time by two MPC codes, 15002 (*Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children*) and 31622 (*Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)*).

Code	RVU	Pre Eval	Pre Positioning	Pre S/D/W	Total Pre	Intra	Post	Total	IWP/UT
31622	2.78	10	5	5	30	30	15	65	0.0688

<b>19083</b>	<b>3.10</b>	<b>13</b>	<b>1</b>	<b>5</b>	<b>19</b>	<b>25</b>	<b>15</b>		
15002	3.65	45	15	15	75	20	20	115	0.0868

### Comparison Within the Family

The recommendations maintain appropriate rank order across the entire family of breast biopsy codes as summarized in the table below. As discussed above, the inherent level of patient discomfort throughout this examination and the variability of visualization of the biopsy target, procedures performed under stereotactic guidance are, by definition, more intense than other breast biopsies. The MRI guided biopsies have similar proposed RVU values yet significantly longer intra service times due to the much longer acquisition times to obtain MRI sequences to verify lesion location and needle placement than the acquisition times for stereotactic procedures. Similarly ultrasound guided procedures require less intra service time due to the use of real-time imaging.

### Conclusion

In summary, the panel recommends the median survey value for the base surgical code of 3.10 RVU. We believe this relative value is appropriate based on comparisons to the KRS, the two MPC codes provided, and within the larger family of breast intervention codes.

### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

### FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 19103, 19295, 76942

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology                      How often? Commonly

Specialty General Surgery                              How often? Commonly

Specialty    How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We are unable to accurately estimate the number of times this service might be provided nationally in a one year period.

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?  
108,668 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. see work neutrality estimates.

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 32551

## AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 19084      Tracking Number 04      Original Specialty Recommended RVU: **1.55**  
 Presented Recommended RVU: **1.55**  
 Global Period: ZZZ      RUC Recommended RVU: **1.55**

CPT Descriptor: Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)

### CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year old female has two indeterminate nodules seen in the right breast on ultrasound at the 10 o'clock and 2 o'clock locations. Ultrasound-guided biopsy of the lesion at 2 o'clock is performed after initial ultrasound-guided biopsy of the lesion at 10 o'clock. (Initial biopsy reported separately, using 19083)

Percentage of Survey Respondents who found Vignette to be Typical: 92%

### Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

### Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 16%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 17%

### Description of Pre-Service Work:

- Reposition the patient as needed to optimally target second lesion.
- Target second separate lesion. Position patient on the ultrasound table to best localize the lesion.
- Prepare the skin with an appropriate surgical antiseptic solution and administer local anesthesia.

### Description of Intra-Service Work:

- Make a small incision with a scalpel.
- Under ultrasound visualization, move the tip of the needle to the edge of the lesion. Once needle position is verified, "fire" the needle. Obtain pre-fire and post-fire images.
- Activate vacuum system. While watching with ultrasound, obtain a series of samples through the lesion until the lesion is determined to be adequately sampled by the physician.
- Once adequate sampling has been determined, place a marker into the breast utilizing ultrasound guidance to mark the site of biopsy. Document marker deployment with an ultrasound image.
- Withdraw the needle and obtain hemostasis with manual compression over the biopsy site.
- Close the skin incision with steri-strips

### Description of Post-Service Work:

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Zeke Silva, MD; Kurt Schoppe, MD; Mark Alson, MD; Jan Jeske, MD; Eric Whitacre, MD FACS; Christopher Senkowski, MD FACS; Charles Mabry, MD FACS				
<b>Specialty(s):</b>	American College of Radiology, American College of Surgeons, American Society of Breast Surgeons				
<b>CPT Code:</b>	19084				
<b>Sample Size:</b>	2600	<b>Resp N:</b>	52	<b>Response:</b> 2.0 %	
<b>Description of Sample:</b>	Random Sample				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	28.00	50.00	82.00	600.00
<b>Survey RVW:</b>	0.50	1.65	2.25	3.50	4.50
<b>Pre-Service Evaluation Time:</b>			5.00		
<b>Pre-Service Positioning Time:</b>			0.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.00		
<b>Intra-Service Time:</b>	5.00	15.00	20.00	30.00	46.00
<b>Immediate Post Service-Time:</b>	<u>5.00</u>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: ZZZ Global Code

<b>CPT Code:</b>	19084	<b>Recommended Physician Work RVU: 1.55</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		0.00	0.00	0.00
<b>Pre-Service Positioning Time:</b>		1.00	0.00	1.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		4.00	0.00	4.00
<b>Intra-Service Time:</b>		20.00		
<b>Immediate Post Service-Time:</b>	<u>0.00</u>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
36479	ZZZ	3.38	RUC Time

CPT Descriptor Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; second and subsequent veins treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
64480	ZZZ	1.20	RUC Time	30,408

CPT Descriptor 1 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level (List separately in addition to code for primary procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99292	ZZZ	2.25	RUC Time	434,114

CPT Descriptor 2 Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
---------------------------------	---------------	-----------------	--------------------

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 13      % of respondents: 25.0 %

**TIME ESTIMATES (Median)**

	<u>CPT Code: 19084</u>	<u>Key Reference CPT Code: 36479</u>	<u>Source of Time RUC Time</u>
Median Pre-Service Time	5.00	0.00	
Median Intra-Service Time	20.00	45.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>25.00</b>	<b>45.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.85	3.62
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.08	3.62
--	------	------

Urgency of medical decision making	2.92	3.23
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.00	3.54
--------------------------	------	------

Physical effort required	2.92	3.38
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.85	3.54
---	------	------

Outcome depends on the skill and judgment of physician	3.31	3.69
--	------	------

Estimated risk of malpractice suit with poor outcome	3.15	3.69
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.00	3.83
----------------------------------	------	------

Intra-Service intensity/complexity	3.08	3.62
------------------------------------	------	------

Post-Service intensity/complexity	2.92	3.46
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**



Several breast intervention codes were identified by the 75% screen including the following:

Code	Descriptor
<b>19103</b>	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance
<b>19295</b>	Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)
<b>19290</b>	Preoperative placement of needle localization wire, breast;
<b>77031</b>	Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation
<b>76098</b>	Radiological examination, surgical specimen
<b>77032</b>	Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation

To improve the reporting of breast interventions, the entire family of existing breast intervention codes was sent to the CPT Editorial Panel who created a new family of 14 bundled codes to describe image-guided breast interventions. This new family consists of two main groups: (1) 6 codes to describe breast biopsy (19081-19086) differentiated by the imaging modality used, either stereotactic, ultrasound, or MR guidance, with each guidance method then divided into a base code for the 1<sup>st</sup> lesion and an add-on code for each additional lesion biopsied; (2) 8 new codes (19281-19288) to describe the placement of breast localization device(s) also differentiated by the imaging guidance used with base and add-on codes created.

The American College of Radiology, American College of Surgeons, and the American Society of Breast Surgeons randomly surveyed their respective members, and an expert panel was convened to review the survey results. The MR guidance codes (19085, 19085, 19287, and 19288) and the mammo guided localization codes (19281 and 19282) were only surveyed by the ACR.

### Biopsy Codes (19081-19086)

#### Compelling Evidence

The Society recommendations detailed below satisfy budget neutrality requirements, so compelling evidence arguments are not required. However, the societies would like to point out that since the original breast biopsy codes were developed, advances in imaging guidance have made it possible to target and sample progressively smaller and more subtle lesions. Lesions that previously were impossible to biopsy by stereotactic guidance are now routinely performed. Similar advancements in ultrasound and MRI technology have allowed sampling of lesions that previously needed open surgical biopsy for diagnosis.

CPT code 19084 (*Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)*) describes image guided breast biopsy of each additional lesion utilizing ultrasound imaging guidance including the placement of a breast localizing device and imaging of the biopsy specimen, when performed. Currently, these are typically performed using multiple localization wires to “bracket” the lesion. Depending on lesion morphology, this procedure can involve placement of 1-4 wires, with 2 being most typical. This CPT code was designed to utilize a single CPT code, reported only once, regardless of the number or type of markers placed in or around a second separate lesion under ultrasound guidance. This service is currently reported using the following codes:

Code	Descriptor	Work RVU
<b>19103-51</b>	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance	1.85
<b>76942</b>	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	0.67
<b>19295</b>	Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)	0.00

#### Work RVU Recommendation

The expert panel recommends a work RVU of 1.55, which is half the recommended value of 19083 the base code with which add-on code 19084 will be reported. The intra-service time for these 2 codes is nearly identical (25 vs. 20 minutes), suggesting the application of the surgical MPPR to reach our recommendation is appropriate. Our recommendation is below the 25th percentile of our survey and below the existing value of the three codes currently used to describe this service.

#### Pre and Post-Service Time

The respondents indicated 5 minutes of pre service time and 5 minutes of post service time for this ZZZ add-on code. The expert panel attributes this time to the following activities which occur after and in addition to similar activities involved in treating the 1<sup>st</sup> lesion.

pre-service activities:

- Target second separate lesion. Position patient on the ultrasound table to best localize the lesion.
- Prepare the skin with an appropriate surgical antiseptic solution and administer local anesthesia.

and post-service activities:

- Apply dressing.

### Intra Service Time

We are recommending the median intra service time of 20 minutes which is slightly less than the 25 minutes of intra-service time for the base code, 191XX3, with which this ZZZ code is reported. The panel again points out that treating the second lesion involves completely new skin preparation, lesion localization, biopsy, wound dressing and recovery. If it is concluded that our recommended pre and post times are not appropriate for this ZZZ code, we suggest adding those minutes to the intra-service work since survey respondents could have easily shifted what is otherwise intra-service time to the pre and post service periods.

### Comparison to Key Reference Service

The panel would like to point out that many of our survey respondents practice nearly 100% breast imaging. Since the surveyed code family essentially includes all of the services this survey population performs, respondents may have struggled to find a ZZZ day global KRS they commonly perform. Nonetheless, the most commonly chosen KRS is 36479 (*Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; second and subsequent veins treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)*) which has a higher RVU of 3.38 and a longer intra service time of 45 minutes and, hence, a higher RVU.

Code	RVU	Pre Eval	Pre Positioning	Pre S/D/W	Total Pre	Intra	Post	Total	IWPUT
<b>19084</b>	<b>1.55</b>		<b>1</b>	<b>4</b>	<b>5</b>	<b>20</b>		<b>25</b>	
36479	3.38					45		45	0.0750

### MPC Comparison

Our recommendation is bracketed in both RVUs and intra-service time by two ZZZ MPC codes, 64480 (*Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level (List separately in addition to code for primary procedure)*) and 99292 (*Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)*).

Code	RVU	Pre Eval	Pre Positioning	Pre S/D/W	Total Pre	Intra	Post	Total	IWPUT
64480	1.20					15		15	0.0800
<b>19084</b>	<b>1.55</b>		<b>1</b>	<b>4</b>	<b>5</b>	<b>20</b>		<b>25</b>	
99292	2.25					30		30	0.0750

### Comparison Within the Family

The recommendations maintain appropriate rank order across the entire family of breast biopsy codes as summarized in the table below. As discussed above, the inherent level of patient discomfort throughout this examination and the variability of visualization of the biopsy target, procedures performed under stereotactic guidance are, by definition, more intense than other breast biopsies. The MRI guided biopsies have similar proposed RVU values yet significantly longer intra service times due to the much longer acquisition times to obtain MRI sequences to verify lesion location and needle placement than the acquisition times for stereotactic procedures. Similarly ultrasound guided procedures require less intra service time due to the use of real-time imaging.

### Conclusion

In summary, the panel recommends an RVU of 1.55, half the value of the base code with which this code will be reported. We believe this relative value is appropriate based on comparisons to the KRS, the two MPC codes provided and within the larger family of breast biopsy codes.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 19103-51, 19295, 76942

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology How often? Commonly

Specialty General Surgery How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. unable to estimate

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

10,812 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. see work neutrality estimates

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

**Professional Liability Insurance Information (PLI)**

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 64480

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 19085      Tracking Number 05      Original Specialty Recommended RVU: **3.64**  
 Presented Recommended RVU: **3.64**  
 Global Period: 000      RUC Recommended RVU: **3.64**

CPT Descriptor: Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including magnetic resonance guidance

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 49-year-old female has recently been diagnosed with invasive ductal carcinoma in the right breast. Pre-operative MRI demonstrates a small indeterminate nodule in the left breast upper outer quadrant with suspicious enhancement characteristics. MRI-guided biopsy is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 18%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 21%

**Description of Pre-Service Work:**

- Review medical records and previous imaging and decide on appropriate guidance method and initial approach based on prior imaging.
- Discuss procedure details, including alternatives and risks with the patient and family and obtain informed consent.
- Review set up in the biopsy suite. Ensure accurate calibration of the equipment. Supervise positioning and preparation of the patient.
- Surgical time out performed.
- Supervise and review initial magnetic resonance sequences and target the lesion to be biopsied. Transmit coordinates to work station. Choose grid coordinates.
- Prepare the skin with an appropriate surgical antiseptic solution and administer local anesthesia.

**Description of Intra-Service Work:**

- Make a small incision with a scalpel.
- Move the trocar into appropriate position. Confirm placement with MR imaging. Adjust as necessary.
- Advance vacuum assisted needle system through trocar. After proper position is obtained, remove multiple samples of tissue. Remove biopsy device and image the biopsy bed with MRI to evaluate for sample adequacy.
- If additional tissue is deemed necessary, retarget the lesion, reposition the trocar, re-advance the needle to the lesion, and obtain additional tissue. Obtain an additional set of MRI images of the biopsy bed. This is repeated until the physician is convinced that an adequate sample has been obtained for the pathologist.
- Once adequate sampling has been determined, place a marker into the breast through the MRI trocar system to mark the site of biopsy.

- Obtain MRI images of biopsy bed after marker deployment.
- Review post-marker placement images for successful deployment.
- Withdraw the trocar and obtain hemostasis with manual compression over the biopsy site.
- Close the skin incision with steri-strips.

Description of Post-Service Work:

- Apply dressing.
- Monitor the patient's condition prior to discharge including wound check.
- Review post-procedure wound care and activity level instructions with the patient and her family.
- A formal report of the procedure is dictated into the permanent medical record.
- The results and further management are discussed with the patient and their family, as well as the requesting physician.
- Review and sign procedure report.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Zeke Silva, MD; Kurt Schoppe, MD; Mark Alson, MD; Jan Jeske, MD				
<b>Specialty(s):</b>	American College of Radiology				
<b>CPT Code:</b>	19085				
<b>Sample Size:</b>	1200	<b>Resp N:</b>	64	<b>Response:</b> 5.3 %	
<b>Description of Sample:</b>	Random Sample				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	5.00	10.00	20.00	150.00
<b>Survey RVW:</b>	1.70	2.99	3.64	5.00	6.00
<b>Pre-Service Evaluation Time:</b>			40.00		
<b>Pre-Service Positioning Time:</b>			11.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			6.00		
<b>Intra-Service Time:</b>	10.00	25.00	45.00	60.00	67.00
<b>Immediate Post Service-Time:</b>	<u>20.00</u>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1a-FAC Straightforw Pat/Procedure(no sedate/anesth

<b>CPT Code:</b>	19085	<b>Recommended Physician Work RVU: 3.64</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		13.00	13.00	0.00
<b>Pre-Service Positioning Time:</b>		3.00	1.00	2.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		6.00	6.00	0.00
<b>Intra-Service Time:</b>		45.00		
<b>Immediate Post Service-Time:</b>	<u>15.00</u>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00		

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
49411	000	3.82	RUC Time

CPT Descriptor Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum, single or multiple

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
15002	000	3.65	RUC Time	16,473

CPT Descriptor 1 Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
31628	000	3.80	RUC Time	38,792

CPT Descriptor 2 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
---------------------------------	---------------	-----------------	--------------------

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 12      % of respondents: 18.7 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 19085</b>	<b>Key Reference CPT Code: 49411</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	22.00	25.00	
Median Intra-Service Time	45.00	40.00	
Median Immediate Post-service Time	15.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	



Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>82.00</b>	<b>85.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.75	3.75
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.83	3.67
--	------	------

Urgency of medical decision making	3.08	3.17
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.92	3.75
--------------------------	------	------

Physical effort required	3.33	3.42
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.08	3.42
---	------	------

Outcome depends on the skill and judgment of physician	3.75	3.75
--	------	------

Estimated risk of malpractice suit with poor outcome	3.67	3.50
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.50	3.50
----------------------------------	------	------

Intra-Service intensity/complexity	3.92	4.00
------------------------------------	------	------

Post-Service intensity/complexity	3.75	3.75
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**

Several breast intervention codes were identified by the 75% screen including the following:

Code	Descriptor
<b>19103</b>	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance
<b>19295</b>	Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)
<b>19290</b>	Preoperative placement of needle localization wire, breast;
<b>77031</b>	Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation
<b>76098</b>	Radiological examination, surgical specimen
<b>77032</b>	Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation

To improve the reporting of breast interventions, the entire family of existing breast intervention codes was sent to the CPT Editorial Panel who created a new family of 14 bundled codes to describe image-guided breast interventions. This new family consists of two main groups: (1) 6 codes to describe breast biopsy (19081-19086) differentiated by the imaging modality used, either stereotactic, ultrasound, or MR guidance, with each guidance method then divided into a base code for the 1<sup>st</sup> lesion and an add-on code for each additional lesion biopsied; (2) 8 new codes (19281-19288) to describe the placement of breast localization device(s) also differentiated by the imaging guidance used with base and add-on codes created.

The American College of Radiology, American College of Surgeons, and the American Society of Breast Surgeons randomly surveyed their respective members, and an expert panel was convened to review the survey results. The MR guidance codes (19085, 19085, 19287, and 19288) and the mammo guided localization codes (19281 and 19282) were only surveyed by the ACR.

### Biopsy Codes (19081-19086)

#### Compelling Evidence

The Society recommendations detailed below satisfy budget neutrality requirements, so compelling evidence arguments are not required. However, the societies would like to point out that since the original breast biopsy codes were developed, advances in imaging guidance have made it possible to target and sample progressively smaller and more subtle lesions. Lesions that previously were impossible to biopsy by stereotactic guidance are now routinely performed. Similar advancements in ultrasound and MRI technology have allowed sampling of lesions that previously needed open surgical biopsy for diagnosis.

CPT code 19085 (*Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including magnetic resonance guidance*) describes image guided breast biopsy of a first lesion utilizing magnetic resonance imaging guidance including the placement of a breast localizing device(s) and imaging of the biopsy specimen, when performed. This service is currently reported using the following codes:

Code	Descriptor	Work RVU
<b>19103</b>	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance	3.69
<b>77021</b>	Magnetic resonance guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation	1.50
<b>19295</b>	Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)	0.00

#### Work RVU Recommendation

**The expert panel recommends** the median survey RVU of 3.64. This is below the existing value of the three codes currently used to describe this service.

#### Pre-Service Time

The expert panel recommends pre-service package 1a (Straightforward Patient/Straightforward Procedure (No sedation/anesthesia care)) with the following adjustments:

(1) Increase the total pre-service evaluation time by 5 minutes to 18 minutes total to accommodate an extra 3 minutes necessary for "history and exam (Performance and review of appropriate pre-tests) and an additional 2 minutes for "Communicate with patient and/or family (Discuss procedure / obtain consent)". Patients undergoing magnetic resonance (MR) breast biopsy typically have a large number of prior examinations which must be reviewed in detail including prior screening mammography, diagnostic mammography, diagnostic ultrasound, prior biopsies and clip placements. Moreover, a careful review of the prior pathology, previous medical and surgical treatment and planned therapy is performed. It is incumbent on the performing physician to review the entire breast imaging record prior to the biopsy being performed including imaging of the opposite breast. These patients are often well informed women appropriately requiring and expecting detailed discussion of the expected course and outcome. Unlike other biopsies performed elsewhere in the body, there is high anxiety, both because the biopsy is often unanticipated and because it involves the breast. For these reasons, breast biopsy patients have more anxiety, have more questions, and frequently bring multiple family members to the consent, which increases time to address all of their needs as well.

(2) Increase the positioning time by 2 minutes to 3 minutes to accommodate the additional time necessary to optimally position these patients on the MR table and ensure that operator and imaging equipment are likewise well positioned relative to the patient. Further, it is reasonable to conclude that survey respondents would consider imaging to localize the mass and guide skin prep prior to biopsy to be considered pre-service work.

### Intra and Post Service Times

We are recommending the median intra and post-service times of 45 and 15 minutes, respectively. The intraservice time for MRI guided procedures is longer than for stereotactic biopsies because of the time needed to image after each step which is several minutes.

### Comparison to Key Reference Service

The panel would like to point out that many of our survey respondents practice nearly 100% breast imaging. Since the surveyed code family essentially includes all of the 0 day global services this survey population performs, respondents may have struggled to find a 0 day global reference service they commonly perform. Nonetheless, the most commonly chosen KRS is 49411 (*Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum, single or multiple*), which has slightly lower intra-service time of 40 minutes but also higher RVUs of 3.82. 49411 and 19085 were equal on four complexity measures, with 49411 showing higher complexity also on four other measures. This reflects the unique nature of breast interventions. These procedures are associated with very high patient and family anxiety, which tends to increase the psychological stress of the physician performing the exam. Additionally, these types of exams have a higher frequency to be associated with malpractice suits, which adds to the stress as well.

Our recommendation yields an IWPUT of 0.0619, reflecting the intensity of this procedure in this subset of patients. Indeed, the patient is laying prone with her breast immobilized throughout the intra service period of this procedure. The MR table is inherently uncomfortable leading to frequent complaints of neck and shoulder pain during the procedure as time passes. Due to the need for the patient to remain fully aware and not move even a few millimeters, the atmosphere in the room can become quite tense. The images for the biopsy are performed on a biopsy device rather than a dedicated breast coil and as such correlating the lesion to be biopsied to the initial lesion of concern can be challenging especially for very small lesions which are typically the ones for which MRI has to be performed since they cannot be visualized sonographically. Many patients have feelings of claustrophobia even if they are actually able to tolerate the machine, which increases the anxiety level of the patient and the pressure on the physician thus increasing the intensity of the procedure.

Code	RVU	Pre Eval	Pre Positioning	Pre S/D/W	Total Pre	Intra	Post	Total	IWPUT
49411	3.82	19	1	5	25	40	20	85	0.0721

### MPC Comparison

Our recommendation compares favorably to two MPC codes both of which have similar RVUs but less intra-service time: 15002 (*Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children*) and 31628 (*Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe*).

Code	RVU	Pre Eval	Pre Positioning	Pre S/D/W	Total Pre	Intra	Post	Total	IWPUT
15002	3.65	45	15	15	75	20	20	115	0.0868
31628	3.80	10	10	10	30	40	20	90	0.0706

### Comparison Within the Family

The recommendations maintain appropriate rank order across the entire family of breast biopsy codes as summarized in the table below. As discussed above, the inherent level of patient discomfort throughout this examination and the variability of visualization of the biopsy target, procedures performed under stereotactic guidance are, by definition, more intense than other breast biopsies. The MRI guided biopsies have similar proposed RVU values yet significantly longer intra service times due to the much longer acquisition times to obtain MRI sequences to verify lesion location and needle placement than the acquisition times for stereotactic procedures. Similarly ultrasound guided procedures require less intra service time due to the use of real-time imaging.

#### Conclusion

In summary, the panel recommends the median survey value for the base surgical code of 3.64 RVU. We believe this relative value is appropriate based on comparisons to the KRS, the two MPC codes provided, and within the larger family of breast intervention codes.

### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

### FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 19103, 19295, 77021

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology                      How often? Commonly

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We are unable to accurately estimate the number of times this service might be provided nationally in a one year period.

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 6,483  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. see work neutrality estimates.

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? Yes

---

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 36565

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 19086      Tracking Number 06      Original Specialty Recommended RVU: **1.82**  
 Presented Recommended RVU: **1.82**  
 Global Period: ZZZ      RUC Recommended RVU: **1.82**

CPT Descriptor: Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 58-year-old female has recently been diagnosed with invasive ductal carcinoma in the right breast. Pre-operative MRI demonstrates a small nodule in the left breast upper-outer quadrant with suspicious enhancement characteristics, and a second separate similar mass in the left breast upper-inner quadrant. The nodule in the left upper-inner quadrant is biopsied under MRI-guidance after initial MRI-guided biopsy of the nodule in the left upper-outer quadrant. (Initial biopsy reported separately, using 19085)

Percentage of Survey Respondents who found Vignette to be Typical: 97%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 22%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 22%

**Description of Pre-Service Work:**

- Reposition patient back into the MRI biopsy system.
- Target second separate lesion. Supervise and review initial magnetic resonance sequences and target the lesion to be biopsied. Transmit coordinates to work station. Choose grid coordinates.
- Prepare the skin with an appropriate surgical antiseptic solution and administer local anesthesia.

**Description of Intra-Service Work:**

- Make a small incision with a scalpel.
- Move the trocar into appropriate position. Confirm placement with MR imaging. Adjust as necessary.
- Advance vacuum-assisted needle system through trocar. After proper position is obtained, remove multiple samples of tissue. Remove biopsy device and image the biopsy bed with MRI to evaluate for sample adequacy.
- If additional tissue is deemed necessary, retarget the lesion, reposition the trocar, re-advance the needle to the lesion, and obtain additional tissue. Obtain an additional set of MRI images of the biopsy bed. This is repeated until the physician is convinced that an adequate sample has been obtained for the pathologist.
- Once adequate sampling has been determined, place a marker into the breast through the MRI trocar system to mark the site of biopsy.
- Obtain MRI images of biopsy bed after marker deployment.
- Review post-marker placement images for successful deployment.

- Withdraw the trocar and obtain hemostasis with manual compression over the biopsy site.
- Close the skin incision with steri-strips.

Description of Post-Service Work:

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Zeke Silva, MD; Kurt Schoppe, MD; Mark Alson, MD; Jan Jeske, MD				
<b>Specialty(s):</b>	American College of Radiology				
<b>CPT Code:</b>	19086				
<b>Sample Size:</b>	1200	<b>Resp N:</b>	40	<b>Response:</b> 3.3 %	
<b>Description of Sample:</b>	Random Sample				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	2.00	3.00	10.00	21.00
<b>Survey RVW:</b>	1.00	1.80	2.05	3.81	4.50
<b>Pre-Service Evaluation Time:</b>			6.00		
<b>Pre-Service Positioning Time:</b>			0.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.00		
<b>Intra-Service Time:</b>	15.00	19.00	38.00	60.00	69.00
<b>Immediate Post Service-Time:</b>	6.00				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	0.00	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

ZZZ Global Code

<b>CPT Code:</b>	19086	<b>Recommended Physician Work RVU: 1.82</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		0.00	0.00	0.00
<b>Pre-Service Positioning Time:</b>		1.00	0.00	1.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		4.00	0.00	4.00
<b>Intra-Service Time:</b>		38.00		
<b>Immediate Post Service-Time:</b>	0.00			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	0.00	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	0.00	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	0.00	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		
<b>Sub Obs Care:</b>	0.00	99224x 0.00 99225x 0.00 99226x 0.00		



**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
76812	ZZZ	1.78	RUC Time

CPT Descriptor Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
64480	ZZZ	1.20	RUC Time	30,408

CPT Descriptor 1 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level (List separately in addition to code for primary procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99292	ZZZ	2.25	RUC Time	434,114

CPT Descriptor 2 Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
---------------------------------	---------------	-----------------	--------------------

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 13      % of respondents: 32.5 %**

**TIME ESTIMATES (Median)**

	<b>CPT Code: 19086</b>	<b>Key Reference CPT Code: 76812</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	5.00	0.00	
Median Intra-Service Time	38.00	25.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>43.00</b>	<b>25.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.85	2.46
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.85	2.31
Urgency of medical decision making	3.69	2.46

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.62	2.23
Physical effort required	3.69	1.92

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.62	2.31
Outcome depends on the skill and judgment of physician	3.85	2.08
Estimated risk of malpractice suit with poor outcome	3.77	2.23

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.69	2.38
Intra-Service intensity/complexity	3.77	2.38
Post-Service intensity/complexity	3.54	2.31

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**

Several breast intervention codes were identified by the 75% screen including the following:

Code	Descriptor
<b>19103</b>	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance
<b>19295</b>	Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)
<b>19290</b>	Preoperative placement of needle localization wire, breast;
<b>77031</b>	Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation
<b>76098</b>	Radiological examination, surgical specimen
<b>77032</b>	Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation

To improve the reporting of breast interventions, the entire family of existing breast intervention codes was sent to the CPT Editorial Panel who created a new family of 14 bundled codes to describe image-guided breast interventions. This new family consists of two main groups: (1) 6 codes to describe breast biopsy (19081-19086) differentiated by the imaging modality used, either stereotactic, ultrasound, or MR guidance, with each guidance method then divided into a base code for the 1<sup>st</sup> lesion and an add-on code for each additional lesion biopsied; (2) 8 new codes (19281-19288) to describe the placement of breast localization device(s) also differentiated by the imaging guidance used with base and add-on codes created.

The American College of Radiology, American College of Surgeons, and the American Society of Breast Surgeons randomly surveyed their respective members, and an expert panel was convened to review the survey results. The MR guidance codes (19085, 19085, 19287, and 19288) and the mammo guided localization codes (19281 and 19282) were only surveyed by the ACR.

#### **Biopsy Codes (19081-19086)**

##### **Compelling Evidence**

The Society recommendations detailed below satisfy budget neutrality requirements, so compelling evidence arguments are not required. However, the societies would like to point out that since the original breast biopsy codes were developed, advances in imaging guidance have made it possible to target and sample progressively smaller and more subtle lesions. Lesions that previously were impossible to biopsy by stereotactic guidance are now routinely performed. Similar advancements in ultrasound and MRI technology have allowed sampling of lesions that previously needed open surgical biopsy for diagnosis.

CPT code 19086 (*Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)*) describes image guided breast biopsy of each additional lesion utilizing magnetic resonance imaging guidance including the placement of a breast localizing device and imaging of the biopsy specimen, when performed. Currently, these are typically performed using multiple localization wires to “bracket” the lesion. Depending on lesion morphology, this procedure can involve placement of 1-4 wires, with 2 being most typical. This CPT code was designed to utilize a single CPT code, reported only once, regardless of the number or type of markers placed in or around a second separate lesion under MRI guidance. This service is currently reported using the following codes:

Code	Descriptor	Work RVU
<b>19103-51</b>	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance	1.85
<b>77021</b>	Magnetic resonance guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation	1.50
<b>19295</b>	Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)	0.00

## Work RVU Recommendation

The expert panel recommends a work RVU value of 1.82, which is half the recommended value of 19085, the base code with which add-on code 19086 will be reported. The intra-service time for these 2 codes is nearly identical (45 vs. 38 minutes), suggesting the application of the surgical MPPR to reach our recommendation is appropriate. Our recommendation is close to the 25th percentile of our survey and below the existing value of the three codes currently used to describe this service.

## Pre and Post-Service Time

The respondents indicated 6 minutes of pre service time and 6 minutes of post service time for this ZZZ add-on code; the specialties are recommending 5 minutes of pre and post time to maintain consistency across the add-on codes. The expert panel attributes this time to the following activities which occur after and in addition to similar activities involved in treating the 1<sup>st</sup> lesion

pre-service activities:

- Target second separate lesion. Supervise and review initial magnetic resonance sequences and target the lesion to be biopsied. Transmit coordinates to work station. Choose grid coordinates.
- Prepare the skin with an appropriate surgical antiseptic solution and administer local anesthesia.

and post-service activities:

- Apply dressing.

## Intra Service Time

We are recommending the median intra service time of 38 minutes, which is slightly less than the 45 minutes of intra-service time for the base code, 191XX5, with which this ZZZ code is reported. The panel again points out that treating the second lesion involves completely new skin preparation, lesion localization, biopsy, wound dressing and recovery. If it is concluded that our recommended pre and post times are not appropriate for this ZZZ code, we suggest adding those minutes to the intra-service work since survey respondents could have easily shifted what is otherwise intra-service time to the pre and post service periods.

## Comparison to Key Reference Service

The most commonly chosen KRS is 76812 (*Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)*) which has a lower RVU of 1.78 and a shorter intra service time of 25 minutes.

Code	RVU	Pre Eval	Pre Positioning	Pre S/D/W	Total Pre	Intra	Post	Total	IWPUT
76812	1.78					25		25	0.0712

## MPC Comparison

Our recommendation is bracketed in RVUs by two ZZZ MPC codes, both of which have shorter intra-service times: 64480 (*Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level (List separately in addition to code for primary procedure)*) and 99292 (*Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)*).

Code	RVU	Pre Eval	Pre Positioning	Pre S/D/W	Total Pre	Intra	Post	Total	IWPUT
64480	1.20					15		15	0.0800
99292	2.25					30		30	0.0750

### Comparison Within the Family

The recommendations maintain appropriate rank order across the entire family of breast biopsy codes as summarized in the table below. As discussed above, the inherent level of patient discomfort throughout this examination and the variability of visualization of the biopsy target, procedures performed under stereotactic guidance are, by definition, more intense than other breast biopsies. The MRI guided biopsies have similar proposed RVU values yet significantly longer intra service times due to the much longer acquisition times to obtain MRI sequences to verify lesion location and needle placement than the acquisition times for stereotactic procedures. Similarly ultrasound guided procedures require less intra service time due to the use of real-time imaging.

### Conclusion

In summary, the panel recommends an RVU of 1.82, half the value of the base code with which this code will be reported. We believe this relative value is appropriate based on comparisons to the KRS, the two MPC codes provided, and within the larger family of breast biopsy codes.

### SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

### FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 19103-51, 19295, 77021

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology                      How often? Commonly

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We are unable to accurately estimate the number of times this service might be provided nationally in a one year period.

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 203

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. see work neutrality estimates

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 76812

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 19281      Tracking Number 07      Original Specialty Recommended RVU: **2.00**  
 Presented Recommended RVU: **2.00**  
 Global Period: 000      RUC Recommended RVU: **2.00**

CPT Descriptor: Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including mammographic guidance

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 70-year-old female has recently had invasive ductal carcinoma in the upper-outer quadrant of the right breast diagnosed using stereotactic core biopsy and is a candidate for breast conservation surgery. Trailing microcalcifications are seen in two directions from original biopsy site. A dual-wire/needle localization is performed under mammographic guidance to bracket the lesion for surgical planning.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

**Description of Pre-Service Work:**

- Review medical records and previous imaging and decide on appropriate guidance method and initial approach based on prior imaging.
- Discuss procedure details, including alternatives and risks with the patient and family and obtain informed consent.
- Review set up in the procedure suite. Ensure accurate calibration of the equipment. Supervise positioning and preparation of the patient.
- Surgical time out performed.
- Obtain initial mammographic image. Determine coordinates for marker placement.
- Prepare the skin with an appropriate surgical antiseptic solution and administer local anesthesia at each marker insertion site.

**Description of Intra-Service Work:**

- Advance introducer(s) to site(s) bracketing lesion. Obtain mammographic images in orthogonal planes to confirm location.
- Deploy marker(s). Obtain post-deployment mammographic images to confirm adequacy.
- Annotate images.
- Secure markers as needed.

**Description of Post-Service Work:**

- Cover area with sterile dressing. Confirm patient stability. Transfer patient and marked images to pre-surgical area.

- A formal report of the procedure is dictated into the permanent medical record.
- The results and further management are discussed with the patient and their family, as well as the requesting physician.
- Review and sign procedure report.



**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Zeke Silva, MD; Kurt Schoppe, MD; Mark Alson, MD; Jan Jeske, MD				
<b>Specialty(s):</b>	American College of Radiology				
<b>CPT Code:</b>	19281				
<b>Sample Size:</b>	1200	<b>Resp N:</b>	62	<b>Response:</b> 5.1 %	
<b>Description of Sample:</b>	Random Sample				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	21.00	50.00	80.00	400.00
<b>Survey RVW:</b>	0.85	1.76	2.00	3.00	5.00
<b>Pre-Service Evaluation Time:</b>			34.00		
<b>Pre-Service Positioning Time:</b>			10.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			6.00		
<b>Intra-Service Time:</b>	5.00	15.00	30.00	35.00	90.00
<b>Immediate Post Service-Time:</b>	<b>15.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1a-FAC Straightforw Pat/Procedure(no sedate/anesth

<b>CPT Code:</b>	19281	<b>Recommended Physician Work RVU: 2.00</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		13.00	13.00	0.00
<b>Pre-Service Positioning Time:</b>		1.00	1.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		6.00	6.00	0.00
<b>Intra-Service Time:</b>		30.00		
<b>Immediate Post Service-Time:</b>	<b>15.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00		

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
36556	000	2.50	RUC Time

CPT Descriptor Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
64483	000	1.90	RUC Time	852,187

CPT Descriptor 1 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
90937	000	2.11	RUC Time	84,829

CPT Descriptor 2 Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
---------------------------------	---------------	-----------------	--------------------

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 23      % of respondents: 37.0 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 19281</b>	<b>Key Reference CPT Code: 36556</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	20.00	25.00	
Median Intra-Service Time	30.00	15.00	
Median Immediate Post-service Time	15.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
<b>Median Total Time</b>	<b>65.00</b>	<b>50.00</b>	

Other time if appropriate		
---------------------------	--	--

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.48	3.35
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.43	3.30
--	------	------

Urgency of medical decision making	3.30	3.26
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.43	3.30
--------------------------	------	------

Physical effort required	3.30	3.13
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.39	3.22
---	------	------

Outcome depends on the skill and judgment of physician	3.39	3.04
--	------	------

Estimated risk of malpractice suit with poor outcome	3.65	3.26
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.43	3.48
----------------------------------	------	------

Intra-Service intensity/complexity	3.43	3.43
------------------------------------	------	------

Post-Service intensity/complexity	3.35	3.30
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**

Several breast intervention codes were identified by the 75% screen including the following:

Code	Descriptor
<b>19103</b>	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance
<b>19295</b>	Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)
<b>19290</b>	Preoperative placement of needle localization wire, breast;
<b>77031</b>	Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation
<b>76098</b>	Radiological examination, surgical specimen
<b>77032</b>	Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation

To improve the reporting of breast interventions, the entire family of existing breast intervention codes was sent to the CPT Editorial Panel who created a new family of 14 bundled codes to describe image-guided breast interventions. This new family consists of two main groups: (1) 6 codes to describe breast biopsy (19081-19086) differentiated by the imaging modality used, either stereotactic, ultrasound, or MR guidance, with each guidance method then divided into a base code for the 1<sup>st</sup> lesion and an add-on code for each additional lesion biopsied; (2) 8 new codes (19281-19288) to describe the placement of breast localization device(s) also differentiated by the imaging guidance used with base and add-on codes created.

The American College of Radiology, American College of Surgeons, and the American Society of Breast Surgeons randomly surveyed their respective members, and an expert panel was convened to review the survey results. The MR guidance codes (19085, 19085, 19287, and 19288) and the mammo guided localization codes (19281 and 19282) were only surveyed by the ACR.

### Localization Device Placement Codes (19281-19288)

#### Compelling Evidence

We believe the localization device placement codes satisfy compelling evidence standards in a number of ways. Previously, placement of a marker into a breast was a relatively simple and straightforward procedure. This often consisted of using imaging guidance to place only a single marker at the lesion for subsequent localization at the time of excision, or placement of a single marker in the lesion at the time of percutaneous biopsy for future localization or mammographic follow-up. Currently, improvements in open breast surgical technique have made it necessary to not only mark a lesion, but often mark multiple edges of a lesion to better define the lesion's extent preoperatively. This allows closer surgical margins and improved cosmetic results. Additionally, in the era of neo-adjuvant chemotherapy, not all patients go immediately to surgery upon discovery of a breast tumor. Rather, a subset of breast cancer patients is treated with chemotherapy prior to surgical excision. In those cases, it is necessary to mark the lesion along multiple margins to aid in subsequent evaluation of response to the neo-adjuvant chemotherapy.

CPT code 19281 (*Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including mammographic guidance*) describes image guided placement of a wire (or wires) for localization of a tumor utilizing mammographic imaging guidance. Currently, breast wire localizations are typically performed using multiple localization wires to "bracket" the lesion. Depending on lesion morphology, this procedure can involve placement of 1-4 wires, with 2 being most typical. This new CPT code was designed to utilize a single CPT code, reported only once, regardless of the number or type of markers placed in or around a single lesion under mammographic guidance.

This service is currently reported using the following codes:

Code	Descriptor	Work RVU
<b>19290</b>	Preoperative placement of needle localization wire, breast;	1.27

<b>77032</b>	Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation	0.56
--------------	---	------

## Work RVU Recommendation

The expert panel recommends the median survey value of 2.00 RVUs, slightly higher than the existing value of 1.83.

### Pre-Service Time

The expert panel recommends pre-service package 1a (Straightforward Patient/Straightforward Procedure (No sedation/anesthesia care)) with the following adjustments:

(1) Increase the total pre-service evaluation time by 5 minutes to 18 minutes total to accommodate an extra 3 minutes necessary for "history and exam (Performance and review of appropriate pre-tests) and an additional 2 minutes for "Communicate with patient and/or family (Discuss procedure / obtain consent)". Patients undergoing mammographic-guided clip placement typically have a large number of prior examinations which must be reviewed in detail including prior screening mammography, diagnostic mammography, diagnostic ultrasound, prior biopsies and clip placements. Moreover, a careful review of the prior pathology, previous medical and surgical treatment and planned therapy is performed. It is incumbent on the performing physician to review the entire breast imaging record prior to the biopsy being performed including imaging of the opposite breast. These patients are often well informed women appropriately requiring and expecting detailed discussion of the expected course and outcome. Unlike other biopsies performed elsewhere in the body, there is high anxiety, both because the biopsy is often unanticipated and because it involves the breast. For these reasons, breast biopsy patients have more anxiety, have more questions, and frequently bring multiple family members to the consent, which increases time to address all of their needs as well.

(2) Increase the positioning time by 2 minutes to 3 minutes to accommodate the additional time necessary to optimally position these patients on the mammography machine and ensure that operator and imaging equipment are likewise well positioned relative to the patient. Further, it is reasonable to conclude that survey respondents would consider imaging to localize the mass and guide skin prep prior to biopsy to be considered pre-service work.

### Intra and Post Service Times

We are recommending the median intra and post-service times of 30 and 15 minutes, respectively.

## Comparison to Key Reference Service

The panel would like to point out that many of our survey respondents practice nearly 100% breast imaging. Since the surveyed code family essentially includes all of the 0 day global services this survey population performs, respondents may have struggled to find a 0 day global reference service they commonly perform. Nonetheless, the most commonly chosen KRS is 36556 (*Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older*), which has a lower intra-service time of 15 minutes but higher RVUs of 2.50. While both of these procedures include imaging guidance, 19281 scored higher on 9 of the 11 complexity measures and equal on another. This reflects the unique nature of breast interventions. These procedures are associated with very high patient and family anxiety, which tends to increase the psychological stress of the physician performing the exam. Additionally, these types of exams have a higher frequency to be associated with malpractice suits, which adds to the stress as well.

Our recommendation yields an IWPUT of 0.0382, reflecting the intensity of this procedure in this subset of patients. Indeed, the patient has her breast in compression throughout the intra service period of this procedure. The mammography machine is inherently uncomfortable leading to frequent complaints of neck and shoulder pain during the procedure as time passes. Due to the need for the patient to remain fully aware and not move even a few millimeters, the atmosphere in the room can become quite tense.

Code	RVU	Pre Eval	Pre Positioning	Pre S/D/W	Total Pre	Intra	Post	Total	IWPUT
36556	2.50	15	5	5	25	15	10	50	0.1192

## MPC Comparison

Our recommendation is bracketed in RVUs and intra-service time by two MPC codes, 64483 (*Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level*) and 90937 (*Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription*).

Code	RVU	Pre Eval	Pre Positioning	Pre S/D/W	Total Pre	Intra	Post	Total	IWPUT
64483	1.90	13	5	6	24	15	10	49	0.0816
90937	2.11	10			10	40	10	60	0.0415

## Comparison Within the Family

The recommendations maintain appropriate rank order across the entire family of localization device placement codes as summarized in the table below. As discussed above, the inherent level of patient discomfort throughout this examination and the variability of visualization of the biopsy target, procedures performed under stereotactic guidance are, by definition, more intense than other breast biopsies. The MRI guided biopsies have similar proposed RVU values yet significantly longer intra service times due to the much longer acquisition times to obtain MRI sequences to verify lesion location and needle placement than the acquisition times for stereotactic procedures. Similarly ultrasound guided procedures require less intra service time due to the use of real-time imaging.

## Conclusion

In summary, the panel recommends the median survey value of 2.00 RVUs. We believe this relative value is appropriate based on comparisons to the KRS, the two MPC codes provided, and within the larger family of breast localization device placement codes.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 19290, 77032

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology                      How often? Commonly

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We are unable to accurately estimate the number of times this service might be provided nationally in a one year period.

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

52,702 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Please explain the rationale for this estimate. see work neutrality estimates.

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 50387

## AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 19282      Tracking Number O8      Original Specialty Recommended RVU: **1.00**  
 Presented Recommended RVU: **1.00**  
 Global Period: ZZZ      RUC Recommended RVU: **1.00**

CPT Descriptor: Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including mammographic guidance (List separately in addition to code for primary procedure)

### CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66-year-old female with recent stereotactic biopsy demonstrating invasive ductal carcinoma at two separate locations within the right breast upper-outer quadrant. She is still a candidate for breast conservation. Using mammographic guidance, second lesion is marked after initial marking of first lesion for localization during surgery. [Note: This is an add-on code. Marker placement(s) at the initial lesion reported separately using 19281.]

Percentage of Survey Respondents who found Vignette to be Typical: 97%

### Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

### Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

### Description of Pre-Service Work:

- Reposition patient back into the mammographic biopsy system.
- Target second separate lesion. Obtain mammographic image. Determine coordinates for marker placement.
- Prepare the skin with an appropriate surgical antiseptic solution and administer local anesthesia at each marker insertion site.

### Description of Intra-Service Work:

- Advance introducer(s) to site(s) bracketing lesion. Obtain mammographic images in orthogonal planes to confirm location.
- Deploy marker(s). Obtain post-deployment mammographic images to confirm adequacy.
- Annotate images.
- Secure markers as needed.

### Description of Post-Service Work:



**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Zeke Silva, MD; Kurt Schoppe, MD; Mark Alson, MD; Jan Jeske, MD				
<b>Specialty(s):</b>	American College of Radiology				
<b>CPT Code:</b>	19282				
<b>Sample Size:</b>	1200	<b>Resp N:</b>	37	<b>Response:</b> 3.0 %	
<b>Description of Sample:</b>	Random Sample				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	20.00	40.00	50.00	175.00
<b>Survey RVW:</b>	0.50	1.30	2.10	3.20	4.33
<b>Pre-Service Evaluation Time:</b>			5.00		
<b>Pre-Service Positioning Time:</b>			0.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.00		
<b>Intra-Service Time:</b>	7.00	18.00	20.00	35.00	39.00
<b>Immediate Post Service-Time:</b>	5.00				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	0.00	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

ZZZ Global Code

<b>CPT Code:</b>	19282	<b>Recommended Physician Work RVU: 1.00</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		0.00	0.00	0.00
<b>Pre-Service Positioning Time:</b>		1.00	0.00	1.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		4.00	0.00	4.00
<b>Intra-Service Time:</b>		20.00		
<b>Immediate Post Service-Time:</b>	0.00			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	0.00	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	0.00	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	0.00	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		
<b>Sub Obs Care:</b>	0.00	99224x 0.00 99225x 0.00 99226x 0.00		

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
76812	ZZZ	1.78	RUC Time

CPT Descriptor Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
64484	ZZZ	1.00	RUC Time	442,912

CPT Descriptor 1 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional level (List separately in addition to code for primary procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
-----------------------	---------------	-----------------	--------------------	---

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
---------------------------------	---------------	-----------------	--------------------

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 25      % of respondents: 67.5 %**

**TIME ESTIMATES (Median)**

	<b>CPT Code: 19282</b>	<b>Key Reference CPT Code: 76812</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	5.00	0.00	
Median Intra-Service Time	20.00	25.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

<b>Median Total Time</b>	<b>25.00</b>	<b>25.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.40	2.44
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.40	2.56
--	------	------

Urgency of medical decision making	3.36	2.40
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.40	2.48
--------------------------	------	------

Physical effort required	3.36	2.52
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.32	2.60
---	------	------

Outcome depends on the skill and judgment of physician	3.32	2.56
--	------	------

Estimated risk of malpractice suit with poor outcome	3.36	2.48
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.36	2.68
----------------------------------	------	------

Intra-Service intensity/complexity	3.36	2.68
------------------------------------	------	------

Post-Service intensity/complexity	3.32	2.64
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**

Several breast intervention codes were identified by the 75% screen including the following:

Code	Descriptor
<b>19103</b>	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance
<b>19295</b>	Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)
<b>19290</b>	Preoperative placement of needle localization wire, breast;
<b>77031</b>	Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation
<b>76098</b>	Radiological examination, surgical specimen
<b>77032</b>	Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation

To improve the reporting of breast interventions, the entire family of existing breast intervention codes was sent to the CPT Editorial Panel who created a new family of 14 bundled codes to describe image-guided breast interventions. This new family consists of two main groups: (1) 6 codes to describe breast biopsy (19081-19086) differentiated by the imaging modality used, either stereotactic, ultrasound, or MR guidance, with each guidance method then divided into a base code for the 1st lesion and an add-on code for each additional lesion biopsied; (2) 8 new codes (19281-19288) to describe the placement of breast localization device(s) also differentiated by the imaging guidance used with base and add-on codes created.

The American College of Radiology, American College of Surgeons, and the American Society of Breast Surgeons randomly surveyed their respective members, and an expert panel was convened to review the survey results. The MR guidance codes (19085, 19085, 19287, and 19288) and the mammo guided localization codes (19281 and 19282) were only surveyed by the ACR.

### Localization Device Placement Codes (19281-19288)

#### Compelling Evidence

We believe the localization device placement codes satisfy compelling evidence standards in a number of ways.

Previously, placement of a marker into a breast was a relatively simple and straightforward procedure. This often consisted of using imaging guidance to place only a single marker at the lesion for subsequent localization at the time of excision, or placement of a single marker in the lesion at the time of percutaneous biopsy for future localization or mammographic follow-up. Currently, improvements in open breast surgical technique have made it necessary to not only mark a lesion, but often mark multiple edges of a lesion to better define the lesion's extent preoperatively. This allows closer surgical margins and improved cosmetic results. Additionally, in the era of neo-adjuvant chemotherapy, not all patients go immediately to surgery upon discovery of a breast tumor. Rather, a subset of breast cancer patients is treated with chemotherapy prior to surgical excision. In those cases, it is necessary to mark the lesion along multiple margins to aid in subsequent evaluation of response to the neo-adjuvant chemotherapy.

CPT code 19282 (*Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including mammographic guidance (List separately in addition to code for primary procedure)*) describes image guided wire localization placement, each additional lesion utilizing mammographic imaging guidance including the placement of a breast localizing device(s) and imaging of the biopsy specimen, when performed. Currently, these are typically performed using multiple localization wires to "bracket" the lesion. Depending on lesion morphology, this procedure can involve placement of 1-4 wires, with 2 being most typical. This CPT code was designed to utilize a single CPT code, reported only once, regardless of the number or type of markers placed in or around a second separate lesion under mammographic guidance. This service is currently reported using the following codes:

Code	Descriptor	Work RVU
<b>19291</b>	Preoperative placement of needle localization wire, breast; each additional lesion (List separately in addition to code for primary procedure)	0.63

<b>77032</b>	Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation	0.56
--------------	---	------

### Work RVU Recommendation

The expert panel recommends a work RVU of 1.00, which is half the recommended value of 19281, the base code with which add on code 19282 code will be reported. The intra-service time for these 2 codes is nearly identical (30 vs. 20 minutes) suggesting the application of the surgical MPPR to reach our recommendation is appropriate. Our recommendation is below the 25th percentile of our survey and below the existing value of the two codes currently used to describe this service.

#### Pre-Service Time

The respondents indicated 5 minutes of pre service time and 5 minutes of post service time for this ZZZ add-on code. The expert panel attributes this time to the following activities which occur after and in addition to similar activities involved in treating the 1<sup>st</sup> lesion

pre-service activities:

- Target second separate lesion. Obtain mammographic image. Determine coordinates for marker placement.
- Prepare the skin with an appropriate surgical antiseptic solution and administer local anesthesia at each marker insertion site.

and post-service activities:

- Cover area with sterile dressing.

#### Intra Service Times

We are recommending the median intra service time of 20 minutes which is slightly less than the 30 minutes of intra-service time for the base code, 19281, with which this ZZZ code is reported.

### Comparison to Key Reference Service

Our recommendation compares favorably to the most commonly chosen KRS, 76812 (*Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)*), which has a higher RVU of 1.78 and slightly longer intra-service time of 25 minutes. Our surveyed code is an intervention whereas the KRS is an imaging study and our respondents found the localization clip placement more complex on 11 out of 11 complexity measures.

Code	RVU	Pre Eval	Pre Positioning	Pre S/D/W	Total Pre	Intra	Post	Total	IWPUT
76812	1.78					25		25	0.0712

### MPC Comparison

Our recommendation of 1.00 RVUs compares favorably to ZZZ MPC code 64484, which has less intra-service time than our surveyed code.

Code	RVU	Pre	Pre Positioning	Pre S/D/W	Total Pre	Intra	Post	Total	IWPUT
------	-----	-----	-----------------	-----------	-----------	-------	------	-------	-------

		Eval							
64484	1.00					10		10	0.1000

### Comparison Within the Family

The recommendations maintain appropriate rank order across the entire family of localization device placement codes as summarized in the table below. As discussed above, the inherent level of patient discomfort throughout this examination and the variability of visualization of the biopsy target, procedures performed under stereotactic guidance are, by definition, more intense than other breast biopsies. The MRI guided biopsies have similar proposed RVU values yet significantly longer intra service times due to the much longer acquisition times to obtain MRI sequences to verify lesion location and needle placement than the acquisition times for stereotactic procedures. Similarly ultrasound guided procedures require less intra service time due to the use of real-time imaging.

### Conclusion

In summary, the panel recommends and RVU of 1.00, half the value of the base code with which this code will be reported. We believe this relative value is appropriate based on comparisons to the KRS, the MPC code provided and within the larger family of breast biopsy codes.

### SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

### FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 19291, 77032

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology                      How often? Commonly

Specialty    How often?

Specialty    How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We are unable to accurately estimate the number of times this service might be provided nationally in a one year period.

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 4,276

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. see work neutrality estimates.

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 76812

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 19283      Tracking Number 09      Original Specialty Recommended RVU: **2.00**  
 Presented Recommended RVU: **2.00**  
 Global Period: 000      RUC Recommended RVU: **2.00**

CPT Descriptor: Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 59-year-old female has recently been diagnosed with invasive ductal carcinoma in the inferior left breast. Wire/needle localization with stereotactic guidance is performed from an inferior approach prior to sending the patient to the operating room.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 1%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 1%

**Description of Pre-Service Work:**

- Review medical records and previous imaging and decide on appropriate guidance method and initial approach based on prior imaging.
- Discuss procedure details, including alternatives and risks with the patient and family and obtain informed consent.
- Review set up in the procedure suite. Ensure accurate calibration of the equipment. Supervise positioning and preparation of the patient.
- Surgical time out performed.
- Supervise and review initial scout image and stereotactic pair of images. Target the lesion to be localized. Transmit coordinates to the stereotactic device. If the lesion is not adequately visualized, change patient position and repeat the localizing process.
- Move the needle into appropriate position on the machine.
- Prepare the skin with an appropriate surgical antiseptic solution and administer local anesthesia.

**Description of Intra-Service Work:**

- Advance needle to stereotactic coordinates. Confirm placement with stereotactic images.
- Deploy marker.
- Obtain stereotactic images after marker deployment.
- Review post-marker placement images for successful deployment.
- Repeat process as needed to place markers at additional locations around periphery of same lesion.
- Annotate images.
- Secure markers as needed.



Description of Post-Service Work:

- Cover area with sterile dressing. Confirm patient stability. Transfer patient and marked images to pre-surgical area.
- A formal report of the procedure is dictated into the permanent medical record.
- The results and further management are discussed with the patient and their family, as well as the requesting physician.
- Review and sign procedure report.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Zeke Silva, MD; Kurt Schoppe, MD; Mark Alson, MD; Jan Jeske, MD; Eric Whitacre, MD FACS; Christopher Senkowski, MD FACS; Charles Mabry, MD FACS				
<b>Specialty(s):</b>	American College of Radiology, American College of Surgeons, American Society of Breast Surgeons				
<b>CPT Code:</b>	19283				
<b>Sample Size:</b>	2600	<b>Resp N:</b>	93	<b>Response:</b> 3.5 %	
<b>Description of Sample:</b>	Random Sample				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	0.00	5.00	40.00	200.00
<b>Survey RVW:</b>	1.00	2.00	2.50	3.23	5.00
<b>Pre-Service Evaluation Time:</b>			32.00		
<b>Pre-Service Positioning Time:</b>			10.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			6.00		
<b>Intra-Service Time:</b>	4.00	10.00	20.00	33.00	90.00
<b>Immediate Post Service-Time:</b>	<u>15.00</u>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1a-FAC Straightforw Pat/Procedure(no sedate/anesth

<b>CPT Code:</b>	19283	<b>Recommended Physician Work RVU: 2.00</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		13.00	13.00	0.00
<b>Pre-Service Positioning Time:</b>		3.00	1.00	2.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		6.00	6.00	0.00
<b>Intra-Service Time:</b>		20.00		
<b>Immediate Post Service-Time:</b>	<u>15.00</u>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
36556	000	2.50	RUC Time

CPT Descriptor Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
64483	000	1.90	RUC Time	852,187

CPT Descriptor 1 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
90937	000	2.11	RUC Time	84,829

CPT Descriptor 2 Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
---------------------------------	---------------	-----------------	--------------------

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 24      % of respondents: 25.8 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 19283</b>	<b>Key Reference CPT Code: 36556</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	22.00	25.00	
Median Intra-Service Time	20.00	15.00	
Median Immediate Post-service Time	15.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

<b>Median Total Time</b>	<b>57.00</b>	<b>50.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.50	3.13
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.46	3.21
--	------	------

Urgency of medical decision making	3.46	3.29
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.63	3.33
--------------------------	------	------

Physical effort required	3.46	3.29
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.46	3.21
---	------	------

Outcome depends on the skill and judgment of physician	3.54	3.29
--	------	------

Estimated risk of malpractice suit with poor outcome	3.83	3.25
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.38	3.17
----------------------------------	------	------

Intra-Service intensity/complexity	3.46	3.38
------------------------------------	------	------

Post-Service intensity/complexity	3.25	3.13
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**

Several breast intervention codes were identified by the 75% screen including the following:

Code	Descriptor
<b>19103</b>	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance
<b>19295</b>	Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)
<b>19290</b>	Preoperative placement of needle localization wire, breast;
<b>77031</b>	Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation
<b>76098</b>	Radiological examination, surgical specimen
<b>77032</b>	Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation

To improve the reporting of breast interventions, the entire family of existing breast intervention codes was sent to the CPT Editorial Panel who created a new family of 14 bundled codes to describe image-guided breast interventions. This new family consists of two main groups: (1) 6 codes to describe breast biopsy (19081-19086) differentiated by the imaging modality used, either stereotactic, ultrasound, or MR guidance, with each guidance method then divided into a base code for the 1<sup>st</sup> lesion and an add-on code for each additional lesion biopsied; (2) 8 new codes (19281-19288) to describe the placement of breast localization device(s) also differentiated by the imaging guidance used with base and add-on codes created.

The American College of Radiology, American College of Surgeons, and the American Society of Breast Surgeons randomly surveyed their respective members, and an expert panel was convened to review the survey results. The MR guidance codes (19085, 19085, 19287, and 19288) and the mammo guided localization codes (19281 and 19282) were only surveyed by the ACR.

### Localization Device Placement Codes (19281-19288)

#### Compelling Evidence

We believe the localization device placement codes satisfy compelling evidence standards in a number of ways. Previously, placement of a marker into a breast was a relatively simple and straightforward procedure. This often consisted of using imaging guidance to place only a single marker at the lesion for subsequent localization at the time of excision, or placement of a single marker in the lesion at the time of percutaneous biopsy for future localization or mammographic follow-up. Currently, improvements in open breast surgical technique have made it necessary to not only mark a lesion, but often mark multiple edges of a lesion to better define the lesion's extent preoperatively. This allows closer surgical margins and improved cosmetic results. Additionally, in the era of neo-adjuvant chemotherapy, not all patients go immediately to surgery upon discovery of a breast tumor. Rather a subset of breast cancer patients is treated with chemotherapy prior to surgical excision. In those cases, it is necessary to mark the lesion along multiple margins to aid in subsequent evaluation of response to the neo-adjuvant chemotherapy.

CPT code 19283 (*Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance*) describes image guided placement of a wire for localization of a tumor utilizing stereotactic imaging guidance. This new CPT code will be coded only once, no matter how many markers are placed in or around the lesion. This takes into account the evolution of practice and the use of more than one marker to better define the margins of a lesion. This code also addressed a coding shortcoming as no code existed for placement of a marker which was not preceded by a biopsy. It is now common to place a marker in a lesion without a biopsy on the same day, such as prior to initiating neo-adjuvant chemotherapy.

This service is currently reported using the following codes:

Code	Descriptor	Work RVU
<b>19499</b>	Unlisted procedure, breast	0.00

<b>77031</b>	Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation	1.59
--------------	---	------

### Work RVU Recommendation

The expert panel recommends the 25<sup>th</sup> percentile value of 2.00 RVUs, higher than the existing value of 1.59.

#### Pre-Service Time

The expert panel recommends pre-service package 1a (Straightforward Patient/Straightforward Procedure (No sedation/anesthesia care)) with the following adjustments:

(1) Increase the total pre-service evaluation time by 5 minutes to 18 minutes total to accommodate an extra 3 minutes necessary for "history and exam (Performance and review of appropriate pre-tests) and an additional 2 minutes for "Communicate with patient and/or family (Discuss procedure / obtain consent)". Patients undergoing stereotactic guided clip placement typically have a large number of prior examinations which must be reviewed in detail including prior screening mammography, diagnostic mammography, diagnostic ultrasound, prior biopsies and clip placements. Moreover, a careful review of the prior pathology, previous medical and surgical treatment and planned therapy is performed. It is incumbent on the performing physician to review the entire breast imaging record prior to the biopsy being performed including imaging of the opposite breast. These patients are often well informed women appropriately requiring and expecting detailed discussion of the expected course and outcome. Unlike other biopsies performed elsewhere in the body, there is high anxiety, both because the biopsy is often unanticipated and because it involves the breast. For these reasons, breast biopsy patients have more anxiety, have more questions, and frequently bring multiple family members to the consent, which increases time to address all of their needs as well.

(2) Increase the positioning time by 2 minutes to 3 minutes to accommodate the additional time necessary to optimally position these patients on the stereotactic table and ensure that operator and imaging equipment are likewise well positioned relative to the patient. Further, it is reasonable to conclude that survey respondents would consider imaging to localize the mass and guide skin prep prior to biopsy to be considered pre-service work.

#### Intra and Post Service Times

We are recommending the median intra and post-service times of 20 and 15 minutes, respectively.

### Comparison to Key Reference Service

The panel would like to point out that many of our survey respondents practice nearly 100% breast imaging. Since the surveyed code family essentially includes all of the 0 global day services this survey population performs, respondents may have struggled to find a 0 day global reference service they commonly perform. Nonetheless, the most commonly chosen KRS is 36556 (*Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older*), which has a lower intra-service time of 15 minutes but higher RVUs of 2.50. While both of these procedures include imaging guidance, 19283 scored higher on 11 of 11 complexity measures. This reflects the unique nature of breast interventions. These procedures are associated with very high patient and family anxiety, which tends to increase the psychological stress of the physician performing the exam. Additionally, these types of exams have a higher frequency to be associated with malpractice suits, which adds to the stress as well.

Our recommendation yields an IWPUT of 0.0573, reflecting the intensity of this procedure in this subset of patients. Indeed, the patient is laying prone with her breast in compression throughout the intra service period of this procedure. The stereotactic table is inherently uncomfortable leading to frequent complaints of neck and shoulder pain during the procedure as time passes. Due to the need for the patient to remain fully aware and not move even a few millimeters, the atmosphere in the room can become quite tense. Calcifications which are readily visible on a high resolution digital mammogram are often poorly seen on the much lower resolution screen of the stereotactic machine. In addition, surrounding landmarks are often not visible in the much smaller field of view. This can lead to multiple changes of patient position which can be very unsettling for the patient and increase pressure on the physician thus increasing the intensity of the procedure.

Code	RVU	Pre Eval	Pre Positioning	Pre S/D/W	Total Pre	Intra	Post	Total	IWPUT
36556	2.50	15	5	5	25	15	10	50	0.1192

## MPC Comparison

Our recommendation is bracketed in RVUs and intra-service time by two MPC codes, 64483 (*Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level*) and 90937 (*Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription*).

Code	RVU	Pre Eval	Pre Positioning	Pre S/D/W	Total Pre	Intra	Post	Total	IWPUT
64483	1.90	13	5	6	24	15	10	49	0.0816
90937	2.11	10			10	40	10	60	0.0415

## Comparison Within the Family

The recommendations maintain appropriate rank order across the entire family of localization device placement codes as summarized in the table below. As discussed above, the inherent level of patient discomfort throughout this examination and the variability of visualization of the biopsy target, procedures performed under stereotactic guidance are, by definition, more intense than other breast biopsies. The MRI guided biopsies have similar proposed RVU values yet significantly longer intra service times due to the much longer acquisition times to obtain MRI sequences to verify lesion location and needle placement than the acquisition times for stereotactic procedures. Similarly ultrasound guided procedures require less intra service time due to the use of real-time imaging.

## Conclusion

In summary, the panel recommends the 25<sup>th</sup> percentile value of 2.00 RVUs. We believe this relative value is appropriate based on comparisons to the KRS, the two MPC codes provided and within the larger family of breast localization device placement codes.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 19499, 77031

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology                      How often? Commonly

Specialty General Surgery                              How often? Commonly

Specialty    How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We are unable to accurately estimate the number of times this service might be provided nationally in a one-year period

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 100

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. see work neutrality estimates.

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 50387



## AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 19284      Tracking Number   O10

Original Specialty Recommended RVU: **1.00**Presented Recommended RVU: **1.00**

Global Period: ZZZ

RUC Recommended RVU: **1.00**

CPT Descriptor: Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)

### CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 52-year-old female recently underwent stereotactic biopsy of two separate lesions within the inferior right breast. One region demonstrated ductal carcinoma in-situ (DCIS) and the second was diagnosed as invasive ductal carcinoma. Stereotactic-guided wire/needle localization of the focus of DCIS is performed after initial stereotactic-guided marker localization of the separate invasive ductal carcinoma. [Note: This is an add-on code. Marker placement(s) at the initial lesion reported separately using 19283.]

Percentage of Survey Respondents who found Vignette to be Typical: 96%

### Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

### Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

### Description of Pre-Service Work:

- Reposition patient back into the stereotactic biopsy system.
- Target second separate lesion. Supervise and review initial scout image and stereotactic pair of images. Target the lesion to be localized. Transmit coordinates to the stereotactic device. If the lesion is not adequately visualized, change patient position and repeat the localizing process.
- Move the needle into appropriate position on the machine.
- Prepare the skin with an appropriate surgical antiseptic solution and administer local anesthesia.

### Description of Intra-Service Work:

- Advance needle to stereotactic coordinates. Confirm placement with stereotactic images.
- Deploy marker.
- Obtain stereotactic images after marker deployment.
- Review post-marker placement images for successful deployment.
- Repeat process as needed to place markers at additional locations around periphery of same lesion.
- Annotate images.
- Secure markers as needed.

### Description of Post-Service Work:

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Zeke Silva, MD; Kurt Schoppe, MD; Mark Alson, MD; Jan Jeske, MD; Eric Whitacre, MD FACS; Christopher Senkowski, MD FACS; Charles Mabry, MD FACS				
<b>Specialty(s):</b>	American College of Radiology, American College of Surgeons, American Society of Breast Surgeons				
<b>CPT Code:</b>	19284				
<b>Sample Size:</b>	2600	<b>Resp N:</b>	48	<b>Response:</b> 1.8 %	
<b>Description of Sample:</b>	Random Sample				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	5.00	<b>28.00</b>	40.00	80.00
<b>Survey RVW:</b>	0.50	1.42	<b>2.15</b>	2.60	3.65
<b>Pre-Service Evaluation Time:</b>			<b>5.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>0.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>0.00</b>		
<b>Intra-Service Time:</b>	5.00	15.00	<b>20.00</b>	31.00	60.00
<b>Immediate Post Service-Time:</b>	<b>5.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x <b>0.00</b> 99292x <b>0.00</b>			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x <b>0.00</b> 99232x <b>0.00</b> 99233x <b>0.00</b>			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x <b>0.00</b> 99239x <b>0.00</b> 99217x <b>0.00</b>			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x <b>0.00</b> 12x <b>0.00</b> 13x <b>0.00</b> 14x <b>0.00</b> 15x <b>0.00</b>			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x <b>0.00</b> 55x <b>0.00</b> 56x <b>0.00</b> 57x <b>0.00</b>			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x <b>0.00</b> 99225x <b>0.00</b> 99226x <b>0.00</b>			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: ZZZ Global Code

<b>CPT Code:</b>	19284	<b>Recommended Physician Work RVU: 1.00</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>1.00</b>	<b>0.00</b>	<b>1.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>4.00</b>	<b>0.00</b>	<b>4.00</b>
<b>Intra-Service Time:</b>		<b>20.00</b>		
<b>Immediate Post Service-Time:</b>	<b>0.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x <b>0.00</b> 99292x <b>0.00</b>		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x <b>0.00</b> 99232x <b>0.00</b> 99233x <b>0.00</b>		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x <b>0.0</b> 99239x <b>0.0</b> 99217x <b>0.00</b>		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x <b>0.00</b> 12x <b>0.00</b> 13x <b>0.00</b> 14x <b>0.00</b> 15x <b>0.00</b>		
<b>Prolonged Services:</b>	<b>0.00</b>	99354x <b>0.00</b> 55x <b>0.00</b> 56x <b>0.00</b> 57x <b>0.00</b>		
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x <b>0.00</b> 99225x <b>0.00</b> 99226x <b>0.00</b>		

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
76812	ZZZ	1.78	RUC Time

CPT Descriptor Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
64484	ZZZ	1.00	RUC Time	442,912

CPT Descriptor 1 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional level (List separately in addition to code for primary procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
-----------------------	---------------	-----------------	--------------------	---

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
---------------------------------	---------------	-----------------	--------------------

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 26      % of respondents: 54.1 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 19284</b>	<b>Key Reference CPT Code: 76812</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	5.00	0.00	
Median Intra-Service Time	20.00	25.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>25.00</b>	<b>25.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.38	2.65
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.38	2.46
--	------	------

Urgency of medical decision making	3.31	2.35
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.42	2.58
--------------------------	------	------

Physical effort required	3.27	2.46
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.35	2.42
---	------	------

Outcome depends on the skill and judgment of physician	3.42	2.38
--	------	------

Estimated risk of malpractice suit with poor outcome	3.46	2.46
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.46	2.50
----------------------------------	------	------

Intra-Service intensity/complexity	3.23	2.54
------------------------------------	------	------

Post-Service intensity/complexity	3.31	2.58
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**

Several breast intervention codes were identified by the 75% screen including the following:

Code	Descriptor
19103	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance
19295	Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)
19290	Preoperative placement of needle localization wire, breast;
77031	Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation
76098	Radiological examination, surgical specimen
77032	Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation

To improve the reporting of breast interventions, the entire family of existing breast intervention codes was sent to the CPT Editorial Panel who created a new family of 14 bundled codes to describe image-guided breast interventions. This new family consists of two main groups: (1) 6 codes to describe breast biopsy (19081-19086) differentiated by the imaging modality used, either stereotactic, ultrasound, or MR guidance, with each guidance method then divided into a base code for the 1<sup>st</sup> lesion and an add-on code for each additional lesion biopsied; (2) 8 new codes (19281-19288) to describe the placement of breast localization device(s) also differentiated by the imaging guidance used with base and add-on codes created.

The American College of Radiology, American College of Surgeons, and the American Society of Breast Surgeons randomly surveyed their respective members, and an expert panel was convened to review the survey results. The MR guidance codes (19085, 19085, 19287, and 19288) and the mammo guided localization codes (19281 and 19282) were only surveyed by the ACR.

### Localization Device Placement Codes (19281-19288)

#### Compelling Evidence

We believe the localization device placement codes satisfy compelling evidence standards in a number of ways. Previously, placement of a marker into a breast was a relatively simple and straightforward procedure. This often consisted of using imaging guidance to place only a single marker at the lesion for subsequent localization at the time of excision, or placement of a single marker in the lesion at the time of percutaneous biopsy for future localization or mammographic follow-up. Currently, improvements in open breast surgical technique have made it necessary to not only mark a lesion, but often mark multiple edges of a lesion to better define the lesion's extent preoperatively. This allows closer surgical margins and improved cosmetic results. Additionally, in the era of neo-adjuvant chemotherapy, not all patients go immediately to surgery upon discovery of a breast tumor. Rather a subset of breast cancer patients is treated with chemotherapy prior to surgical excision. In those cases, it is necessary to mark the lesion along multiple margins to aid in subsequent evaluation of response to the neo-adjuvant chemotherapy.

CPT code 19284 (*Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)*) describes image guided wire localization placement, each additional lesion utilizing stereotactic imaging guidance including the placement of a breast localizing device and imaging of the biopsy specimen, when performed. The panel would like to point out that. This new CPT code will be coded only once, no matter how many markers are placed in or around the lesion. This takes into account the evolution of practice and the use of more than one marker to better define the margins of a lesion. This code also addressed a coding shortcoming as no code existed for placement of a marker which was not preceded by a biopsy. It is now common to place a marker in a lesion without a biopsy on the same day, such as prior to initiating neo-adjuvant chemotherapy. This service is currently reported using the following codes:

Code	Descriptor	Work RVU
------	------------	-------------

<b>19499</b>	Unlisted procedure, breast	0.00
<b>77031</b>	Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation	1.59

### Work RVU Recommendation

The expert panel recommends a work RVU of 1.00, which is half the recommended value 19283, the base code with which add on code 19284 will be reported. The intra-service time for these 2 codes is identical (20 minutes), suggesting the application of the surgical MPPR to reach our recommendation is appropriate. Our recommendation is below the 25th percentile of our survey and below the existing value of the two codes currently used to describe this service.

#### Pre-Service Time

The respondents indicated 5 minutes of pre service time and 5 minutes of post service time for this ZZZ add-on code. The expert panel attributes this time to the following activities which occur after and in addition to similar activities involved in treating the 1<sup>st</sup> lesion.

pre-service activities:

- Target second separate lesion. Supervise and review initial scout image and stereotactic pair of images. Target the lesion to be localized. Transmit coordinates to the stereotactic device. If the lesion is not adequately visualized, change patient position and repeat the localizing process.
- Move the needle into appropriate position on the machine.
- Prepare the skin with an appropriate surgical antiseptic solution and administer local anesthesia.

and post-service activities:

- Cover area with sterile dressing.

#### Intra Service Times

We are recommending the median intra service times of 20 minutes which is the same as the intra-service time for the base code, 19283, with which this ZZZ code is reported.

### Comparison to Key Reference Service

Our recommendation compares favorably to the most commonly chosen KRS, 76812 (*Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)*), which has a higher RVU of 1.78 and slightly longer intra-service time of 25 minutes. Our surveyed code is an intervention whereas the KRS is an imaging study and our respondents found the localization clip placement more complex on 11 out of 11 complexity measures.

Code	RVU	Pre Eval	Pre Positioning	Pre S/D/W	Total Pre	Intra	Post	Total	IWPUT
76812	1.78					25		25	0.0712

### MPC Comparison

Our recommendation of 1.00 RVU compares favorably to ZZZ MPC code 64484, which has less intra-service time than our surveyed code.

Code	RVU	Pre Eval	Pre Positioning	Pre S/D/W	Total Pre	Intra	Post	Total	IWPUT
64484	1.00					10		10	0.1000

## Comparison Within the Family

The recommendations maintain appropriate rank order across the entire family of localization device placement codes as summarized in the table below. As discussed above, the inherent level of patient discomfort throughout this examination and the variability of visualization of the biopsy target, procedures performed under stereotactic guidance are, by definition, more intense than other breast biopsies. The MRI guided biopsies have similar proposed RVU values yet significantly longer intra service times due to the much longer acquisition times to obtain MRI sequences to verify lesion location and needle placement than the acquisition times for stereotactic procedures. Similarly ultrasound guided procedures require less intra service time due to the use of real-time imaging.

## Conclusion

In summary, the panel recommends an RVU of 1.00, half the value of the base code with which this code will be reported. We believe this relative value is appropriate based on comparisons to the KRS, the MPC code provided, and within the larger family of breast biopsy codes.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 19499, 77031

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology                      How often? Commonly

Specialty General Surgery                              How often? Commonly

Specialty    How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We are unable to accurately estimate the number of times this service might be provided nationally in a one-year period.

Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 100  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. see work neutrality estimates.

Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 76812



## AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 19285      Tracking Number   O11

Original Specialty Recommended RVU: **1.70**Presented Recommended RVU: **1.70**

Global Period: 000

RUC Recommended RVU: **1.70**

CPT Descriptor: Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including ultrasound guidance

### CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old female has recently had an ultrasound-guided biopsy, which demonstrated a papilloma. Ultrasound guidance is used to place a marker into the nodule to facilitate localization and excision.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

### Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

### Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

### Description of Pre-Service Work:

- Review medical records and previous imaging and decide on appropriate guidance method and initial approach based on prior imaging.
- Discuss procedure details, including alternatives and risks with the patient and family and obtain informed consent.
- Review set up in the procedure suite. Ensure accurate calibration of the equipment. Supervise positioning and preparation of the patient.
- Surgical time out performed.
- Position patient on the ultrasound table to best localize the lesion. Image sonographically to confirm adequate lesion visualization and approach to lesion.
- Prepare the skin with an appropriate surgical antiseptic solution and administer local anesthesia at each marker insertion site.

### Description of Intra-Service Work:

- Under ultrasound visualization, advance introducer(s) to edge(s) of lesion(s). Document position with ultrasound image(s).
- Deploy marker(s). Obtain post-deployment ultrasound images to confirm adequacy.
- Withdraw the introducer(s) and obtain hemostasis with manual compression over the procedure site.
- Repeat process as needed to place markers at additional locations around periphery of same lesion.
- Close wound(s)

### Description of Post-Service Work:

- Apply dressing.

- Monitor the patient's condition prior to discharge including wound check.
- A formal report of the procedure is dictated into the permanent medical record.
- The results and further management are discussed with the patient and their family, as well as the requesting physician.
- Review and sign procedure report.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Zeke Silva, MD; Kurt Schoppe, MD; Mark Alson, MD; Jan Jeske, MD; Eric Whitacre, MD FACS; Christopher Senkowski, MD FACS; Charles Mabry, MD FACS				
<b>Specialty(s):</b>	American College of Radiology, American College of Surgeons, American Society of Breast Surgeons				
<b>CPT Code:</b>	19285				
<b>Sample Size:</b>	2600	<b>Resp N:</b>	101	<b>Response:</b> 3.8 %	
<b>Description of Sample:</b>	Random Sample				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	10.00	30.00	60.00	650.00
<b>Survey RVW:</b>	1.00	1.70	2.20	3.00	5.00
<b>Pre-Service Evaluation Time:</b>			30.00		
<b>Pre-Service Positioning Time:</b>			10.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			6.00		
<b>Intra-Service Time:</b>	4.00	10.00	15.00	30.00	90.00
<b>Immediate Post Service-Time:</b>	<u>15.00</u>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1a-FAC Straightforw Pat/Procedure(no sedate/anesth

<b>CPT Code:</b>	19285	<b>Recommended Physician Work RVU: 1.70</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		13.00	13.00	0.00
<b>Pre-Service Positioning Time:</b>		2.00	1.00	1.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		6.00	6.00	0.00
<b>Intra-Service Time:</b>		15.00		
<b>Immediate Post Service-Time:</b>	<u>15.00</u>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00		

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
36556	000	2.50	RUC Time

CPT Descriptor Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
64483	000	1.90	RUC Time	852,187

CPT Descriptor 1 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 25      % of respondents: 24.7 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 19285</b>	<b>Key Reference CPT Code: 36556</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	21.00	25.00	
Median Intra-Service Time	15.00	15.00	
Median Immediate Post-service Time	15.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
<b>Median Total Time</b>	<b>51.00</b>	<b>50.00</b>	

Other time if appropriate		
---------------------------	--	--

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.44	3.08
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.44	3.12
--	------	------

Urgency of medical decision making	3.52	3.16
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.48	3.40
--------------------------	------	------

Physical effort required	3.44	3.24
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.52	3.08
---	------	------

Outcome depends on the skill and judgment of physician	3.64	3.20
--	------	------

Estimated risk of malpractice suit with poor outcome	3.68	3.24
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.56	3.24
----------------------------------	------	------

Intra-Service intensity/complexity	3.24	3.20
------------------------------------	------	------

Post-Service intensity/complexity	3.24	3.08
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**

Several breast intervention codes were identified by the 75% screen including the following:

Code	Descriptor
<b>19103</b>	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance
<b>19295</b>	Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)
<b>19290</b>	Preoperative placement of needle localization wire, breast;
<b>77031</b>	Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation
<b>76098</b>	Radiological examination, surgical specimen
<b>77032</b>	Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation

To improve the reporting of breast interventions, the entire family of existing breast intervention codes was sent to the CPT Editorial Panel who created a new family of 14 bundled codes to describe image-guided breast interventions. This new family consists of two main groups: (1) 6 codes to describe breast biopsy (19081-19086) differentiated by the imaging modality used, either stereotactic, ultrasound, or MR guidance, with each guidance method then divided into a base code for the 1<sup>st</sup> lesion and an add-on code for each additional lesion biopsied; (2) 8 new codes (19281-19288) to describe the placement of breast localization device(s) also differentiated by the imaging guidance used with base and add-on codes created.

The American College of Radiology, American College of Surgeons, and the American Society of Breast Surgeons randomly surveyed their respective members, and an expert panel was convened to review the survey results. The MR guidance codes (19085, 19085, 19287, and 19288) and the mammo guided localization codes (19281 and 19282) were only surveyed by the ACR.

### Localization Device Placement Codes (19281-19288)

#### Compelling Evidence

We believe the localization device placement codes satisfy compelling evidence standards in a number of ways. Previously, placement of a marker into a breast was a relatively simple and straightforward procedure. This often consisted of using imaging guidance to place only a single marker at the lesion for subsequent localization at the time of excision, or placement of a single marker in the lesion at the time of percutaneous biopsy for future localization or mammographic follow-up. Currently, improvements in open breast surgical technique have made it necessary to not only mark a lesion, but often mark multiple edges of a lesion to better define the lesion's extent preoperatively. This allows closer surgical margins and improved cosmetic results. Additionally, in the era of neo-adjuvant chemotherapy, not all patients go immediately to surgery upon discovery of a breast tumor. Rather a subset of breast cancer patients is treated with chemotherapy prior to surgical excision. In those cases, it is necessary to mark the lesion along multiple margins to aid in subsequent evaluation of response to the neo-adjuvant chemotherapy.

CPT code 19285 (*Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including ultrasound guidance*) describes image guided placement of a wire for localization of a tumor utilizing ultrasound imaging guidance. This new CPT code will be coded only once, no matter how many markers are placed in or around the lesion. This takes into account the evolution of practice and the use of more than one marker to better define the margins of a lesion. This code also addressed a coding shortcoming as no code existed for placement of a marker which was not preceded by a biopsy. It is now common to place a marker in a lesion without a biopsy on the same day, such as prior to initiating neo-adjuvant chemotherapy.

This service is currently reported using the following codes:

Code	Descriptor	Work RVU
<b>19499</b>	Unlisted procedure, breast	0.00

<b>76942</b>	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	0.67
--------------	---	------

### Work RVU Recommendation

The expert panel recommends the 25<sup>th</sup> percentile RVU of 1.70, higher than the existing value of 0.67.

#### Pre-Service Time

The expert panel recommends pre-service package 1a (Straightforward Patient/Straightforward Procedure (No sedation/anesthesia care)) with the following adjustments:

(1) Increase the total pre-service evaluation time by 5 minutes to 18 minutes total to accommodate an extra 3 minutes necessary for "history and exam (Performance and review of appropriate pre-tests) and an additional 2 minutes for "Communicate with patient and/or family (Discuss procedure / obtain consent)". Patients undergoing ultrasound guided clip placement typically have a large number of prior examinations which must be reviewed in detail including prior screening mammography, diagnostic mammography, diagnostic ultrasound, prior biopsies and clip placements. Moreover, a careful review of the prior pathology, previous medical and surgical treatment and planned therapy is performed. It is incumbent on the performing physician to review the entire breast imaging record prior to the biopsy being performed including imaging of the opposite breast. These patients are often well informed women appropriately requiring and expecting detailed discussion of the expected course and outcome. Unlike other biopsies performed elsewhere in the body, there is high anxiety, both because the biopsy is often unanticipated and because it involves the breast. For these reasons, breast biopsy patients have more anxiety, have more questions, and frequently bring multiple family members to the consent, which increases time to address all of their needs as well.

(2) Increase the positioning time by 2 minutes to 3 minutes to accommodate the additional time necessary to optimally position these patients on the ultrasound table and ensure that operator and imaging equipment are likewise well positioned relative to the patient. Further, it is reasonable to conclude that survey respondents would consider imaging to localize the mass and guide skin prep prior to biopsy to be considered pre-service work.

#### Intra and Post Service Times

We are recommending the median intra and post-service times of 15 and 15 minutes, respectively.

### Comparison to Key Reference Service

The panel would like to point out that many of our survey respondents practice nearly 100% breast imaging. Since the surveyed code family essentially includes all of the 0 day global services this survey population performs, respondents may have struggled to find a 0 day global reference service they commonly perform. Nonetheless, the most commonly chosen KRS is 36556 (*Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older*), which has the same intra-service time of 15 minutes but higher RVUs of 2.50. While both of these procedures include imaging guidance, 19285 scored higher on all of the complexity measures. This reflects the unique nature of breast interventions. These procedures are associated with very high patient and family anxiety, which tends to increase the psychological stress of the physician performing the exam. Additionally, these types of exams have a higher frequency to be associated with malpractice suits, which adds to the stress as well.

Our recommendation yields an IWPUT of 0.0563, reflecting the intensity of this procedure in this subset of patients. Due to the need for the patient to remain fully aware and not move even a few millimeters, the atmosphere in the room can become quite intense. The patient is typically able to view the large biopsy device entering her breast which makes many patients very anxious. Some lesions can be quite mobile both initially and difficult to see after local anesthesia administration leading to difficulty localizing the lesion which can add to the anxiety.

Code	RVU	Pre Eval	Pre Positioning	Pre S/D/W	Total Pre	Intra	Post	Total	IWPUT
36556	2.50	15	5	5	25	15	10	50	0.1192

### MPC Comparison

Our MPC code is 64483 (*Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level*). 19285 has the same intra-service time as 64483 but a lower work RVU.

Code	RVU	Pre Eval	Pre Positioning	Pre S/D/W	Total Pre	Intra	Post	Total	IWPUT
64483	1.90	13	5	6	24	15	10	49	0.0816

### Comparison Within the Family

The recommendations maintain appropriate rank order across the entire family of localization device placement codes as summarized in the table below. As discussed above, the inherent level of patient discomfort throughout this examination and the variability of visualization of the biopsy target, procedures performed under stereotactic guidance are, by definition, more intense than other breast biopsies. The MRI guided biopsies have similar proposed RVU values yet significantly longer intra service times due to the much longer acquisition times to obtain MRI sequences to verify lesion location and needle placement than the acquisition times for stereotactic procedures. Similarly ultrasound guided procedures require less intra service time due to the use of real-time imaging.

### Conclusion

In summary, the panel recommends the median survey value of 1.70 RVUs. We believe this relative value is appropriate based on comparisons to the KRS, the MPC code provided, and within the larger family of breast localization device placement codes.

### SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

### FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 19499, 76942

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.



Specialty Diagnostic Radiology                      How often? Commonly

Specialty General Surgery                      How often? Commonly

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We are unable to accurately estimate the number of times this service might be provided nationally in a one-year period.

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 100

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. see work neutrality estimates.

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 36569

## AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 19286      Tracking Number   O12

Original Specialty Recommended RVU: **0.85**Presented Recommended RVU: **0.85**

Global Period: ZZZ

RUC Recommended RVU: **0.85**

CPT Descriptor: Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)

### CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72-year-old female with recently diagnosed invasive ductal carcinoma in the left breast at 2 o'clock, 3 cm from the nipple, and a second carcinoma in the left breast at 1 o'clock, 8 cm from the nipple. Ultrasound-guided wire/needle localization of the lesion at 1 o'clock performed after initial ultrasound-guided wire/needle localization of the lesion at 2 o'clock. [Note: This is an add-on code. Marker placement(s) at the initial lesion reported separately using 19285.]

Percentage of Survey Respondents who found Vignette to be Typical: 96%

### Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

### Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

### Description of Pre-Service Work:

- Reposition the patient as needed to optimally target second lesion.
- Target second separate lesion. Position patient on the ultrasound table to best localize the lesion. Image sonographically to confirm adequate lesion visualization and approach to lesion.
- Prepare the skin with an appropriate surgical antiseptic solution and administer local anesthesia at each marker insertion site.

### Description of Intra-Service Work:

- Under ultrasound visualization, advance introducer(s) to edge(s) of lesion(s). Document position with ultrasound image(s).
- Deploy marker(s). Obtain post-deployment ultrasound images to confirm adequacy.
- Withdraw the introducer(s) and obtain hemostasis with manual compression over the procedure site.
- Repeat process as needed to place markers at additional locations around periphery of same lesion.
- Close wound(s).

### Description of Post-Service Work:

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Zeke Silva, MD; Kurt Schoppe, MD; Mark Alson, MD; Jan Jeske, MD; Eric Whitacre, MD FACS; Christopher Senkowski, MD FACS; Charles Mabry, MD FACS				
<b>Specialty(s):</b>	American College of Radiology, American College of Surgeons, American Society of Breast Surgeons				
<b>CPT Code:</b>	19286				
<b>Sample Size:</b>	2600	<b>Resp N:</b>	48	<b>Response:</b> 1.8 %	
<b>Description of Sample:</b>	Random Sample				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	1.00	19.00	<b>40.00</b>	51.00	100.00
<b>Survey RVW:</b>	0.50	1.22	<b>1.87</b>	2.60	3.65
<b>Pre-Service Evaluation Time:</b>			<b>5.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>0.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>0.00</b>		
<b>Intra-Service Time:</b>	1.00	14.00	<b>19.00</b>	30.00	39.00
<b>Immediate Post Service-Time:</b>	<b>5.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: ZZZ Global Code

<b>CPT Code:</b>	19286	<b>Recommended Physician Work RVU: 0.85</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>1.00</b>	<b>0.00</b>	<b>1.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>4.00</b>	<b>0.00</b>	<b>4.00</b>
<b>Intra-Service Time:</b>		<b>19.00</b>		
<b>Immediate Post Service-Time:</b>	<b>0.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
76812	ZZZ	1.78	RUC Time

CPT Descriptor Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
90945	000	1.56	RUC Time	136,276

CPT Descriptor 1 Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), with single evaluation by a physician or other qualified health care professional

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
55876	000	1.73	RUC Time	21,177

CPT Descriptor 2 Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
---------------------------------	---------------	-----------------	--------------------

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 26      % of respondents: 54.1 %

**TIME ESTIMATES (Median)**

	CPT Code: 19286	Key Reference CPT Code: 76812	Source of Time RUC Time
Median Pre-Service Time	5.00	0.00	
Median Intra-Service Time	19.00	25.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>24.00</b>	<b>25.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.58	2.50
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	2.31
--	------	------

Urgency of medical decision making	3.46	2.19
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.35	2.46
--------------------------	------	------

Physical effort required	3.23	2.38
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.38	2.46
---	------	------

Outcome depends on the skill and judgment of physician	3.35	2.31
--	------	------

Estimated risk of malpractice suit with poor outcome	3.23	2.38
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.27	2.58
----------------------------------	------	------

Intra-Service intensity/complexity	3.27	2.58
------------------------------------	------	------

Post-Service intensity/complexity	3.27	2.50
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

## Background

Several breast intervention codes were identified by the 75% screen including the following:

Code	Descriptor
<b>19103</b>	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance
<b>19295</b>	Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)
<b>19290</b>	Preoperative placement of needle localization wire, breast;
<b>77031</b>	Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation
<b>76098</b>	Radiological examination, surgical specimen
<b>77032</b>	Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation

To improve the reporting of breast interventions, the entire family of existing breast intervention codes was sent to the CPT Editorial Panel who created a new family of 14 bundled codes to describe image-guided breast interventions. This new family consists of two main groups: (1) 6 codes to describe breast biopsy (19081-19086) differentiated by the imaging modality used, either stereotactic, ultrasound, or MR guidance, with each guidance method then divided into a base code for the 1<sup>st</sup> lesion and an add-on code for each additional lesion biopsied; (2) 8 new codes (19281-19288) to describe the placement of breast localization device(s) also differentiated by the imaging guidance used with base and add-on codes created.

The American College of Radiology, American College of Surgeons, and the American Society of Breast Surgeons randomly surveyed their respective members, and an expert panel was convened to review the survey results. The MR guidance codes (19085, 19085, 19287, and 19288) and the mammo guided localization codes (19281 and 19282) were only surveyed by the ACR.

## Localization Device Placement Codes (19281-19288)

### Compelling Evidence

We believe the localization device placement codes satisfy compelling evidence standards in a number of ways. Previously, placement of a marker into a breast was a relatively simple and straightforward procedure. This often consisted of using imaging guidance to place only a single marker at the lesion for subsequent localization at the time of excision, or placement of a single marker in the lesion at the time of percutaneous biopsy for future localization or mammographic follow-up. Currently, improvements in open breast surgical technique have made it necessary to not only mark a lesion, but often mark multiple edges of a lesion to better define the lesion's extent preoperatively. This allows closer surgical margins and improved cosmetic results. Additionally, in the era of neo-adjuvant chemotherapy, not all patients go immediately to surgery upon discovery of a breast tumor. Rather a subset of breast cancer patients is treated with chemotherapy prior to surgical excision. In those cases, it is necessary to mark the lesion along multiple margins to aid in subsequent evaluation of response to the neo-adjuvant chemotherapy.

CPT code 19286 (*Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)*) describes image guided wire localization placement, each additional lesion utilizing ultrasound imaging guidance including the placement of a breast localizing device and imaging of the biopsy specimen, when performed. The panel would like to point out that. This new CPT code will be coded only once, no matter how many markers are placed in or around the lesion. This takes into account the evolution of practice and the use of more than one marker to better define the margins of a lesion. This code also addressed a coding shortcoming as no code existed for placement of a marker which was not preceded by a biopsy. It is now common to place a marker in a lesion without a biopsy on the same day, such as prior to initiating neo-adjuvant chemotherapy. This service is currently reported using the following codes:

Code	Descriptor	Work
------	------------	------

		RVU
19499	Unlisted procedure, breast	0.00
76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	0.67

### Work RVU Recommendation

The expert panel recommends a work RVU of 0.85, which is half the recommended value of 19285, the base code with which add on code 19286 will be reported. The intra-service time for these 2 codes is nearly identical (15 vs. 19 minutes), suggesting the application of the surgical MPPR to reach our recommendation is appropriate. Our recommendation is below the 25th percentile of our survey and below the existing value of the two codes currently used to describe this service.

#### Pre-Service Time

The respondents indicated 5 minutes of pre service time and 5 minutes of post service time for this ZZZ add-on code. The expert panel attributes this time to the following which occur after and in addition to similar activities involved in treating the 1<sup>st</sup> lesion

pre-service activities:

- Target second separate lesion. Position patient on the ultrasound table to best localize the lesion. Image sonographically to confirm adequate lesion visualization and approach to lesion.
- Prepare the skin with an appropriate surgical antiseptic solution and administer local anesthesia at each marker insertion site.

and post-service activities:

- Apply dressing.

#### Intra Service Times

We are recommending the median intra service time of 19 minutes which is slightly more than the 15 minutes of intra-service time for the base code, 19285, with which this ZZZ code is reported.

### Comparison to Key Reference Service

Our recommendation compares favorably to the most commonly chosen KRS, 76812 (*Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)*), which has a higher RVU of 1.78 and slightly longer intra-service time of 25 minutes. Our surveyed code is an intervention whereas the KRS is an imaging study and our respondents found the localization clip placement more complex on 11 out of 11 complexity measures.

Code	RVU	Pre Eval	Pre Positioning	Pre S/D/W	Total Pre	Intra	Post	Total	IWPUT
76812	1.78					25		25	0.0712

### MPC Comparison

Our recommendation is similar in RVU and intra-service time by two 000 MPC codes, 90945 (*Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), with single evaluation by a physician or other qualified health care professional*) and 55876 (*Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple*).

Code	RVU	Pre	Pre Positioning	Pre S/D/W	Total Pre	Intra	Post	Total	IWPUT
------	-----	-----	-----------------	-----------	-----------	-------	------	-------	-------

		Eval							
90945	1.56	10			10	27	10	47	0.0412
55876	1.73	19	10		19	20	10	49	0.0428

### Comparison Within the Family

The recommendations maintain appropriate rank order across the entire family of localization device placement codes as summarized in the table below. As discussed above, the inherent level of patient discomfort throughout this examination and the variability of visualization of the biopsy target, procedures performed under stereotactic guidance are, by definition, more intense than other breast biopsies. The MRI guided biopsies have similar proposed RVU values yet significantly longer intra service times due to the much longer acquisition times to obtain MRI sequences to verify lesion location and needle placement than the acquisition times for stereotactic procedures. Similarly ultrasound guided procedures require less intra service time due to the use of real-time imaging.

### Conclusion

In summary, the panel recommends an RVU of 0.85, half the value of the base code with which this code will be reported. We believe this relative value is appropriate based on comparisons to the KRS, the MPC codes provided, and within the larger family of breast biopsy codes.

### SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

### FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 19499, 76942

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology                      How often? Commonly

Specialty General Surgery                              How often? Commonly

Specialty    How often?



Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We are unable to accurately estimate the number of times this service might be provided nationally in a one-year period.

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 100

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. see work neutrality estimates.

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 76812

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 19287      Tracking Number   013

Original Specialty Recommended RVU: **3.02**Presented Recommended RVU: **3.02**

Global Period: 000

RUC Recommended RVU: **3.02**

CPT Descriptor: Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including magnetic resonance guidance

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 59-year-old female has a large invasive ductal carcinoma in the right breast and is a candidate for neoadjuvant chemotherapy prior to surgery. MRI guidance is used to place markers at the edges of the lesion prior to therapy to monitor response to treatment.

Percentage of Survey Respondents who found Vignette to be Typical: 81%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 2%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 8%

**Description of Pre-Service Work:**

- Review medical records and previous imaging and decide on appropriate guidance method and initial approach based on prior imaging.
- Discuss procedure details, including alternatives and risks with the patient and family and obtain informed consent.
- Review set up in the procedure suite. Ensure accurate calibration of the equipment. Supervise positioning and preparation of the patient.
- Surgical time out performed.
- Supervise and review initial magnetic resonance sequences. Target the lesion to be localized. Transmit coordinates to the work station. Choose grid coordinates.
- Prepare the skin with an appropriate surgical antiseptic solution and administer local anesthesia.

**Description of Intra-Service Work:**

- Make a small incision with a scalpel.
- Move the trocar(s) into appropriate position(s). Confirm placement with MR imaging. Adjust as necessary.
- Advance introducer(s) through trocar(s). Deploy marker(s). Remove introducer(s).
- Obtain and review post-marker placement MRI images for successful deployment.
- Withdraw the trocar(s) and obtain hemostasis with manual compression over the procedure site.
- Repeat process as needed to place markers at additional locations around periphery of same lesion.
- Close wound(s).

**Description of Post-Service Work:**

- Apply dressing.
- Monitor the patient's condition prior to discharge including wound check.
- A formal report of the procedure is dictated into the permanent medical record.
- The results and further management are discussed with the patient and their family, as well as the requesting physician.
- Review and sign procedure report.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Zeke Silva, MD; Kurt Schoppe, MD; Mark Alson, MD; Jan Jeske, MD				
<b>Specialty(s):</b>	American College of Radiology				
<b>CPT Code:</b>	19287				
<b>Sample Size:</b>	1200	<b>Resp N:</b>	64	<b>Response:</b> 5.3 %	
<b>Description of Sample:</b>	Random Sample				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	0.00	<b>2.00</b>	5.00	80.00
<b>Survey RVW:</b>	1.20	2.24	<b>3.02</b>	3.81	5.00
<b>Pre-Service Evaluation Time:</b>			<b>40.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>11.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>6.00</b>		
<b>Intra-Service Time:</b>	10.00	20.00	<b>37.00</b>	45.00	60.00
<b>Immediate Post Service-Time:</b>	<b>15.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1a-FAC Straightforw Pat/Procedure(no sedate/anesth

<b>CPT Code:</b>	19287	<b>Recommended Physician Work RVU: 3.02</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>13.00</b>	<b>13.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>3.00</b>	<b>1.00</b>	<b>2.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>6.00</b>	<b>6.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>37.00</b>		
<b>Immediate Post Service-Time:</b>	<b>15.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00		

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
36556	000	2.50	RUC Time

CPT Descriptor Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
31622	000	2.78	RUC Time	83,969

CPT Descriptor 1 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
-----------------------	---------------	-----------------	--------------------	---

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
---------------------------------	---------------	-----------------	--------------------

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 22      % of respondents: 34.3 %

**TIME ESTIMATES (Median)**

	<b>CPT Code:</b> 19287	<b>Key Reference CPT Code:</b> 36556	<b>Source of Time</b> RUC Time
Median Pre-Service Time	22.00	25.00	
Median Intra-Service Time	37.00	15.00	
Median Immediate Post-service Time	15.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
<b>Median Total Time</b>	<b>74.00</b>	<b>50.00</b>	
<b>Other time if appropriate</b>			

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered

3.55

3.32

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed

3.50

3.27

Urgency of medical decision making

3.32

3.09

**Technical Skill/Physical Effort (Mean)**

Technical skill required

3.36

3.14

Physical effort required

3.45

3.18

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality

3.45

2.91

Outcome depends on the skill and judgment of physician

3.32

3.00

Estimated risk of malpractice suit with poor outcome

3.41

3.00

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity

3.50

3.41

Intra-Service intensity/complexity

3.41

3.09

Post-Service intensity/complexity

3.50

3.23

---

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**

Several breast intervention codes were identified by the 75% screen including the following:

Code	Descriptor
<b>19103</b>	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance
<b>19295</b>	Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)
<b>19290</b>	Preoperative placement of needle localization wire, breast;
<b>77031</b>	Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation
<b>76098</b>	Radiological examination, surgical specimen
<b>77032</b>	Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation

To improve the reporting of breast interventions, the entire family of existing breast intervention codes was sent to the CPT Editorial Panel who created a new family of 14 bundled codes to describe image-guided breast interventions. This new family consists of two main groups: (1) 6 codes to describe breast biopsy (19081-19086) differentiated by the imaging modality used, either stereotactic, ultrasound, or MR guidance, with each guidance method then divided into a base code for the 1<sup>st</sup> lesion and an add-on code for each additional lesion biopsied; (2) 8 new codes (19281-19288) to describe the placement of breast localization device(s) also differentiated by the imaging guidance used with base and add-on codes created.

The American College of Radiology, American College of Surgeons, and the American Society of Breast Surgeons randomly surveyed their respective members, and an expert panel was convened to review the survey results. The MR guidance codes (19085, 19085, 19287, and 19288) and the mammo guided localization codes (19281 and 19282) were only surveyed by the ACR.

### Localization Device Placement Codes (19281-19288)

#### Compelling Evidence

We believe the localization device placement codes satisfy compelling evidence standards in a number of ways. Previously, placement of a marker into a breast was a relatively simple and straightforward procedure. This often consisted of using imaging guidance to place only a single marker at the lesion for subsequent localization at the time of excision, or placement of a single marker in the lesion at the time of percutaneous biopsy for future localization or mammographic follow-up. Currently, improvements in open breast surgical technique have made it necessary to not only mark a lesion, but often mark multiple edges of a lesion to better define the lesion's extent preoperatively. This allows closer surgical margins and improved cosmetic results. Additionally, in the era of neo-adjuvant chemotherapy, not all patients go immediately to surgery upon discovery of a breast tumor. Rather a subset of breast cancer patients is treated with chemotherapy prior to surgical excision. In those cases, it is necessary to mark the lesion along multiple margins to aid in subsequent evaluation of response to the neo-adjuvant chemotherapy.

CPT code 19287 (*Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including magnetic resonance guidance*) describes image guided placement of a wire for localization of a tumor utilizing magnetic resonance imaging guidance. This new CPT code will be coded only once, no matter how many markers are placed in or around the lesion. This takes into account the evolution of practice and the use of more than one marker to better define the margins of a lesion. This code also addressed a coding shortcoming as no code existed for placement of a marker which was not preceded by a biopsy. It is now common to place a marker in a lesion without a biopsy on the same day, such as prior to initiating neo-adjuvant chemotherapy.

This service is currently reported using the following codes:

Code	Descriptor	Work RVU
<b>19499</b>	Unlisted procedure, breast	0.00

<b>77021</b>	Magnetic resonance guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation	1.50
--------------	--	------

## Work RVU Recommendation

The expert panel recommends the median RVU of 3.02.

### Pre-Service Time

The expert panel recommends pre-service package 1a (Straightforward Patient/Straightforward Procedure (No sedation/anesthesia care)) with the following adjustments:

(1) Increase the total pre-service evaluation time by 5 minutes to 18 minutes total to accommodate an extra 3 minutes necessary for "history and exam (Performance and review of appropriate pre-tests) and an additional 2 minutes for "Communicate with patient and/or family (Discuss procedure / obtain consent)". Patients undergoing MR guided clip placement typically have a large number of prior examinations which must be reviewed in detail including prior screening mammography, diagnostic mammography, diagnostic ultrasound, prior biopsies and clip placements. Moreover, a careful review of the prior pathology, previous medical and surgical treatment and planned therapy is performed. It is incumbent on the performing physician to review the entire breast imaging record prior to the biopsy being performed including imaging of the opposite breast. These patients are often well informed women appropriately requiring and expecting detailed discussion of the expected course and outcome. Unlike other biopsies performed elsewhere in the body, there is high anxiety, both because the biopsy is often unanticipated and because it involves the breast. For these reasons, breast biopsy patients have more anxiety, have more questions, and frequently bring multiple family members to the consent, which increases time to address all of their needs as well.

(2) Increase the positioning time by 2 minutes to 3 minutes to accommodate the additional time necessary to optimally position these patients on the MR table and ensure that operator and imaging equipment are likewise well positioned relative to the patient. Further, it is reasonable to conclude that survey respondents would consider imaging to localize the mass and guide skin prep prior to biopsy to be considered pre-service work.

### Intra and Post Service Times

We are recommending the median intra and post-service times of 37 and 15 minutes, respectively.

## Comparison to Key Reference Service

The panel would like to point out that many of our survey respondents practice nearly 100% breast imaging. Since the surveyed code family essentially includes all of the 0 day global services this survey population performs, respondents may have struggled to find a 0 day global reference service they commonly perform. Nonetheless, the most commonly chosen KRS is 36556 (*Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older*), which has a lower intra-service time of 15 minutes and lower RVUs of 2.50. While both of these procedures include imaging guidance, 19287 scored higher on 11 of 11 complexity measures. This reflects the unique nature of breast interventions. These procedures are associated with very high patient and family anxiety, which tends to increase the psychological stress of the physician performing the exam. Additionally, these types of exams have a higher frequency to be associated with malpractice suits, which adds to the stress as well.

Our recommendation yields an IWPUT of 0.0585, reflecting the intensity of this procedure in this subset of patients. Indeed, the patient is laying prone with her breast in compression throughout the intra service period of this procedure. The MR table is inherently uncomfortable leading to frequent complaints of neck and shoulder pain during the procedure as time passes. Due to the need for the patient to remain fully aware and not move even a few millimeters, the atmosphere in the room can become quite tense. The images for the biopsy are performed on a biopsy device rather than a dedicated breast coil and as such correlating the lesion to be marked to the initial lesion of concern can be challenging especially for very small lesions which are typically the ones for which MRI has to be performed since they cannot be visualized sonographically. Many patients have feelings of claustrophobia even if they are actually able to tolerate the machine which increases the anxiety level of the patient and the pressure on the physician thus increasing the intensity of the procedure.

Code	RVU	Pre Eval	Pre Positioning	Pre S/D/W	Total Pre	Intra	Post	Total	IWPUT
------	-----	----------	-----------------	-----------	-----------	-------	------	-------	-------



36556	2.50	15	5	5	25	15	10	50	0.1192
-------	------	----	---	---	----	----	----	----	--------

### MPC Comparison

Our recommendation has higher RVU than the MPC code, 31622 (*Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)*), with 7 more minutes of intra-service time.

Code	RVU	Pre Eval	Pre Positioning	Pre S/D/W	Total Pre	Intra	Post	Total	IWPUT
31622	2.78	10	5	5	20	30	15	65	0.0688

### Comparison Within the Family

The recommendations maintain appropriate rank order across the entire family of localization device placement codes as summarized in the table below. As discussed above, the inherent level of patient discomfort throughout this examination and the variability of visualization of the biopsy target, procedures performed under stereotactic guidance are, by definition, more intense than other breast biopsies. The MRI guided biopsies have similar proposed RVU values yet significantly longer intra service times due to the much longer acquisition times to obtain MRI sequences to verify lesion location and needle placement than the acquisition times for stereotactic procedures. Similarly ultrasound guided procedures require less intra service time due to the use of real-time imaging.

### Conclusion

In summary, the panel recommends the median survey value of 3.02 RVUs. We believe this relative value is appropriate based on comparisons to the KRS, the MPC code provided, and within the larger family of breast localization device placement codes.

### SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

### FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 19499, 77021

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
 If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology                      How often? Commonly

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We are unable to accurately estimate the number of times this service might be provided nationally in a one-year period.

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 100

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. see work neutrality estimates.

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 32551

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 19288      Tracking Number    O14

Original Specialty Recommended RVU: **1.51**Presented Recommended RVU: **1.51**

Global Period: ZZZ

RUC Recommended RVU: **1.51**

CPT Descriptor: Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 67-year-old female has two separate recently biopsied areas of invasive ductal carcinoma in the lower-outer quadrant of the left breast. She is a candidate for neoadjuvant therapy prior to surgery. MRI guidance is used to place markers at the edges of the second lesion after initial MRI-guided localization to place markers around the first lesion. [Note: This is an add-on code. Marker placement at the initial lesion reported separately using 19287.]

Percentage of Survey Respondents who found Vignette to be Typical: 100%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 3%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

**Description of Pre-Service Work:**

- Reposition patient back into the MRI biopsy system.
- Target second separate lesion. Supervise and review initial magnetic resonance sequences. Transmit coordinates to the work station. Choose grid coordinates.
- Prepare the skin with an appropriate surgical antiseptic solution and administer local anesthesia.

**Description of Intra-Service Work:**

- Make a small incision with a scalpel.
- Move the trocar(s) into appropriate position(s). Confirm placement with MR imaging. Adjust as necessary.
- Advance introducer(s) through trocar(s). Deploy marker(s). Remove introducer(s).
- Obtain and review post-marker placement MRI images for successful deployment.
- Withdraw the trocar(s) and obtain hemostasis with manual compression over the procedure site.
- Repeat process as needed to place markers at additional locations around periphery of same lesion.
- Close wound(s).

**Description of Post-Service Work:**

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Zeke Silva, MD; Mark Alson, MD; Kurt Schoppe, MD; Jan Jeske, MD				
<b>Specialty(s):</b>	American College of Radiology				
<b>CPT Code:</b>	19288				
<b>Sample Size:</b>	1200	<b>Resp N:</b>	40	<b>Response:</b> 3.3 %	
<b>Description of Sample:</b>	Random Sample				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	0.00	<b>2.00</b>	5.00	20.00
<b>Survey RVW:</b>	0.90	1.88	<b>2.55</b>	3.15	4.50
<b>Pre-Service Evaluation Time:</b>			<b>5.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>0.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>0.00</b>		
<b>Intra-Service Time:</b>	10.00	18.00	<b>30.00</b>	46.00	60.00
<b>Immediate Post Service-Time:</b>	<b>5.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

ZZZ Global Code

<b>CPT Code:</b>	19288	<b>Recommended Physician Work RVU: 1.51</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>1.00</b>	<b>0.00</b>	<b>1.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>4.00</b>	<b>0.00</b>	<b>4.00</b>
<b>Intra-Service Time:</b>		<b>30.00</b>		
<b>Immediate Post Service-Time:</b>	<b>0.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
76812	ZZZ	1.78	RUC Time

CPT Descriptor Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99292	ZZZ	2.25	RUC Time	434,114

CPT Descriptor 1 Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
-----------------------	---------------	-----------------	--------------------	---

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
---------------------------------	---------------	-----------------	--------------------

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code:** 28      **% of respondents:** 70.0 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 19288</b>	<b>Key Reference CPT Code: 76812</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	5.00	0.00	
Median Intra-Service Time	30.00	25.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

<b>Median Total Time</b>	<b>35.00</b>	<b>25.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.46	2.50
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.39	2.43
--	------	------

Urgency of medical decision making	3.25	2.46
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.50	2.61
--------------------------	------	------

Physical effort required	3.25	2.46
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.39	2.43
---	------	------

Outcome depends on the skill and judgment of physician	3.36	2.39
--	------	------

Estimated risk of malpractice suit with poor outcome	3.29	2.36
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.39	2.39
----------------------------------	------	------

Intra-Service intensity/complexity	3.36	2.57
------------------------------------	------	------

Post-Service intensity/complexity	3.29	2.43
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**

Several breast intervention codes were identified by the 75% screen including the following:

Code	Descriptor
<b>19103</b>	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance
<b>19295</b>	Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)
<b>19290</b>	Preoperative placement of needle localization wire, breast;
<b>77031</b>	Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation
<b>76098</b>	Radiological examination, surgical specimen
<b>77032</b>	Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation

To improve the reporting of breast interventions, the entire family of existing breast intervention codes was sent to the CPT Editorial Panel who created a new family of 14 bundled codes to describe image-guided breast interventions. This new family consists of two main groups: (1) 6 codes to describe breast biopsy (19081-19086) differentiated by the imaging modality used, either stereotactic, ultrasound, or MR guidance, with each guidance method then divided into a base code for the 1<sup>st</sup> lesion and an add-on code for each additional lesion biopsied; (2) 8 new codes (19281-19288) to describe the placement of breast localization device(s) also differentiated by the imaging guidance used with base and add-on codes created.

The American College of Radiology, American College of Surgeons, and the American Society of Breast Surgeons randomly surveyed their respective members, and an expert panel was convened to review the survey results. The MR guidance codes (19085, 19085, 19287, and 19288) and the mammo guided localization codes (19281 and 19282) were only surveyed by the ACR.

### Localization Device Placement Codes (19281-19288)

#### Compelling Evidence

We believe the localization device placement codes satisfy compelling evidence standards in a number of ways. Previously, placement of a marker into a breast was a relatively simple and straightforward procedure. This often consisted of using imaging guidance to place only a single marker at the lesion for subsequent localization at the time of excision, or placement of a single marker in the lesion at the time of percutaneous biopsy for future localization or mammographic follow-up. Currently, improvements in open breast surgical technique have made it necessary to not only mark a lesion, but often mark multiple edges of a lesion to better define the lesion's extent preoperatively. This allows closer surgical margins and improved cosmetic results. Additionally, in the era of neo-adjuvant chemotherapy, not all patients go immediately to surgery upon discovery of a breast tumor. Rather a subset of breast cancer patients is treated with chemotherapy prior to surgical excision. In those cases, it is necessary to mark the lesion along multiple margins to aid in subsequent evaluation of response to the neo-adjuvant chemotherapy.

CPT code 19288 (Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)) describes image guided wire localization placement, each additional lesion utilizing magnetic resonance imaging guidance including the placement of a breast localizing device and imaging of the biopsy specimen, when performed. The panel would like to point out that. This new CPT code will be coded only once, no matter how many markers are placed in or around the lesion. This takes into account the evolution of practice and the use of more than one marker to better define the margins of a lesion. This code also addressed a coding shortcoming as no code existed for placement of a marker which was not preceded by a biopsy. It is now common to place a marker in a lesion without a biopsy on the same day, such as prior to initiating neo-adjuvant chemotherapy. This service is currently reported using the following codes:

Code	Descriptor	Work RVU
<b>19499</b>	Unlisted procedure, breast	0.00
<b>77021</b>	Magnetic resonance guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological	1.50

supervision and interpretation

## Work RVU Recommendation

The expert panel recommends a work RVU of 1.51, which is half the recommended value of 19287, the base code with which add on code 19288 will be reported. The intra-service time for these 2 codes is nearly identical (37 vs. 30 minutes), suggesting the application of the surgical MPPR to reach our recommendation is appropriate. Our recommendation is below the 25th percentile of our survey and close to the existing value of the two codes currently used to describe this service.

### Pre-Service Time

The respondents indicated 5 minutes of pre service time and 5 minutes of post service time for this ZZZ add-on code. The expert panel attributes this time to the following activities which occur after and in addition to similar activities involved in treating the 1<sup>st</sup> lesion

pre-service activities:

- Target second separate lesion. Supervise and review initial magnetic resonance sequences. Transmit coordinates to the work station. Choose grid coordinates.
- Prepare the skin with an appropriate surgical antiseptic solution and administer local anesthesia.

and post-service activities:

- Apply dressing.

### Intra Service Times

We are recommending the median intra service time of 30 minutes which is slightly less than the 37 minutes of intra-service time for the base code, 19287, with which this ZZZ code is reported.

## Comparison to Key Reference Service

Our recommendation compares favorably to the most commonly chosen KRS, 76812 (*Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)*), which has a higher RVU of 1.78 and slightly longer intra-service time of 25 minutes. Our surveyed code is an intervention whereas the KRS is an imaging study and our respondents found the localization clip placement more complex on 11 out of 11 complexity measures.

Code	RVU	Pre Eval	Pre Positioning	Pre S/D/W	Total Pre	Intra	Post	Total	IWPUT
76812	1.78					25		25	0.0712

## MPC Comparison

Our recommendation of 1.51 RVUs compares favorably to ZZZ MPC code 99292 (*Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)*), which has the same intra-service time and a higher RVU than our surveyed code.



Code	RVU	Pre Eval	Pre Positioning	Pre S/D/W	Total Pre	Intra	Post	Total	IWPUT
99292	2.25					30		30	0.750

### Comparison Within the Family

The recommendations maintain appropriate rank order across the entire family of localization device placement codes as summarized in the table below. As discussed above, the inherent level of patient discomfort throughout this examination and the variability of visualization of the biopsy target, procedures performed under stereotactic guidance are, by definition, more intense than other breast biopsies. The MRI guided biopsies have similar proposed RVU values yet significantly longer intra service times due to the much longer acquisition times to obtain MRI sequences to verify lesion location and needle placement than the acquisition times for stereotactic procedures. Similarly ultrasound guided procedures require less intra service time due to the use of real-time imaging.

### Conclusion

In summary, the panel recommends and RVU of 1.51, half the value of the base code with which this code will be reported. We believe this relative value is appropriate based on comparisons to the KRS, the MPC code provided, and within the larger family of breast biopsy codes.

### SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

### FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 19499, 77021

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology

How often? Commonly

Specialty

How often?

Specialty

How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We are unable to accurately estimate the number of times this service might be provided nationally in a one-year period.

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 100

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. see work neutrality estimates.

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 76812

						RVW					TOT	PRE			INTRA					POST
	CPT	DESC	glob	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	P-SD
REF	37191	Insertion of intravascular vena	000	20	0.120			4.71			83	30	3	5			30			15
current	19103	Biopsy of breast; percutaneou	000		0.097			3.69			65	20					30			15
current	76098	Radiological examination, surg	XXX		0.032			0.16			5						5			
current	19295	Image guided placement, meta	ZZZ		n/a			0.00			0						0			
current	77031	Stereotactic localization guida	XXX		0.033			1.59			49	2					45			2
SVY	19081	Bx+marker w-stereotactic guid	000	99	0.080	1.25	2.62	3.80	4.80	5.68	96	35	10	6	5	20	30	50	70	15
REC	19081				0.0849			3.29			67	13	3	6			30			15

REF	36479	Endovenous ablation therapy	ZZZ	19	0.075			3.38			45	0					45			0
current	19103-51	Biopsy of breast; percutaneou	000		0.035			1.85			65	20					30			15
current	76098	Radiological examination, surg	XXX		0.032			0.16			5						5			
current	19295	Image guided placement, meta	ZZZ		n/a			0.00			0						0			
current	77031	Stereotactic localization guida	XXX		0.033			1.59			49	2					45			2
SVY	19082	Bx+marker w-stereotactic guid	ZZZ	52	0.107	0.50	2.28	2.90	3.50	4.75	35	5	0	0	5	18	25	40	60	5
REC	19082				0.0638			1.65			30	0	1	4			25			0

REF	37191	Insertion of intravascular vena	000	16	0.120			4.71			83	30	3	5			30			15
current	19103	Biopsy of breast; percutaneou	000		0.097			3.69			65	20					30			15
current	19295	Image guided placement, meta	ZZZ		n/a			0.00			0						0			
current	76942	Ultrasonic guidance for needle	XXX		0.022			0.67			30						30			
SVY	19083	Bx+marker w-ultrasound guida	000	97	0.066	1.50	2.50	3.10	4.30	5.60	93	38	10	5	5	15	25	36	60	15
REC	19083				0.0964			3.10			59	13	1	5			25			15

REF	36479	Endovenous ablation therapy	ZZZ	13	0.075			3.38			45						45			
current	19103-51	Biopsy of breast; percutaneou	000		0.035			1.85			65	20					30			15
current	19295	Image guided placement, meta	ZZZ		n/a			0.00			0						0			
current	76942	Ultrasonic guidance for needle	XXX		0.022			0.67			30						30			
SVY	19084	Bx+marker w-ultrasound guida	ZZZ	52	0.101	0.50	1.65	2.25	3.50	4.50	30	5	0	0	5	15	20	30	46	5
REC	19084				0.0748			1.55			25	0	1	4			20			0

**ISSUE: Breast Biopsy**  
**TAB: 4**

						RVW					TOT Time	PRE			INTRA				POST	
	CPT	DESC	glob	Resp	IWPUT	MIN	25th	MED	75th	MAX		EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	P-SD
REF	49411	Placement of interstitial device	000	12	0.072			3.82			85	19	1	5			40		20	
current	19103	Biopsy of breast; percutaneous	000		0.097			3.69			65	20					30		15	
current	19295	Image guided placement, meta	ZZZ		n/a			0.00			0						0			
current	77021	Magnetic resonance guidance	XXX		0.017			1.50			77.5	20					42.5		15	
SVY	19085	Bx+marker w-MR guidance	000	64	0.044	1.70	2.99	3.64	5.00	6.00	122	40	11	6	10	25	45	60	67	20
REC	19085				0.0644			3.64			82	13	3	6			45		15	
REF	76812	Ultrasound, pregnant uterus, r	ZZZ	13	0.071			1.78			25						25			
current	19103-51	Biopsy of breast; percutaneous	000		0.097			3.69			65	20					30		15	
current	19295	Image guided placement, meta	ZZZ		n/a			0.00			0						0			
current	77021	Magnetic resonance guidance	XXX		0.017			1.50			77.5	20					42.5		15	
SVY	19086	Bx+marker w-MR guidance - a	ZZZ	40	0.047	1.00	1.80	2.05	3.81	4.50	50	6	0	0	15	19	38	60	69	6
REC	19086				0.0465			1.82			43	0	1	4			38		0	

**TAB: 4**

REF	76812	Ultrasound, pregnant uterus, r	ZZZ	26	0.071		1.78		25			25		
current	19499	Unlisted procedure, breast	000		#DIV/0!		0.00		0					
current	77031	Stereotactic localization guida	XXX		0.033		1.59		49	2		45		2
SVY	19284	Marker w-stereotactic guidanc	ZZZ	48	0.096	0.50 1.42	2.15	2.60 3.65	30	5 0 0	5 15	20	31 60	5
REC	19284				0.0473		1.00		25	0 1 4		20		0

						RVW					TOT	PRE			INTRA					POST
	CPT	DESC	glob	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	P-SD
REF	36556	Insertion of non-tunneled cent	000	25	0.119			2.50			50	15	5	5			15			10
current	19499	Unlisted procedure, breast	000		#DIV/0!			0.00			0									
current	76942	Ultrasonic guidance for needle	XXX		0.022			0.67			30						30			
SVY	19285	Marker w-ultrasound guidance	000	101	0.069	1.00	1.70	2.20	3.00	5.00	71	30	10	6	4	10	15	30	90	10
REC	19285				0.0668			1.70			50	13	1	6			15			15

REF	76812	Ultrasound, pregnant uterus, r	ZZZ	26	0.071			1.78			25						25			
current	19499	Unlisted procedure, breast	000		#DIV/0!			0.00			0									
current	76942	Ultrasonic guidance for needle	XXX		0.022			0.67			30						30			
SVY	19286	Marker w-ultrasound guidance	ZZZ	48	0.087	0.50	1.22	1.87	2.60	3.65	29	5	0	0	1	14	19	30	39	5
REC	19286				0.0419			0.85			24	0	1	4			19			0

REF	36556	Insertion of non-tunneled cent	000	22	0.119			2.50			50	15	5	5			15			10
current	19499	Unlisted procedure, breast	000		#DIV/0!			0.00			0									
current	77021	Magnetic resonance guidance	XXX		0.017			1.50			77.5	20					42.5			15
SVY	19287	Marker w-MR guidance	000	64	0.040	1.20	2.24	3.02	3.81	5.00	109	40	11	6	10	20	37	45	60	15
REC	19287				0.0615			3.02			74	13	3	6			37			15

REF	76812	Ultrasound, pregnant uterus, r	ZZZ	28	0.071			1.78			25						25			
current	19499	Unlisted procedure, breast	000		#DIV/0!			0.00			0									
current	77021	Magnetic resonance guidance	XXX		0.017			1.50			77.5	20					42.5			15
SVY	19288	Marker w-MR guidance - add'l	ZZZ	40	0.078	0.90	1.88	2.55	3.15	4.50	40	5	0	0	10	18	30	46	60	5
REC	19288				0.0485			1.51			35	0	1	4			30			0

**AMA/Specialty Society Update Process**  
**Practice Expense Summary of Recommendation**  
**Non Facility Direct Inputs**

CPT Long Descriptor:

<b>19281</b>	Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including mammographic guidance
<b>19282</b>	Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including mammographic guidance (List separately in addition to code for primary procedure)

Global Period: 000, ZZZ Meeting Date: April 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The American College of Radiology convened a consensus panel to finalize the practice expense data for the codes listed above.

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

For the mammographic guidance marker placement codes, the current mammo guidance code, 77032, and needle localization codes, 19290 and 19291, were used as a PE reference. 77032, 19290, and 19291 will be deleted and replaced by 19281 and 19282.

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:

We have increased minutes over the PE Subcommittee standards for several activities to accommodate the complex nature of mammography guided breast biopsy.

- **Prepare room, equipment, supplies** – The extra minute is necessary since complex biopsy equipment is involved.
- **Prepare and position patient/ monitor patient/ set up IV** – Since the breast is a round structure, positioning can vary to assure operator, biopsy devices and imaging equipment are properly oriented.

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:

We have increased the staff time, supplies and equipment to accommodate the evolution of mammography guided breast biopsy since the original PEAC review.

**Staff time**

- **Retrieve prior images for comparison** – Prior pathology is always reviewed prior to biopsy to help direct the current biopsy or prior to marker placement to decide on the type of marker placement and number of markers needed.
- **Monitor pt. following service/check tubes, monitors, drains** - Post procedure monitoring typically performed for 5-10 minutes after the procedure for pressure, hemostasis, and monitoring. We frequently do anticoagulated patients as well, which requires prolonged post procedure monitoring.

#### Supplies

- **Drape-towel, sterile OR blue (2 pk uou) (SB020)** – Used to create a sterile work surface.
- **Mask, surgical (SB033)** – Clinically required.
- **Needle-wire for localization (SC045)** - Practice has changed. In the past we put a single wire in the middle of the lesion. Now we are most typically asked to bracket the lesion with 2 wires or markers for excision.
- **Syringe 10-12ml (SC051)** - Rather than 20cc of lido as was used in the past, it is now typically 10 cc lido superficially and 10 cc lido with epi deep. That is why 2 syringes required.
- **Guide, needle for localization (SD087)** – Dual wires require dual guides.
- **Gauze, sterile 4in x 4in (10 pack uou) (SG056)** - These are used around the needles and wires when taping them down to send to the OR, and also used to blot blood drips during the procedure, as well as bandaging at the end.
- **Tape, elastic, 2in (Elastoplast, Elasticon) (5yd uou) (SG076)** - Used to tape down bandages and wires to send patients to OR.
- **Lidocaine 1% w-epi inj (Xylocaine w-epi) (SH046)** - Rather than 20cc of lido as was used in the past, it is now typically 10 cc lido superficially and 10 cc lido with epi deep.
- **Sodium chloride 0.9% inj (250-1000ml uou) (SH067)** - Placed into the lidocaine to buffer it and decrease the burn of the lido in the skin.
- **Cetacaine spray (56gm size bottle) (SJ012)** - Used to "pre-numb" the skin a bit for the lidocaine needle.
- **Povidone swabsticks (3 pack uou) (SJ043)** – Typically used instead of Betadine.
- **Swab-pad, alcohol (SJ053)** - 2 alcohol pads to clean tops of lido and lido with epi.

5. Please describe in detail the clinical activities of your staff:

#### Pre-Service Clinical Labor Activities:

- Retrieve prior images for comparison

#### Intra-Service Clinical Labor Activities:

- Greet patient, provide gowning, ensure appropriate medical records are available
- Provide pre-service education/obtain consent
- Prepare room, equipment, supplies
- Prepare and position patient/ monitor patient/ set up IV
- Assist physician in performing procedure
- Monitor pt. following service/check tubes, monitors, drains
- Clean room/equipment by physician staff
- Review/read X-ray, lab, and pathology reports
- Check dressings & wound/ home care instructions /coordinate office visits /prescriptions
- Process images, complete data sheet, present images and data to the interpreting physician

#### Post-Service Clinical Labor Activities:



**AMA/Specialty Society Update Process**  
**Practice Expense Summary of Recommendation**  
**Non Facility Direct Inputs**

CPT Long Descriptor:

<b>19085</b>	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including magnetic resonance guidance
<b>19086</b>	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)
<b>19287</b>	Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including magnetic resonance guidance
<b>19288</b>	Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)

Global Period: 000, ZZZ Meeting Date: April 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The American College of Radiology convened a consensus panel to finalize the practice expense data for the codes listed above.

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

19103, 19295, and 77021 were used as the PE reference for the new MR guided breast biopsy and clip placement codes, 19085-19086 and 19287-19288. 19103 and 19295 will be deleted and replaced, by the new codes, which 77021 is the MR guidance code.

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:

We have increased minutes over the PE Subcommittee standards for several activities to accommodate the complex nature of MRI guided breast biopsy.

- **Prepare room, equipment, supplies** – The extra minute is necessary since complex biopsy equipment is involved.
- **Prepare and position patient/ monitor patient/ set up IV** – Since the breast is a round structure, positioning can vary to assure operator, biopsy devices and imaging equipment are properly oriented.

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:

We have increased the staff time, supplies and equipment for the following activities to accommodate the evolution of MRI guided breast biopsy since the original PEAC review.

#### **Staff time**

- **Retrieve prior images for comparison** – Prior pathology is always reviewed prior to biopsy to help direct the current biopsy or prior to marker placement to decide on the type of marker placement and number of markers needed.
- **Monitor pt. following service/check tubes, monitors, drains** - Post procedure monitoring typically performed for 5-10 minutes after the procedure for pressure, hemostasis, and monitoring. We frequently do anticoagulated patients as well, which requires prolonged post procedure monitoring.
- **Process images, complete data sheet, present images and data to the interpreting physician** – Since they are comparable services, we are recommending the same amount of time as the ultrasound guidance code, 76942.

#### **Supplies**

- **Gloves, non-sterile (SB022)** - For the biopsy codes, one pair of non-sterile gloves needed for the assistant in the procedure. The second pair is for handling the specimen to prepare for pathology. For the marker codes, only 1 set of non-sterile gloves is needed for the assistant.
- **Gown, patient (SB026)** – Clinically required.
- **Underpad 2ft x 3ft (Chux) (SB044)** - Blood from biopsy drips down and needs to be collected.
- **Scalpel, safety, surgical, with blade (#10-20) (SF047)** – Safety scalpel typically used.
- **Gauze, sterile 4in x 4in (10 pack uou) (SG056)** - These are used around the needles and wires when taping them down to send to the OR, and also used to blot blood drips during the procedure, as well as bandaging at the end.
- **Lidocaine 1% w-epi inj (Xylocaine w-epi) (SH046)** - Rather than 20cc of lido as was used in the past, it is now typically 10 cc lido superficially and 10 cc lido with epi deep.
- **Swab-pad, alcohol (SJ053)** - 2 alcohol pads to clean tops of lido and lido with epi.
- **Filter paper, qualitative, <15.0cm (SL064)** - To filter samples out of saline and place in formaldehyde.
- **20MM Handpiece –MR** – Needle used to collect the sample.
- **Vacuum line assembly** – Tubing connected to the needle.
- **Introducer localization set (trocar)** – An MR-compatible trocar is used to advance through the grid to the lesion to confirm placement before inserting the vacuum needle and obtaining the specimen.
- **Breast biopsy device (coil)** – the patient lays on top of the device during the procedure
- **Lateral Grid** - The grid is inserted into the coil and projects onto the patient. It is used to assist the radiologist with determining the location of the specimen sample.
- **Tissue filter** – basket that holds the specimen

5. Please describe in detail the clinical activities of your staff:

#### **Pre-Service Clinical Labor Activities:**

- Retrieve prior images for comparison

Intra-Service Clinical Labor Activities:

- Greet patient, provide gowning, ensure appropriate medical records are available
- Provide pre-service education/obtain consent
- Prepare room, equipment, supplies
- Prepare and position patient/ monitor patient/ set up IV
- Assist physician in performing procedure
- Monitor pt. following service/check tubes, monitors, drains
- Clean room/equipment by physician staff
- Review/read X-ray, lab, and pathology reports
- Check dressings & wound/ home care instructions /coordinate office visits /prescriptions
- Process images, complete data sheet, present images and data to the interpreting physician

Post-Service Clinical Labor Activities:

**AMA/Specialty Society Update Process**  
**Practice Expense Summary of Recommendation**  
**Non Facility Direct Inputs**

CPT Long Descriptor:

<b>19081</b>	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance
<b>19082</b>	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)
<b>19283</b>	Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance
<b>19284</b>	Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)

Global Period: 000, ZZZ Meeting Date: April 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The American College of Radiology, American College of Surgeons, American Society of Breast Surgeons convened a consensus panel to finalize the practice expense data for the codes listed above.

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

19103, 19295, 76098, and 77031 is being used as the PE reference for the new stereotactic guided breast biopsy and clip placement codes, 19081-19082 and 19283-19284. The current codes (except the specimen code, 76098, will be deleted and replaced, by the new codes.

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:

We have increased minutes over the PE Subcommittee standards for several activities to accommodate the complex nature of stereotactic breast biopsy.

- **Prepare room, equipment, supplies** – The extra minute is necessary since complex biopsy equipment is involved.
- **Prepare and position patient/ monitor patient/ set up IV** – Since the breast is a round structure, positioning can vary to assure operator, biopsy devices and imaging equipment are properly oriented.

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:

We have increased the staff time, supplies and equipment to accommodate the evolution of stereotactic breast biopsy since the original PEAC review.

**Staff time**

- **Retrieve prior images for comparison** – Prior pathology is always reviewed prior to biopsy to help direct the current biopsy or prior to marker placement to decide on the type of marker placement and number of markers needed.
- **Monitor pt. following service/check tubes, monitors, drains** - Post procedure monitoring typically performed for 5-10 minutes after the procedure for pressure, hemostasis, and monitoring. We frequently do anticoagulated patients as well, which requires prolonged post procedure monitoring.
- **Process images, complete data sheet, present images and data to the interpreting physician** – Since they are comparable services, we are recommending the same amount of time as the ultrasound guidance code, 76942.

**Supplies**

- **Gloves, non-sterile (SB022)** - For the biopsy codes, one pair of non-sterile gloves needed for the assistant in the procedure. The second pair is for handling the specimen to prepare for pathology. For the marker codes, only 1 set of non-sterile gloves is needed for the assistant.
- **Gown, patient (SB026)** – Clinically required.
- **Underpad 2ft x 3ft (Chux) (SB044)** - Blood from biopsy drips down and needs to be collected.
- **Needle-wire for localization (SC045)** - We are typically asked to bracket the lesion with 2 wires or markers for excision.
- **Guide, needle for localization (SD087)** – Dual wires require dual guides.
- **Scalpel, safety, surgical, with blade (#10-20) (SF047)** – Safety scalpel typically used.
- **Gauze, sterile 4in x 4in (10 pack uou) (SG056)** - These are used around the needles and wires when taping them down to send to the OR, and also used to blot blood drips during the procedure, as well as bandaging at the end.
- **Lidocaine 1% w-epi inj (Xylocaine w-epi) (SH046)** - Rather than 20cc of lido as was used in the past, it is now typically 10 cc lido superficially and 10 cc lido with epi deep.
- **Cetacaine spray (56gm size bottle) (SJ012)** - Used to "pre-numb" the skin a bit for the lidocaine needle.
- **Swab-pad, alcohol (SJ053)** - 2 alcohol pads to clean tops of lido and lido with epi.
- **Filter paper, qualitative, <15.0cm (SL064)** - To filter samples out of saline and place in formaldehyde.

5. Please describe in detail the clinical activities of your staff:

**Pre-Service Clinical Labor Activities:**

- Retrieve prior images for comparison

Intra-Service Clinical Labor Activities:

- Greet patient, provide gowning, ensure appropriate medical records are available
- Provide pre-service education/obtain consent
- Prepare room, equipment, supplies
- Prepare and position patient/ monitor patient/ set up IV
- Assist physician in performing procedure
- Monitor pt. following service/check tubes, monitors, drains
- Clean room/equipment by physician staff
- Review/read X-ray, lab, and pathology reports
- Check dressings & wound/ home care instructions /coordinate office visits /prescriptions
- Process images, complete data sheet, present images and data to the interpreting physician

Post-Service Clinical Labor Activities:

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor:

<b>19083</b>	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance
<b>19084</b>	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)
<b>19285</b>	Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including ultrasound guidance
<b>19286</b>	Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)

Global Period: 000, ZZZ Meeting Date: April 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The American College of Radiology, American College of Surgeons, and American Society of Breast Surgeons convened a consensus panel to finalize the practice expense data for the codes listed above.

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

19103, 19295, and 76942 were used as the PE reference for the new ultrasound guided breast biopsy and clip placement codes, 19083-19084 and 19285-19286. The current codes, except for US guidance code 76942, will be deleted and replaced by the new codes.

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:

We have increased minutes over the PE Subcommittee standards for several activities to accommodate the complex nature of ultrasound guided breast biopsy.

- **Prepare room, equipment, supplies** – The extra minute is necessary since complex biopsy equipment is involved.
- **Prepare and position patient/ monitor patient/ set up IV** – Since the breast is a round structure, positioning can vary to assure operator, biopsy devices and imaging equipment are properly oriented.

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:

We have increased the staff time, supplies and equipment to accommodate the evolution of ultrasound guided breast biopsy since the original PEAC review.

#### **Staff time**

- **Retrieve prior images for comparison** – Prior pathology is always reviewed prior to biopsy to help direct the current biopsy or prior to marker placement to decide on the type of marker placement and number of markers needed.
- **Monitor pt. following service/check tubes, monitors, drains** - Post procedure monitoring typically performed for 5-10 minutes after the procedure for pressure, hemostasis, and monitoring. We frequently do anticoagulated patients as well, which requires prolonged post procedure monitoring.

#### **Supplies**

- **Gloves, non-sterile (SB022)** – For the biopsy codes, one pair of non-sterile gloves needed for the assistant in the procedure. The second pair is for handling the specimen to prepare for pathology. For the marker codes, only 1 set of non-sterile gloves is needed for the assistant.
- **Gown, patient (SB026)** – Clinically required.
- **Paper, exam table (SB036)** – Clinically necessary.
- **Clip, tissue marker (SD037)** - For the marker codes, half the time we mark with 2 clips, and half the time we mark with 4 clips depending on morphology of lesion, with 3 clips being average.
- **Scalpel, safety, surgical, with blade (#10-20) (SF047)** – Safety scalpel typically used.
- **Gauze, sterile 4in x 4in (10 pack uou) (SG056)** - These are used around the needles and wires when taping them down to send to the OR, and also used to blot blood drips during the procedure, as well as bandaging at the end.
- **Lidocaine 1% w-epi inj (Xylocaine w-epi) (SH046)** - Rather than 20cc of lido as was used in the past, it is now typically 10 cc lido superficially and 10 cc lido with epi deep.
- **Cetacaine spray (56gm size bottle) (SJ012)** - Used to "pre-numb" the skin a bit for the lidocaine needle.
- **Lubricating jelly (Surgilube) (SJ033)** – 4 oz to go on the patient
- **Swab-pad, alcohol (SJ053)** - 2 alcohol pads to clean tops of lido and lido with epi.
- **Ultrasound transmission gel (SJ062)** - non-sterile gel to put between the transducer and condom cover.
- **Filter paper, qualitative, <15.0cm (SL064)** - To filter samples out of saline and place in formaldehyde.

#### **Equipment**

- **Table, exam (EF023)** – Ultrasound typically done on exam table, not a power table.



5. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Retrieve prior images for comparison

Intra-Service Clinical Labor Activities:

- Greet patient, provide gowning, ensure appropriate medical records are available
- Provide pre-service education/obtain consent
- Prepare room, equipment, supplies
- Prepare and position patient/ monitor patient/ set up IV
- Assist physician in performing procedure
- Monitor pt. following service/check tubes, monitors, drains
- Clean room/equipment by physician staff
- Review/read X-ray, lab, and pathology reports
- Check dressings & wound/ home care instructions /coordinate office visits /prescriptions
- Process images, complete data sheet, present images and data to the interpreting physician

Post-Service Clinical Labor Activities:

	A	B	C	D	E	F	G	H	I	J	K	L	M
				REF CODE	REF CODE	RECOMMENDATION		REF CODE	REF CODE	RECOMMENDATION			
1	<b>REVISED AT RUC 4/25/13</b>												
2	<b>*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.</b>			<b>19290</b>	<b>77032</b>			<b>19281</b>	<b>19291</b>	<b>77032</b>			<b>19282</b>
3	Meeting Date: April 2013 Tab: 4 Specialty: ACR, ASBS, ACS	CMS Code	Staff Type	Preoperative placement of needle localization wire, breast;	Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation	CMS Code	Staff Type	Marker w- mammographic guidance	Preoperative placement of needle localization wire, breast; each additional lesion (List separately in addition to code for primary procedure)	Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation	CMS Code	Staff Type	Marker w- mammographic guidance - add'l
4	LOCATION			Non Fac	Non Fac			Non Fac	Non Fac	Non Fac			Non Fac
5	GLOBAL PERIOD			000	XXX			000	ZZZ	XXX			ZZZ
6	TOTAL CLINICAL LABOR TIME			62	19			66	14	19			47
7	TOTAL PRE-SERV CLINICAL LABOR TIME			0	0	L043A	Mam Tech	3	0	0			0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L041B	Rad Tech		19				14	19			
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L043A	Mam Tech	62		L043A	Mam Tech	63			L043A	Mam Tech	47
10	TOTAL POST-SERV CLINICAL LABOR TIME			0	0			0	0	0			0
11	PRE-SERVICE												
18	*Other Clinical Activity - specify: Retrieve prior images for comparison					L043A	Mam Tech	3			L043A	Mam Tech	0
19	End: When patient enters office/facility for surgery/procedure												
20	SERVICE PERIOD												
21	Start: When patient enters office/facility for surgery/procedure:												
22	Greet patient, provide gowning, ensure appropriate medical records are available	L041B	Rad Tech	3		L043A	Mam Tech	3			L043A	Mam Tech	3
23	Obtain vital signs	L041B	Rad Tech					3					3
24	Provide pre-service education/obtain consent	L041B	Rad Tech	11		L043A	Mam Tech	5			L043A	Mam Tech	5
25	Prepare room, equipment, supplies	L041B	Rad Tech	5		L043A	Mam Tech	3			L043A	Mam Tech	1
26	Setup scope (non facility setting only)												
27	Prepare and position patient/ monitor patient/ set up IV	L041B	Rad Tech	2	10	L043A	Mam Tech	3		10	L043A	Mam Tech	3
28	Sedate/apply anesthesia												
29	*Other Clinical Activity - specify:												
30	Intra-service												
31	Assist physician in performing procedure	L041B	Rad Tech	30		L043A	Mam Tech	30	14		L043A	Mam Tech	20
32	Post-Service												
33	Monitor pt. following service/check tubes, monitors, drains	L041B	Rad Tech			L043A	Mam Tech	5			L043A	Mam Tech	5
34	Clean room/equipment by physician staff	L041B	Rad Tech	3		L043A	Mam Tech	3			L043A	Mam Tech	1
35	Clean Scope												
36	Clean Surgical Instrument Package												
37	Review/read X-ray, lab, and pathology reports	L041B	Rad Tech	2		L043A	Mam Tech	2			L043A	Mam Tech	1
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L041B	Rad Tech	3		L043A	Mam Tech	1			L043A	Mam Tech	0
39	*Other Clinical Activity - specify: Process images, complete data sheet, present images and data to the interpreting physician	L041B	Rad Tech		9	L043A	Mam Tech	5		9	L043A	Mam Tech	5
40	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			n/a					n/a				
41	Dischrg mgmt (1.0 x 99238) (enter 12 min)			n/a					n/a				
42	Dischrg mgmt (1.0 x 99239) (enter 15 min)			n/a					n/a				
43	*Other Clinical Activity - specify: Post procedure documentation	L041B	Rad Tech	3									
44	End: Patient leaves office												
45	POST-SERVICE Period												
46	Start: Patient leaves office/facility												
55	*Other Clinical Activity - specify:												
56	End: with last office visit before end of global period												

	A	B	C	D	E	F	G	H	I	J	K	L	M
1	<b>REVISED AT RUC 4/25/13</b>			<b>REF CODE</b>	<b>REF CODE</b>	<b>RECOMMENDATION</b>			<b>REF CODE</b>	<b>REF CODE</b>	<b>RECOMMENDATION</b>		
2	<b>*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.</b>			<b>19290</b>	<b>77032</b>			<b>19281</b>	<b>19291</b>	<b>77032</b>			<b>19282</b>
3	Meeting Date: April 2013 Tab: 4 Specialty: ACR, ASBS, ACS	<b>CMS Code</b>	<b>Staff Type</b>	Preoperative placement of needle localization wire, breast;	Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation	<b>CMS Code</b>	<b>Staff Type</b>	Marker w- mammographic guidance	Preoperative placement of needle localization wire, breast; each additional lesion (List separately in addition to code for primary procedure)	Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation	<b>CMS Code</b>	<b>Staff Type</b>	Marker w- mammographic guidance - add'l
4	<b>LOCATION</b>			<b>Non Fac</b>	<b>Non Fac</b>			<b>Non Fac</b>	<b>Non Fac</b>	<b>Non Fac</b>			<b>Non Fac</b>
5	<b>GLOBAL PERIOD</b>			<b>000</b>	<b>XXX</b>			<b>000</b>	<b>ZZZ</b>	<b>XXX</b>			<b>ZZZ</b>
57	<b>MEDICAL SUPPLIES**</b>	<b>CODE</b>	<b>UNIT</b>										
58	drape, non-sterile, sheet 40in x 60in	SB006	item										
59	drape-sleeve, sterile, for handpiece	SB018	item										
60	drape-towel, sterile OR blue (2 pk uou)	SB020	item					<b>2</b>					<b>2</b>
61	gloves, non-sterile	SB022	pair	<b>1</b>				<b>1</b>	<b>1</b>				<b>1</b>
62	gloves, sterile	SB024	pair	<b>4</b>				<b>1</b>	<b>2</b>				<b>1</b>
63	gown, patient	SB026	item	<b>1</b>				<b>1</b>					
64	mask, surgical	SB033	item					<b>2</b>					
65	towel, professional 13in x 18in	SB043	item										
66	Mammotome probe guide	SC022	item										
67	needle, 18-27g	SC029	item	<b>2</b>				<b>1</b>	<b>2</b>				<b>1</b>
68	needle-wire for localization	SC045	item	<b>1</b>				<b>2</b>	<b>1</b>				<b>2</b>
69	syringe 10-12ml	SC051	item					<b>2</b>					<b>2</b>
70	syringe 3ml	SC055	item	<b>1</b>					<b>1</b>				
71	canister, vacuum	SD010	item										
72	clip, tissue marker	SD037	item										
73	guide, needle, for localization	SD087	item					<b>2</b>					<b>2</b>
74	Mammotome probe	SD094	item										
75	tubing, vacuum (for Mammotome device)	SD135	item										
76	scalpel with blade, surgical (#10-20)	SF033	item										
77	dressing, 3in x 4in (Telfa, Release)	SG035	item										
78	gauze, non-sterile 4in x 4in	SG051	item										
79	gauze, sterile 4in x 4in	SG055	item	<b>2</b>					<b>2</b>				
80	gauze, sterile 4in x 4in (10 pack uou)	SG056	item					<b>2</b>					<b>2</b>
81	steri-strip (6 strip uou)	SG074	item										
82	tape, elastic, 2in (Elastoplast, Elasticon) (5yd uou)	SG076	item					<b>1</b>					<b>1</b>
83	lidocaine 1% w-epi inj (Xylocaine w-epi)	SH046	ml					<b>5</b>					<b>5</b>
84	lidocaine 1%-2% inj (Xylocaine)	SH047	ml	<b>10</b>				<b>5</b>	<b>10</b>				<b>5</b>
85	Sensorcaine 0.5% inj	SH063	ml										
86	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item					<b>1</b>					<b>1</b>
87	Cetacaine spray (56gm size bottle)	SJ012	gm					<b>1</b>					<b>1</b>
88	ice pack, instant	SJ029	item										
89	povidone soln (Betadine)	SJ041	ml	<b>30</b>					<b>30</b>				
90	povidone swabsticks (3 pack uou)	SJ043	item					<b>1</b>					<b>1</b>
91	swab-pad, alcohol	SJ053	item	<b>1</b>				<b>2</b>	<b>1</b>				<b>2</b>
92	film, x-ray 14in x 17in	SK034	item										
93	film, x-ray 8in x 10in	SK037	item		<b>8</b>			<b>8</b>		<b>8</b>			<b>8</b>
94	x-ray developer solution	SK089	oz		<b>8</b>			<b>8</b>		<b>8</b>			<b>8</b>
95	x-ray envelope	SK091	item		<b>1</b>					<b>1</b>			
96	x-ray fixer solution	SK092	oz		<b>8</b>			<b>8</b>		<b>8</b>			<b>8</b>
97	x-ray ID card (flashcard)	SK093	item										
98	film, x-ray, laser print	SK098	item										
99	cup, biopsy-specimen sterile 4oz	SL036	item										
100	cleaner, x-ray cassette-screen	SM009	oz										
101	disinfectant, surface (Envirocide, Sanizide)	SM013	oz										
102	glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)	SM018	oz										
103	sanitizing cloth-wipe (patient)	SM021	item										
104	<b>EQUIPMENT</b>	<b>CODE</b>											
105	film processor, wet	ED025			<b>9</b>			<b>5</b>		<b>9</b>			<b>5</b>
106	stretcher	EF018			<b>10</b>				<b>14</b>	<b>10</b>			
107	table, exam	EF023		<b>62</b>				<b>39</b>					<b>25</b>
108	table, power	EF031											
109	room, mammography	EL013		<b>62</b>	<b>10</b>			<b>39</b>	<b>14</b>	<b>10</b>			<b>25</b>
110	light, exam	EQ168						<b>39</b>					<b>25</b>
111	film alternator (motorized film viewbox)	ER029			<b>9</b>			<b>5</b>		<b>9</b>			<b>5</b>

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
1	REVISED AT RUC 4/25/13			REF CODE	REF CODE	REF CODE	RECOMMENDATION				REF CODE	REF CODE	RECOMMENDATION			
2	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.			19103	19295	77021			19085	19086	19295	77021			19287	19288
3	Meeting Date: April 2013 Tab: 4 Specialty: ACR, ASBS, ACS	CMS Code	Staff Type	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance	Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)	Magnetic resonance guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation	CMS Code	Staff Type	Bx+marker w-MR guidance	Bx+marker w-MR guidance - add'l	Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)	Magnetic resonance guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation	CMS Code	Staff Type	Marker w-MR guidance	Marker w-MR guidance - add'l
4	LOCATION			Non Fac	Non Fac	Non Fac			Non Fac	Non Fac	Non Fac	Non Fac			Non Fac	Non Fac
5	GLOBAL PERIOD			000	ZZZ	XXX			000	ZZZ	ZZZ	XXX			000	ZZZ
6	TOTAL CLINICAL LABOR TIME			100	5	45	L047A	MRI Tech	91	59	5	45	L047A	MRI Tech	76	46
7	TOTAL PRE-SERV CLINICAL LABOR TIME			0	0	0	L047A	MRI Tech	3	0	0	0	L047A	MRI Tech	3	0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L043A	Mam Tech	100												
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L041B	Rad Tech		5						5					
10	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L047A	MRI Tech			45	L047A	MRI Tech	85	59		45	L047A	MRI Tech	70	46
11	TOTAL POST-SERV CLINICAL LABOR TIME			0	0	0	L047A	MRI Tech	3	0	0	0	L047A	MRI Tech	3	0
12	PRE-SERVICE															
19	*Other Clinical Activity - specify: Retrieve prior images for comparison						L047A	MRI Tech	3	0			L047A	MRI Tech	3	0
20	End: When patient enters office/facility for surgery/procedure															
21	SERVICE PERIOD															
22	Start: When patient enters office/facility for surgery/procedure:															
23	Greet patient, provide gowning, ensure appropriate medical records are available	L043A	Mam Tech	8			L047A	MRI Tech	3				L047A	MRI Tech	3	
24	Obtain vital signs	L043A	Mam Tech	4					3						3	
25	Provide pre-service education/obtain consent	L043A	Mam Tech	12			L047A	MRI Tech	5				L047A	MRI Tech	5	
26	Prepare room, equipment, supplies	L043A	Mam Tech	8			L047A	MRI Tech	3	1			L047A	MRI Tech	3	1
27	Setup scope (non facility setting only)															
28	Prepare and position patient/ monitor patient/ set up IV	L043A	Mam Tech	5			L047A	MRI Tech	3	3			L047A	MRI Tech	3	3
29	Sedate/apply anesthesia	L043A	Mam Tech	2												
30	*Other Clinical Activity - specify:															
31	Intra-service															
32	Assist physician in performing procedure	L043A	Mam Tech	30												
33		L041B	Rad Tech		5						5					
34		L047A	MRI Tech			45	L047A	MRI Tech	45	38		45	L047A	MRI Tech	37	30
35	Post-Service															
36	Monitor pt. following service/check tubes, monitors, drains	L043A	Mam Tech	9			L047A	MRI Tech	10	10			L047A	MRI Tech	5	5
37	Clean room/equipment by physician staff	L043A	Mam Tech	9			L047A	MRI Tech	3	1			L047A	MRI Tech	3	1
38	Clean Scope															
39	Clean Surgical Instrument Package															
40	Complete diagnostic forms, lab & X-ray requisitions	L043A	Mam Tech	4												
41	Review/read X-ray, lab, and pathology reports	L043A	Mam Tech	5			L047A	MRI Tech	2	1			L047A	MRI Tech	2	1
42	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L043A	Mam Tech	4			L047A	MRI Tech	3	0			L047A	MRI Tech	1	0
43	*Other Clinical Activity - specify: Process images, complete data sheet, present images and data to the interpreting physician						L047A	MRI Tech	5	5			L047A	MRI Tech	5	5
44	Dischrg mgmt (1.0 x 99238) (enter 12 min)			n/a	n/a						n/a					
45	Dischrg mgmt (1.0 x 99239) (enter 15 min)			n/a	n/a						n/a					
46	End: Patient leaves office															
47	POST-SERVICE Period															
48	Start: Patient leaves office/facility															
49	Conduct phone calls/call in prescriptions								3						3	
58	End: with last office visit before end of global period															



	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
1	REVISED AT RUC 4/25/13			REF CODE	REF CODE	REF CODE	RECOMMENDATION				REF CODE	REF CODE	RECOMMENDATION			
2	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.			19103	19295	77021			19085	19086	19295	77021			19287	19288
3	Meeting Date: April 2013 Tab: 4 Specialty: ACR, ASBS, ACS	CMS Code	Staff Type	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance	Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)	Magnetic resonance guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation	CMS Code	Staff Type	Bx+marker w-MR guidance	Bx+marker w-MR guidance - add'l	Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)	Magnetic resonance guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation	CMS Code	Staff Type	Marker w-MR guidance	Marker w-MR guidance - add'l
4	LOCATION			Non Fac	Non Fac	Non Fac			Non Fac	Non Fac	Non Fac	Non Fac			Non Fac	Non Fac
5	GLOBAL PERIOD			000	ZZZ	XXX			000	ZZZ	ZZZ	XXX			000	ZZZ
59	MEDICAL SUPPLIES**	CODE	UNIT													
60	drape, non-sterile, sheet 40in x 60in	SB006	item													
61	drape-sleeve, sterile, for handpiece	SB018	item	1												
62	drape-towel, sterile OR blue (2 pk uou)	SB020	item	2					2	2					2	2
63	gloves, non-sterile	SB022	pair	1					2	2					1	1
64	gloves, sterile	SB024	pair	1					1	1					1	1
65	gown, patient	SB026	item						1						1	
66	mask, surgical	SB033	item	2					2						2	
67	towel, professional 13in x 18in	SB043	item													
68	underpad 2ft x 3ft (Chux)	SB044	item						1						1	
69	Mammotome probe guide	SC022	item	1					1	1					1	1
70	needle, 18-27g	SC029	item	1					1	1					1	1
71	needle, biopsy for breast-prostate core sample	SC032	item													
72	needle-wire for localization	SC045	item													
73	syringe 10-12ml	SC051	item	2					2	2					2	2
74	syringe 3ml	SC055	item													
75	canister, vacuum	SD010	item	1					1	1						
76	clip, tissue marker	SD037	item		1				1	1	1				1	1
77	guide, needle, for localization	SD087	item	1												
78	Mammotome probe	SD094	item	1					1	1					1	1
79	tubing, vacuum (for Mammotome device)	SD135	item	1					1	1						
80	scalpel with blade, surgical (#10-20)	SF033	item	1												
81	scalpel, safety, surgical, with blade (#10-20)	SF047	item						1	1					1	1
82	dressing, 3in x 4in (Telfa, Release)	SG035	item	1					1	1					1	1
83	gauze, non-sterile 4in x 4in	SG051	item													
84	gauze, sterile 4in x 4in	SG055	item													
85	gauze, sterile 4in x 4in (10 pack uou)	SG056	item	1					2	2					2	2
86	steri-strip (6 strip uou)	SG074	item	1					1	1						
87	tape, elastic, 2in (Elastoplast, Elasticon) (5yd uou)	SG076	item	1					1	1					1	1
88	lidocaine 1% w-epi inj (Xylocaine w-epi)	SH046	ml						10	10					5	5
89	lidocaine 1%-2% inj (Xylocaine)	SH047	ml	20					10	10					5	5
90	Sensorcaine 0.5% inj	SH063	ml	1												
91	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item	1					1	1					1	1
92	ice pack, instant	SJ029	item	1					1	1					1	1
93	povidone soln (Betadine)	SJ041	ml													
94	povidone swabsticks (3 pack uou)	SJ043	item	1					1	1					1	1
95	swab-pad, alcohol	SJ053	item						2	2					2	2
96	film, x-ray 14in x 17in	SK034	item			2			2	2		2			2	2
97	x-ray developer solution	SK089	oz													
98	x-ray envelope	SK091	item													
99	x-ray fixer solution	SK092	oz													
100	x-ray ID card (flashcard)	SK093	item													
101	film, x-ray, laser print	SK098	item													
102	cup, biopsy-specimen sterile 4oz	SL036	item	1					1	1						
103	filter paper, qualitative, <15.0cm	SL064	item						1	1						
104	cleaner, x-ray cassette-screen	SM009	oz													
105	disinfectant, surface (Envirocide, Sanizide)	SM013	oz													
106	glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)	SM018	oz	0.34					0.34	0.34					0.34	0.34
107	sanitizing cloth-wipe (patient)	SM021	item													
108	20MM handpiece - MR	NEW	item						0	0					0	0
109	vacuum line assembly	NEW	item						0	0					0	0
110	introducer localization set (trocar)	NEW	item						0	0					0	0
111	tissue filter	NEW	item						0	0					0	0

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
1	REVISED AT RUC 4/25/13			REF CODE	REF CODE	REF CODE	RECOMMENDATION				REF CODE	REF CODE	RECOMMENDATION			
2	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.			19103	19295	77021			19085	19086	19295	77021			19287	19288
3	Meeting Date: April 2013 Tab: 4 Specialty: ACR, ASBS, ACS	CMS Code	Staff Type	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance	Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)	Magnetic resonance guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation	CMS Code	Staff Type	Bx+marker w-MR guidance	Bx+marker w-MR guidance - add'l	Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)	Magnetic resonance guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation	CMS Code	Staff Type	Marker w-MR guidance	Marker w-MR guidance - add'l
4	LOCATION			Non Fac	Non Fac	Non Fac			Non Fac	Non Fac	Non Fac	Non Fac			Non Fac	Non Fac
5	GLOBAL PERIOD			000	ZZZ	XXX			000	ZZZ	ZZZ	XXX			000	ZZZ
112	EQUIPMENT	CODE														
113	film processor, dry, laser	ED024							11	11					11	11
114	stretcher	EF018			5						5					
115	table, exam	EF023														
116	table, power	EF031		100					0	0					0	0
117	room, MR	EL008				45			54	43		45			46	35
118	room, mammography	EL013			5						5					
119	breast biopsy device w-system (Mammotome)	EQ074		100					54	43					46	35
120	light, exam	EQ168		100					54	43					46	35
121	film alternator (motorized film viewbox)	ER029							2	2					2	2
122	breast biopsy software	NEW	item						0	0					0	0
123	breast biopsy device (coil)	NEW	item						0	0					0	0
124	lateral grid	NEW	item						0	0					0	0

	A	B	C	D	E	F	G	H	I	J	K	O	P	Q	R
1				REF CODE	REF CODE	REF CODE	REF CODE	RECOMMENDATION				RECOMMENDATION			
2	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code			19103	19295	76098	77031			19081	19082			19283	19284
3	Meeting Date: April 2013 Tab: 4 Specialty: ACR, ASBS, ACS	CMS Code	Staff Type	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance	Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)	Radiological examination, surgical specimen	Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation	CMS Code	Staff Type	Bx+marker w- stereotactic guidance	Bx+marker w- stereotactic guidance - add'l	CMS Code	Staff Type	Marker w- stereotactic guidance	Marker w- stereotactic guidance - add'l
4	LOCATION			Non Fac	Non Fac	Non Fac	Non Fac			Non Fac	Non Fac			Non Fac	Non Fac
5	GLOBAL PERIOD			000	ZZZ	XXX	XXX			000	ZZZ			000	ZZZ
6	TOTAL CLINICAL LABOR TIME			100	5	12	31	L043A	Mam Tech	76	46	L043A	Mam Tech	56	36
7	TOTAL PRE-SERV CLINICAL LABOR TIME			0	0	0	0	L043A	Mam Tech	3	0	L043A	Mam Tech	3	0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L043A	Mam Tech	100		12		L043A	Mam Tech	70	46	L043A	Mam Tech	53	36
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L041B	Rad Tech		5		31								0
10	TOTAL POST-SERV CLINICAL LABOR TIME			0	0	0	0	L043A	Mam Tech	3	0	L043A	Mam Tech	0	0
11	PRE-SERVICE														
18	*Other Clinical Activity - specify: Retrieve prior images for comparison							L043A	Mam Tech	3	0	L043A	Mam Tech	3	0
19	End: When patient enters office/facility for surgery/procedure														
20	SERVICE PERIOD														
21	Start: When patient enters office/facility for surgery/procedure:														
22	Greet patient, provide gowning, ensure appropriate medical records are available	L043A	Mam Tech	8				L043A	Mam Tech	3		L043A	Mam Tech	3	
23		L041B	Rad Tech												
24	Obtain vital signs	L043A	Mam Tech	4						3				3	
25	Provide pre-service education/obtain consent	L043A	Mam Tech	12				L043A	Mam Tech	5		L043A	Mam Tech	5	
26		L041B	Rad Tech												
27	Prepare room, equipment, supplies	L043A	Mam Tech	8				L043A	Mam Tech	3	1	L043A	Mam Tech	3	1
28		L041B	Rad Tech				3								
29	Setup scope (non facility setting only)														
30	Prepare and position patient/ monitor patient/ set up IV	L043A	Mam Tech	5				L043A	Mam Tech	3	3	L043A	Mam Tech	3	3
31		L041B	Rad Tech				20								
32	Sedate/apply anesthesia	L043A	Mam Tech	2											
33	*Other Clinical Activity - specify:														
34	Intra-service														
35	Assist physician in performing procedure	L043A	Mam Tech	30		3		L043A	Mam Tech	30	25	L043A	Mam Tech	20	20
36		L041B	Rad Tech		5		6								
37	Post-Service														
38	Monitor pt. following service/check tubes, monitors, drains	L043A	Mam Tech	9				L043A	Mam Tech	10	10	L043A	Mam Tech	5	5
39	Clean room/equipment by physician staff	L043A	Mam Tech	9		4		L043A	Mam Tech	3	1	L043A	Mam Tech	3	1
40		L041B	Rad Tech												
41	Clean Scope														
42	Clean Surgical Instrument Package														
43	Complete diagnostic forms, lab & X-ray requisitions	L043A	Mam Tech	4											
44	Review/read X-ray, lab, and pathology reports	L043A	Mam Tech	5		5		L043A	Mam Tech	2	1	L043A	Mam Tech	2	1
45		L041B	Rad Tech												
46	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L043A	Mam Tech	4				L043A	Mam Tech	3	0	L043A	Mam Tech	1	0
47		L041B	Rad Tech												
48	*Other Clinical Activity - specify: Process images, complete data sheet, present images and data to the interpreting physician							L043A	Mam Tech	5	5	L043A	Mam Tech	5	5
49	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			n/a	n/a	n/a	n/a			n/a	n/a			n/a	n/a
50	Dischrg mgmt (1.0 x 99238) (enter 12 min)			n/a	n/a	n/a	n/a			n/a	n/a			n/a	n/a
51	Dischrg mgmt (1.0 x 99239) (enter 15 min)			n/a	n/a	n/a	n/a			n/a	n/a			n/a	n/a
52	*Other Clinical Activity - specify: Post procedure documentation	L041B	Rad Tech				2								
53	End: Patient leaves office														
54	POST-SERVICE Period														
55	Start: Patient leaves office/facility														
56	Conduct phone calls/call in prescriptions									3					
65	End: with last office visit before end of global period														

	A	B	C	D	E	F	G	H	I	J	K	O	P	Q	R
1				REF CODE	REF CODE	REF CODE	REF CODE	RECOMMENDATION				RECOMMENDATION			
2	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code			19103	19295	76098	77031			19081	19082			19283	19284
3	Meeting Date: April 2013 Tab: 4 Specialty: ACR, ASBS, ACS	CMS Code	Staff Type	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance	Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)	Radiological examination, surgical specimen	Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation	CMS Code	Staff Type	Bx+marker w- stereotactic guidance	Bx+marker w- stereotactic guidance - add'l	CMS Code	Staff Type	Marker w- stereotactic guidance	Marker w- stereotactic guidance - add'l
4	LOCATION			Non Fac	Non Fac	Non Fac	Non Fac			Non Fac	Non Fac			Non Fac	Non Fac
5	GLOBAL PERIOD			000	ZZZ	XXX	XXX			000	ZZZ			000	ZZZ
66	MEDICAL SUPPLIES**	CODE	UNIT												
67	drape, non-sterile, sheet 40in x 60in	SB006	item			1									
68	drape-sleeve, sterile, for handpiece	SB018	item	1											
69	drape-towel, sterile OR blue (2 pk uou)	SB020	item	2						2	2			2	2
70	gloves, non-sterile	SB022	pair	1		1				2	2			1	1
71	gloves, sterile	SB024	pair	1						1	1			1	1
72	gown, patient	SB026	item							1				1	
73	mask, surgical	SB033	item	2						2				2	
74	towel, professional 13in x 18in	SB043	item			1									
75	underpad 2ft x 3ft (Chux)	SB044	item							1				1	
76	Mammotome probe guide	SC022	item	1						1	1			1	1
77	needle, 18-27g	SC029	item	1						1	1			1	1
78	needle-wire for localization	SC045	item											2	2
79	syringe 10-12ml	SC051	item	2						2	2			2	2
80	syringe 3ml	SC055	item												
81	canister, vacuum	SD010	item	1						1	1				
82	clip, tissue marker	SD037	item		1					1	1				
83	guide, needle, for localization	SD087	item	1										2	2
84	Mammotome probe	SD094	item	1						1	1				
85	tubing, vacuum (for Mammotome device)	SD135	item	1						1	1				
86	scalpel with blade, surgical (#10-20)	SF033	item	1											
87	scalpel, safety, surgical, with blade (#10-20)	SF047	item							1	1				
88	dressing, 3in x 4in (Telfa, Release)	SG035	item	1						1	1			1	1
89	gauze, non-sterile 4in x 4in	SG051	item			1				1	1				
90	gauze, sterile 4in x 4in	SG055	item												
91	gauze, sterile 4in x 4in (10 pack uou)	SG056	item	1						2	2			2	2
92	steri-strip (6 strip uou)	SG074	item	1						1	1				
93	tape, elastic, 2in (Elastoplast, Elasticon) (5yd uou)	SG076	item	1						1	1			1	1
94	lidocaine 1% w-epi inj (Xylocaine w-epi)	SH046	ml							10	10			5	5
95	lidocaine 1%-2% inj (Xylocaine)	SH047	ml	20						10	10			5	5
96	Sensorcaine 0.5% inj	SH063	ml	1											
97	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item	1						1	1			1	1
98	Cetacaine spray (56gm size bottle)	SJ012	gm							1	1			1	1
99	ice pack, instant	SJ029	item	1						1	1			1	1
100	povidone soln (Betadine)	SJ041	ml												
101	povidone swabsticks (3 pack uou)	SJ043	item	1						1	1			1	1
102	swab-pad, alcohol	SJ053	item							2	2			2	2
103	film, x-ray 14in x 17in	SK034	item				1			1	1			1	1
104	x-ray developer solution	SK089	oz				1			1	1			1	1
105	x-ray envelope	SK091	item			1	1								
106	x-ray fixer solution	SK092	oz				1			1	1			1	1
107	x-ray ID card (flashcard)	SK093	item			2				1	1			1	1
108	film, x-ray, laser print	SK098	item			1				1	1				
109	cup, biopsy-specimen sterile 4oz	SL036	item	1						1	1				
110	filter paper, qualitative, <15.0cm	SL064	item							1	1				
111	cleaner, x-ray cassette-screen	SM009	oz			0.5									
112	disinfectant, surface (Envirocide, Sanizide)	SM013	oz			0.5				0.5	0.5			0.5	0.5
113	glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)	SM018	oz	0.34						0.34	0.34			0.34	0.34
114	sanitizing cloth-wipe (patient)	SM021	item			1				1	1			1	1



	A	B	C	D	E	F	G	H	I	J	K	O	P	Q	R
1				REF CODE	REF CODE	REF CODE	REF CODE	RECOMMENDATION				RECOMMENDATION			
2	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code			19103	19295	76098	77031			19081	19082			19283	19284
3	Meeting Date: April 2013 Tab: 4 Specialty: ACR, ASBS, ACS	CMS Code	Staff Type	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance	Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)	Radiological examination, surgical specimen	Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation	CMS Code	Staff Type	Bx+marker w- stereotactic guidance	Bx+marker w- stereotactic guidance - add'l	CMS Code	Staff Type	Marker w- stereotactic guidance	Marker w- stereotactic guidance - add'l
4	LOCATION			Non Fac	Non Fac	Non Fac	Non Fac			Non Fac	Non Fac			Non Fac	Non Fac
5	GLOBAL PERIOD			000	ZZZ	XXX	XXX			000	ZZZ			000	ZZZ
115	EQUIPMENT	CODE													
116	film processor, dry, laser	ED024				2				2	2			2	2
117	stretcher	EF018			5										
118	table, exam	EF023													
119	table, power	EF031		100						0	0			0	0
120	room, mammography	EL013			5					39	30			29	25
121	breast biopsy device w-system (Mammotome)	EQ074		100						39	30			29	25
122	breast biopsy imaging system, stereotactic (imager, table, software)	EQ075					31			39	30			29	25
123	light, exam	EQ168		100						39	30			29	25
124	film alternator (motorized film viewbox)	ER029				2				2	2			2	2

	A	B	C	D	E	F	G	H	I	J	N	O	P	Q
1	<b>REVISED AT RUC 4/25/13</b>			<b>REF CODE</b>	<b>REF CODE</b>	<b>REF CODE</b>	<b>RECOMMENDATION</b>				<b>RECOMMENDATION</b>			
2	<b>*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.</b>			<b>19103</b>	<b>19295</b>	<b>76942</b>			<b>19083</b>	<b>19084</b>			<b>19285</b>	<b>19286</b>
3	<b>Meeting Date: April 2013</b> <b>Tab: 4</b> <b>Specialty: ACR, ASBS, ACS</b>	<b>CMS Code</b>	<b>Staff Type</b>	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance	Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	<b>CMS Code</b>	<b>Staff Type</b>	Bx+marker w-ultrasound guidance	Bx+marker w-ultrasound guidance - <b>add'l</b>	<b>CMS Code</b>	<b>Staff Type</b>	Marker w-ultrasound guidance	Marker w-ultrasound guidance - <b>add'l</b>
4	<b>LOCATION</b>			<b>Non Fac</b>	<b>Non Fac</b>	<b>Non Fac</b>			<b>Non Fac</b>	<b>Non Fac</b>			<b>Non Fac</b>	<b>Non Fac</b>
5	<b>GLOBAL PERIOD</b>			<b>000</b>	<b>ZZZ</b>	<b>XXX</b>			<b>000</b>	<b>ZZZ</b>			<b>000</b>	<b>ZZZ</b>
6	<b>TOTAL CLINICAL LABOR TIME</b>			<b>100</b>	<b>5</b>	<b>61</b>	L051B	RN/DMS	<b>71</b>	<b>41</b>	L051B	RN/DMS	<b>51</b>	<b>31</b>
7	<b>TOTAL PRE-SERV CLINICAL LABOR TIME</b>	L051B	RN/DMS	<b>0</b>	<b>0</b>	<b>3</b>	L051B	RN/DMS	<b>3</b>	<b>0</b>	L051B	RN/DMS	<b>3</b>	<b>0</b>
8	<b>TOTAL SERVICE PERIOD CLINICAL LABOR TIME</b>	L051B	RN/DMS			<b>58</b>	L051B	RN/DMS	<b>65</b>	<b>41</b>	L051B	RN/DMS	<b>48</b>	<b>31</b>
9	<b>TOTAL SERVICE PERIOD CLINICAL LABOR TIME</b>	L043A	Mam Tech	<b>100</b>										
10	<b>TOTAL SERVICE PERIOD CLINICAL LABOR TIME</b>	L041B	Rad Tech		<b>5</b>									
11	<b>TOTAL POST-SERV CLINICAL LABOR TIME</b>			<b>0</b>	<b>0</b>	<b>0</b>	L051B	RN/DMS	<b>3</b>	<b>0</b>	L051B	RN/DMS	<b>0</b>	<b>0</b>
12	<b>PRE-SERVICE</b>													
19	*Other Clinical Activity - specify: <i>Retrieve prior images for comparison</i>	L051B	RN/DMS			<b>3</b>	L051B	RN/DMS	<b>3</b>	<b>0</b>	L051B	RN/DMS	<b>3</b>	<b>0</b>
20	<b>End: When patient enters office/facility for surgery/procedure</b>													
21	<b>SERVICE PERIOD</b>													
22	<b>Start: When patient enters office/facility for surgery/procedure:</b>													
23	Greet patient, provide gowning, ensure appropriate medical records are available	L043A	Mam Tech	<b>8</b>			L051B	RN/DMS	<b>3</b>		L051B	RN/DMS	<b>3</b>	
24	Obtain vital signs	L043A	Mam Tech	<b>4</b>					<b>3</b>				<b>3</b>	
25	Provide pre-service education/obtain consent	L043A	Mam Tech	<b>12</b>			L051B	RN/DMS	<b>5</b>		L051B	RN/DMS	<b>5</b>	
26	Prepare room, equipment, supplies	L043A	Mam Tech	<b>8</b>			L051B	RN/DMS	<b>3</b>	<b>1</b>	L051B	RN/DMS	<b>3</b>	<b>1</b>
27		L051B	RN/DMS			<b>2</b>								
28	Setup scope (non facility setting only)													
29	Prepare and position patient/ monitor patient/ set up IV	L043A	Mam Tech	<b>5</b>			L051B	RN/DMS	<b>3</b>	<b>3</b>	L051B	RN/DMS	<b>3</b>	<b>3</b>
30		L051B	RN/DMS			<b>3</b>								
31	Sedate/apply anesthesia	L043A	Mam Tech	<b>2</b>										
32	*Other Clinical Activity - specify:													
33	<b>Intra-service</b>													
34		L043A	Mam Tech	<b>30</b>			L051B	RN/DMS	<b>25</b>	<b>20</b>	L051B	RN/DMS	<b>15</b>	<b>15</b>
35	Assist physician in performing procedure	L051B	RN/DMS			<b>45</b>								
36		L041B	Rad Tech		<b>5</b>									
37	<b>Post-Service</b>													
38	Monitor pt. following service/check tubes, monitors, drains	L043A	Mam Tech	<b>9</b>			L051B	RN/DMS	<b>10</b>	<b>10</b>	L051B	RN/DMS	<b>5</b>	<b>5</b>
39	Clean room/equipment by physician staff	L043A	Mam Tech	<b>9</b>			L051B	RN/DMS	<b>3</b>	<b>1</b>	L051B	RN/DMS	<b>3</b>	<b>1</b>
40		L051B	RN/DMS			<b>3</b>								
41	Clean Scope													
42	Clean Surgical Instrument Package													
43	Complete diagnostic forms, lab & X-ray requisitions	L043A	Mam Tech	<b>4</b>										
44	Review/read X-ray, lab, and pathology reports	L043A	Mam Tech	<b>5</b>			L051B	RN/DMS	<b>2</b>	<b>1</b>	L051B	RN/DMS	<b>2</b>	<b>1</b>
45	Check dressings & wound/ home care instructions	L043A	Mam Tech	<b>4</b>			L051B	RN/DMS	<b>3</b>	<b>0</b>	L051B	RN/DMS	<b>1</b>	<b>0</b>
46	/coordinate office visits /prescriptions	L041B	Rad Tech											
47	*Other Clinical Activity - specify: <i>Process images, complete data sheet, present images and data to the interpreting physician</i>	L051B	RN/DMS			<b>5</b>	L051B	RN/DMS	<b>5</b>	<b>5</b>	L051B	RN/DMS	<b>5</b>	<b>5</b>
51	<b>End: Patient leaves office</b>													
52	<b>POST-SERVICE Period</b>													
53	<b>Start: Patient leaves office/facility</b>													
54	Conduct phone calls/call in prescriptions								<b>3</b>					
55	<b>Office visits: List Number and Level of Office Visits</b>			<b># visits</b>	<b># visits</b>	<b># visits</b>			<b># visits</b>	<b># visits</b>			<b># visits</b>	
56	99211 16 minutes		16											
57	99212 27 minutes		27											
58	99213 36 minutes		36											
59	99214 53 minutes		53											
60	99215 63 minutes		63											
61	<b>Total Office Visit Time</b>			<b>0.0</b>	<b>0.0</b>	<b>0.0</b>			<b>0.0</b>	<b>0.0</b>			<b>0.0</b>	
62	*Other Clinical Activity - specify:													
63	<b>End: with last office visit before end of global period</b>													

	A	B	C	D	E	F	G	H	I	J	N	O	P	Q
1	REVISED AT RUC 4/25/13			REF CODE	REF CODE	REF CODE	RECOMMENDATION				RECOMMENDATION			
2	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.			19103	19295	76942			19083	19084			19285	19286
3	Meeting Date: April 2013 Tab: 4 Specialty: ACR, ASBS, ACS	CMS Code	Staff Type	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance	Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	CMS Code	Staff Type	Bx+marker w-ultrasound guidance	Bx+marker w-ultrasound guidance - add'l	CMS Code	Staff Type	Marker w-ultrasound guidance	Marker w-ultrasound guidance - add'l
	LOCATION			Non Fac	Non Fac	Non Fac			Non Fac	Non Fac			Non Fac	Non Fac
	GLOBAL PERIOD			000	ZZZ	XXX			000	ZZZ			000	ZZZ
64	MEDICAL SUPPLIES**	CODE	UNIT											
65	cover-condom, transducer or ultrasound probe	SB005	item			1			1				1	
66	drape, non-sterile, sheet 40in x 60in	SB006	item											
67	drape-sleeve, sterile, for handpiece	SB018	item	1					1	1			1	1
68	drape-towel, sterile OR blue (2 pk uou)	SB020	item	2					2	2			2	2
69	gloves, non-sterile	SB022	pair	1					2	2			1	1
70	gloves, sterile	SB024	pair	1					1	1			1	1
71	gown, patient	SB026	item						1				1	
72	mask, surgical	SB033	item	2					2				2	
73	paper, exam table	SB036	foot						5	5			5	5
74	pillow case	SB037	item			1			1				1	
75	towel, professional 13in x 18in	SB043	item											
76	Mammotome probe guide	SC022	item	1					1	1				
77	needle, 18-27g	SC029	item	1					1	1			1	1
78	needle-wire for localization	SC045	item											
79	syringe 10-12ml	SC051	item	2					2	2			2	2
80	syringe 3ml	SC055	item											
81	canister, vacuum	SD010	item	1					1	1				
82	clip, tissue marker	SD037	item		1				1	1			3	3
83	guide, needle, for localization	SD087	item	1										
84	Mammotome probe	SD094	item	1					1	1				
85	tubing, vacuum (for Mammotome device)	SD135	item	1					1	1				
86	scalpel with blade, surgical (#10-20)	SF033	item	1										
87	scalpel, safety, surgical, with blade (#10-20)	SF047	item						1	1				
88	dressing, 3in x 4in (Telfa, Release)	SG035	item	1					1	1			1	1
89	gauze, non-sterile 4in x 4in	SG051	item											
90	gauze, sterile 4in x 4in	SG055	item											
91	gauze, sterile 4in x 4in (10 pack uou)	SG056	item	1					2	2			2	2
92	steri-strip (6 strip uou)	SG074	item	1					1	1				
93	tape, elastic, 2in (Elastoplast, Elasticon) (5yd uou)	SG076	item	1					1	1			1	1
94	lidocaine 1% w-epi inj (Xylocaine w-epi)	SH046	ml						10	10			5	5
95	lidocaine 1%-2% inj (Xylocaine)	SH047	ml	20					10	10			5	5
96	Sensorcaine 0.5% inj	SH063	ml	1										
97	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item	1					1	1			1	1
98	Cetacaine spray (56gm size bottle)	SJ012	gm						1	1			1	1
99	ice pack, instant	SJ029	item	1					1	1			1	1
100	lubricating jelly (Surgilube)	SJ033	oz			1			4	4			4	4
101	povidone soln (Betadine)	SJ041	ml											
102	povidone swabsticks (3 pack uou)	SJ043	item	1					1	1			1	1
103	swab-pad, alcohol	SJ053	item						2	2			2	2
104	ultrasound transmission gel	SJ062	ml						2	2			2	2
105	film, 8inx10in (ultrasound, MRI)	SK022	item			2			2				2	
106	film, x-ray 14in x 17in	SK034	item			3			3				3	
107	x-ray developer solution	SK089	oz			1								
108	x-ray envelope	SK091	item			1								
109	x-ray fixer solution	SK092	oz											
110	x-ray ID card (flashcard)	SK093	item											
111	film, x-ray, laser print	SK098	item											
112	cup, biopsy-specimen sterile 4oz	SL036	item	1					1	1				
113	filter paper, qualitative, <15.0cm	SL064	item						1	1				
114	cleaner, x-ray cassette-screen	SM009	oz											
115	disinfectant spray (Transeptic)	SM012	ml			10			10				10	
116	disinfectant, surface (Envirocide, Sanizide)	SM013	oz											
117	glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)	SM018	oz	0.34					0.34	0.34			0.34	0.34
118	sanitizing cloth-wipe (patient)	SM021	item			2			2	2			2	2

	A	B	C	D	E	F	G	H	I	J	N	O	P	Q
1	<b>REVISED AT RUC 4/25/13</b>			<b>REF CODE</b>	<b>REF CODE</b>	<b>REF CODE</b>	<b>RECOMMENDATION</b>				<b>RECOMMENDATION</b>			
2	<b>*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.</b>			<b>19103</b>	<b>19295</b>	<b>76942</b>			<b>19083</b>	<b>19084</b>			<b>19285</b>	<b>19286</b>
3	Meeting Date: April 2013 Tab: 4 Specialty: ACR, ASBS, ACS	CMS Code	Staff Type	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance	Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	CMS Code	Staff Type	Bx+marker w-ultrasound guidance	Bx+marker w-ultrasound guidance - add'l	CMS Code	Staff Type	Marker w-ultrasound guidance	Marker w-ultrasound guidance - add'l
4	LOCATION			Non Fac	Non Fac	Non Fac			Non Fac	Non Fac			Non Fac	Non Fac
5	GLOBAL PERIOD			000	ZZZ	XXX			000	ZZZ			000	ZZZ
119	<b>EQUIPMENT</b>	<b>CODE</b>												
120	film processor, dry, laser	ED024				58			58	58			58	58
121	stretcher	EF018			5									
122	table, exam	EF023							0				0	
123	table, power	EF031		100										
124	room, ultrasound, general	EL015				58			34	25			24	20
125	room, mammography	EL013			5									
126	breast biopsy device w-system (Mammotome)	EQ074		100					34	25			24	20
127	light, exam	EQ168		100					34	25			24	20
128	film alternator (motorized film viewbox)	ER029				58			58	58			58	58

## AMA/Specialty Society RVS Update Committee Summary of Recommendations

January 2013

### Shoulder Prosthesis Removal

At the April 2012 meeting, the RUC referred CPT codes 23331 *Removal of foreign body, shoulder; deep (eg, Neer hemiarthroplasty removal)* and 23332 *Removal of foreign body, shoulder; complicated (eg, total shoulder)* to the CPT Editorial Panel to clearly distinguish between removal of prosthesis and other types of foreign bodies. At the October 2012 CPT meeting, the Editorial Panel approved three new codes, 23333 *Removal of foreign body, shoulder; deep (subfascial or intramuscular)*, 23334 *Removal of prosthesis, includes debridement and synovectomy when performed; humeral or glenoid component* and 23335 *Removal of prosthesis, includes debridement and synovectomy when performed; humeral and glenoid component(s) (eg, total shoulder)* to delineate between removal of foreign body and prosthesis.

Prior to valuing these procedures, the specialty societies presented compelling evidence to justify a change in the physician work value. The physician work and time components of CPT codes 23331 and 23332 were based on the Harvard studies. Since that time, the technique and technology has changed. In the past, humeral prostheses were straight and smooth and the humeral side was typically not cemented, therefore, more easily removed. Cementing techniques, which previously were hand mixed and finger packed, have changed and are now pressurized and vacuum mixed and include the use of devices, such as a centrifuge and distal restrictor. The new technique has made removal more difficult. For components that are not cemented, current design includes metaphyseal fill, which is difficult to remove. Porous coated bone in growth also makes removal difficult since the bone has attached to the stem. In addition, polyethylene wear with resultant osteolysis and bone loss makes prosthesis and cement removal more complicated due to the increased risk of fracture and/or bone attached to the prosthesis. In order to avoid bone loss or fracture, and allow complete removal of cement to avoid infection, specialized equipment such as special osteotomes, high-speed surgical drill and ultrasound are utilized. Given this information, the RUC accepted compelling evidence that the current work RVU of 7.63 for 23331 and 12.37 for 23332 are potentially misvalued.

#### **23333 Removal of foreign body, shoulder; deep (subfascial or intramuscular)**

The RUC reviewed the survey results from 33 orthopedic and hand surgeons and recommended the following physician time components: pre-service time of 60 minutes, intra-service time of 45 minutes and post-service time of 15 minutes. The RUC agreed that 9 minutes of additional pre-service positioning time from the standard pre-service package is warranted to place the patient in the lateral beach chair position.

After review of physician time, the RUC determined that a work RVU of 6.00, the survey 25<sup>th</sup> percentile, is appropriate. The RUC reviewed the key reference service, 20680 *Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)* (work RVU=5.96) and determined that 23333 was more complex and requires more time. The RUC also reviewed CPT codes 25248 *Exploration with removal of deep foreign body, forearm or wrist* (work RVU=5.31) and 27372 *Removal of foreign body, deep, thigh region or knee area* and agreed that the

physician work and complexity of 23333 was greater and therefore should be valued higher. The RUC reviewed and discussed the appropriate number and level of post-operative visits and determined that one half discharge day, 99238, and two office visits, (1) 99212 and (1) 99213 were appropriate. The RUC agreed with the specialty societies that a level three office visit is necessary following this procedure to account for moderate to high complexity of medical decision making relating to wound care, suture removal, pain medication management, assessment of shoulder, elbow and hand function and coordination of rehabilitation. To support the number and level of post-operative visits, the RUC reviewed CPT code 23071 *Excision, tumor, soft tissue of shoulder area, subcutaneous; 3 cm or greater* (work RVU=5.91) which includes identical post-operative visits, and agreed that 23333 is a more complex procedure. **The RUC recommends a work RVU of 6.00 for CPT code 23333.**

***23334 Removal of prosthesis, includes debridement and synovectomy when performed; humeral or glenoid component***

The RUC reviewed survey results from 31 orthopedic and hand surgeons and determined that the survey respondents overestimated the work value at the median level (work RVU= 20.00). To determine an appropriate value, the RUC agreed that a work RVU of 18.89, a direct crosswalk to CPT code 27269 *Open treatment of femoral fracture, proximal end, head, includes internal fixation, when performed* (work RVU=18.89), is appropriate. The time and intensity components of these two services are similar. In addition, the RUC agreed that 12 minutes of additional pre-service positioning time from the standard pre-service package is warranted to either place the patient in the lateral beach chair position or on a radiolucent table for fluoroscopy. The RUC also reviewed CPT code 24363 *Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)* (work RVU=22.00) and determined that this code should be valued slightly higher due to the physician work and complexity. The RUC reviewed and discussed the appropriate number and level of post-operative visits and determined that two level two hospital visits (99232), one discharge day(99238) and four office visits, (1) 99212 and (3) 99213 were appropriate. The specialty society confirmed that the first hospital visit is done on the day of surgery. The survey data confirmed that it is typical for the physician to perform an Evaluation and Management (E/M) service later on the same day of surgery to evaluate wound, complete neuromuscular exam and monitor any potential respiratory issues. The RUC noted that the typical patient is older and presents with an infection, elevated white blood count and inflammatory markers. The surgeon is typically involved in intensive care coordination including managing PICC line and antibiotics with an infectious disease specialist, which can span 4-6 weeks and coordinating physical and occupational therapy. In addition, a musculoskeletal exam on the entire extremity as well as a neurovascular exam will be completed and determining gait pattern for these patients is essential since the extremity will be considered non-weight bearing post-surgery. **The RUC recommends a work RVU of 18.89 for CPT code 23334.**

***23335 Removal of prosthesis, includes debridement and synovectomy when performed; humeral and glenoid component(s) (eg, total shoulder)***

The RUC reviewed the survey results from 32 orthopedic and hand surgeons and determined that a work RVU of 22.13, a direct crosswalk to CPT code 23472 *Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))* (work RVU=22.13) is appropriate. The intra service and total times are identical for these two services and thus substantiates an identical work RVU for both. In addition, the RUC agreed that 12 minutes of additional pre-service positioning time from the standard pre-service package is warranted to either place the patient in the lateral beach chair position or on a radiolucent table for fluoroscopy. The RUC also reviewed MPC code 37215 *Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection* (work RVU=19.68) and agreed that 23335 requires more physician work and complexity, and therefore, should be valued higher. The RUC reviewed and discussed the



appropriate number and level of post-operative visits and determined that two level two hospital visits(99232) one discharge day (99238) and four office visits, (1) 99212 and (3) 99213 were appropriate. The specialty society confirmed that the first hospital visit is done on the day of surgery. The survey data confirmed that it is typical for the physician to perform an E/M service later on the same day of surgery to evaluate wound, complete neuromuscular exam and monitor any potential respiratory issues. The typical patient is older and presents with pain and decreased motion. Although, white blood count is normal, inflammatory markers are elevated. The surgeon is typically involved in intensive care coordination including managing antibiotics and coordinating physical and occupational therapy. In addition, a musculoskeletal exam on the entire extremity and neurovascular exam will be completed as well as assessing motor function determining restrictions since the entire extremity will be considered non-weight bearing post-surgery. **The RUC recommends a work RVU of 22.13 for CPT code 23335.**

#### Practice Expense:

The RUC accepted the direct practice expense inputs with no modifications as approved by the Practice Expense Subcommittee.

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
23330		Removal of foreign body, shoulder; subcutaneous		
●23333	P1	deep (subfascial or intramuscular)	090	6.00
D23331		<del>deep (eg, Neer hemiarthroplasty removal)</del>	090	N/A
D23332		<del>complicated (eg, total shoulder)</del>	090	N/A
●23334	P2	Removal of prosthesis, includes debridement and synovectomy when performed; humeral <b>or</b> glenoid component	090	18.89

●23335	P3	<p>humeral and glenoid component (eg, total shoulder)</p> <p><u>(Do not report 23334, 23335 in conjunction with 23473, 23474 if a prosthesis [ie, humeral and/or glenoid component(s)] is being removed and replaced in the same shoulder during the same surgical session)</u></p> <p><u>(To report removal of hardware, other than humeral and/or glenoid prosthesis, use 20680)</u></p>	090	22.13
<p><b>Repair, Revision, and/or Reconstruction</b></p> <p>23470      Arthroplasty, glenohumeral joint; hemiarthroplasty</p> <p>23472      total shoulder (glenoid and proximal humeral replacement (eg, total shoulder)</p> <p>              (For removal of total shoulder implants, see <del>23331, 23332</del> <u>23334, 23335</u>)</p> <p>23473      Revision of total shoulder arthroplasty, including allograft when performed; humeral <b>or</b> glenoid component</p> <p>23474      humeral <b>and</b> glenoid component</p> <p>              (Do not report 23473, 23474 in conjunction with <del>23331, 23332</del> <u>23334, 23335</u> if a prosthesis [ie, humeral and/or glenoid component(s)] is being removed and replaced in the same shoulder <u>during the same surgical session</u>)</p>				



## AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 23333	Tracking Number P1	Original Specialty Recommended RVU: <b>7.00</b>
		Presented Recommended RVU: <b>6.00</b>
Global Period: 090		RUC Recommended RVU: <b>6.00</b>

CPT Descriptor: Removal of foreign body, shoulder; deep (subfascial or intramuscular)

### CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 19-year-old male is involved in a motor vehicle collision. The windshield is shattered. A large piece of glass pierces the skin on the lateral aspect of the shoulder and is imbedded deep within the deltoid muscle. (Patient sustained no other injuries.) He undergoes removal of the foreign body.

Percentage of Survey Respondents who found Vignette to be Typical: 76%

### Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 36% , In the ASC 64%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 75% , Overnight stay-less than 24 hours 100% , Overnight stay-more than 24 hours 8%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 3%

### Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Review labs, pathology reports and imaging studies. Meet with patient/family to review planned procedure and post-operative management. Review and have patient sign informed consent. Mark surgical site. Review length and type of anesthesia with anesthesiologist. Assure appropriate selection, timing, and administration of antibiotic. Verify that all required instruments and supplies are available. After induction of anesthesia in supine position, assist with lateral beach chair positioning, exposing the shoulder and stabilizing the patient's torso. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Under anesthesia, the small puncture wound is extended proximally and distally. The defect in the deltoid fascia is exposed and opened further. The deltoid muscle is carefully split in line with its fibers, with care to avoid injury to the axillary nerve. The glass fragment is exposed and removed. The wound is irrigated and the deltoid fascia is closed, followed by layered closure of the wound.

Description of Post-Service Work: Hospital - through discharge: The shoulder is immobilized at the patient's side. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Monitor patient stabilization in the recovery room, with a careful neurologic examination of the extremity. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled analgesia. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy. Write prescriptions for medications needed post-discharge. Home restrictions and activity levels are discussed with the patient, family members and discharging nurse. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-op Office Visits: Review interval chart notes. Examine and talk with patient. Assess surgical wound. Remove staples or sutures, when appropriate. Assess neurovascular status, ROM, circulation, sensation, and motor function of the operated extremity. Assess opposite extremity for comparison. Review activity and restrictions. Order occupational therapy. Supervise rehabilitation. Order radiographs, as necessary. Discuss progress with PCP (verbal and written). Assess pain scores and adequacy of analgesia. Dictate progress notes for medical chart.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	01/2013				
<b>Presenter(s):</b>	William Creevy, MD; John Heiner, MD; Anne Miller, MD				
<b>Specialty(s):</b>	orthopaedic surgery; hand surgery				
<b>CPT Code:</b>	23333				
<b>Sample Size:</b>	300	<b>Resp N:</b>	33	<b>Response:</b> 11.0 %	
<b>Sample Type:</b>	Random <b>Additional Sample Information:</b> Members from AAOS and ASSH were randomly selected				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	1.00	2.00	4.00	5.00	20.00
<b>Survey RVW:</b>	5.00	6.00	7.00	4.50	9.00
<b>Pre-Service Evaluation Time:</b>			30.00		
<b>Pre-Service Positioning Time:</b>			15.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			15.00		
<b>Intra-Service Time:</b>	20.00	30.00	45.00	60.00	60.00
<b>Immediate Post Service-Time:</b>	<b>15.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00    99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00    99232x 0.00    99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>19.00</b>	99238x 0.50    99239x 0.00    99217x 0.00			
<b>Office time/visit(s):</b>	<b>39.00</b>	99211x 0.00 12x 1.00 13x 1.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00    55x 0.00    56x 0.00    57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00    99225x 0.00    99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

**Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:**      3 -FAC Straightforward Patient/Difficult Procedure

<b>CPT Code:</b>	23333	<b>Recommended Physician Work RVU: 6.00</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		33.00	33.00	0.00
<b>Pre-Service Positioning Time:</b>		12.00	3.00	9.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		15.00	15.00	0.00
<b>Intra-Service Time:</b>		45.00		
<b>Immediate Post Service-Time:</b>	<b>15.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00    99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00    99232x 0.00    99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>19.00</b>	99238x 0.5    99239x 0.0    99217x 0.00		
<b>Office time/visit(s):</b>	<b>39.00</b>	99211x 0.00 12x 1.00 13x 1.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00    55x 0.00    56x 0.00    57x 0.00		
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00    99225x 0.00    99226x 0.00		

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
20680	090	5.96	RUC Time

CPT Descriptor Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
15823	090	6.81	RUC Time	99,301

CPT Descriptor 1 Blepharoplasty, upper eyelid; with excessive skin weighting down lid

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
21556	090	7.66	RUC Time	3,331

CPT Descriptor 2 Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); less than 5 cm

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
	090		RUC Time

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 14      % of respondents: 42.4 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 23333</b>	<b>Key Reference CPT Code: 20680</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	60.00	65.00	
Median Intra-Service Time	45.00	50.00	
Median Immediate Post-service Time	15.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	39.0	32.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
<b>Median Total Time</b>	<b>178.00</b>	<b>181.00</b>	

Other time if appropriate		
---------------------------	--	--

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.71	2.64
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.57	2.64
--	------	------

Urgency of medical decision making	2.71	2.64
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.14	3.00
--------------------------	------	------

Physical effort required	2.93	2.79
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.07	2.86
---	------	------

Outcome depends on the skill and judgment of physician	2.93	2.89
--	------	------

Estimated risk of malpractice suit with poor outcome	2.71	2.71
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.64	2.62
----------------------------------	------	------

Intra-Service intensity/complexity	2.64	2.62
------------------------------------	------	------

Post-Service intensity/complexity	2.64	2.38
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background – 23333, 23334, 23335**

At the April 2012 RUC meeting, codes 23331, *Removal of foreign body, shoulder; deep (eg, Neer hemiarthroplasty removal)* and 23332, *Removal of foreign body, shoulder; complicated (eg, total shoulder)* were surveyed as family member codes in conjunction with the survey of new CPT codes 23473 and 23474 (revision shoulder arthroplasty). However, during facilitation, RUC members determined that the descriptor for 23331 at the time was problematic because it stated “foreign body removal” as opposed to “prosthetic removal.” It was believed that a surgeon removing any foreign body from the shoulder could have reported 23331. The RUC referred code 23331 to CPT for better delineation between the removal of a prosthesis and other types of foreign bodies.

In October 2012, the CPT Editorial Panel approved revised and renumbered code descriptors for 23331 and 23332 and added a new code for removal of a foreign body – other than hardware or prosthesis:

23333 Removal of foreign body, shoulder; deep (subfascial or intramuscular)

23334 Removal of prosthesis; humeral or glenoid component

23335 Removal of prosthesis; humeral and glenoid component

For removal of hardware other than prosthesis, new guidelines direct codes to use current codes 20670, *Removal of implant; superficial (eg, buried wire, pin or rod) (separate procedure)* and 20680, *Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)*.

### 23333 – Discussion and Recommendation

The AAOS and ASSH conducted a RUC survey and received 33 responses; this is a low volume procedure. We do not believe 23331 was used to report removal of a foreign body other than prosthesis because of the inclusion of "eg, Neer hemiarthroplasty removal" in the descriptor. Orthopaedic surgeons would not equate removal of a foreign body with removal of prosthetic hardware. Therefore, we believe code 23333 is a new code.

**We recommend the survey median RVW of 7.00.** This value compares well with the key reference service and MPC codes.

We recommend Pre-Time Package 3 with the following modification, crosswalked from similar code 23076, *Excision, tumor, soft tissue of shoulder area, subfascial (eg, intramuscular); less than 5 cm*:

- Evaluation: no change
- Positioning: Add 9 minutes (total positioning time=12). After induction of anesthesia in supine position, the patient will be repositioned in beach chair and slightly lateral to expose the shoulder and stabilize the patient's torso.
- Scrub/Dress/Wait: no change

### Comparison to Key Reference Service (20680)

Code 20680, *Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)* requires less total time and would require less intense/complex total physician work than 23333. Implants are not typically associated with contamination as is the case with removal of non-implant foreign body(s). The latter will typically be associated with trauma, where contamination is likely, resulting in additional post-op work. This is seen in the higher level and number of follow-up visits. Intra-operative work will also be more complex, requiring attention to removal of all fragments. Therefore, we believe these maintain a good rank order.

CPT	RVW	IWPUT	total	eval	posit	sdw	intra	sd-post	99238	99213	99212
<b>23333</b>	<b>7.00</b>	<b>0.066</b>	<b>194</b>	<b>33</b>	<b>12</b>	<b>20</b>	<b>45</b>	<b>15</b>	<b>0.5</b>	<b>2</b>	<b>1</b>
<b>20680</b>	<b>5.96</b>	<b>0.056</b>	<b>181</b>	35	15	20	50	15	0.5		2

### Comparison to MPC Codes

CPT	Desc	RVW	total	eval	posit	sdw	intra	sd-post	99238	99213	99212
<b>15823</b>	Revision of upper eyelid	<b>6.81</b>	<b>161</b>	10	1	5	45	10	0.5	1	3
<b>23333</b>	Removal FB deep, shoulder	<b>7.00</b>	<b>194</b>	<b>33</b>	<b>12</b>	<b>20</b>	<b>45</b>	<b>15</b>	<b>0.5</b>	<b>2</b>	<b>1</b>
<b>21556</b>	Exc neck tum deep < 5 cm	<b>7.66</b>	<b>234</b>	33	20	15	60	25	0.5	2	1

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 23331 or 23332

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty orthopaedic surgery                      How often? Rarely

Specialty hand surgery                      How often? Rarely

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national frequency unknown

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 500

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We believe this will be rarely billed as it is an infrequently performed procedure, however, because it is a new code we have no historical data to reference.

Specialty orthopaedic surgery	Frequency 470	Percentage 94.00 %
-------------------------------	---------------	--------------------

Specialty hand surgery	Frequency 30	Percentage 6.00 %
------------------------	--------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? Yes

---

**Professional Liability Insurance Information (PLI)**

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 23472



**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 23334      Tracking Number P2      Original Specialty Recommended RVU: **20.00**  
 Presented Recommended RVU: **18.89**  
 Global Period: 090      RUC Recommended RVU: **18.89**

CPT Descriptor: Removal of prosthesis; humeral or glenoid component

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 64-year-old female is 8 months following a cemented shoulder hemi-arthroplasty for a proximal humerus fracture. She has pain, decreased motion, and drainage from the wound. The WBC and inflammatory markers are elevated. Radiographs show minimal lucency at the bone cement interface. She undergoes removal of the humeral component, removal of all the cement in the medullary canal, with joint debridement and synovectomy.

Percentage of Survey Respondents who found Vignette to be Typical: 87%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 13% , Overnight stay-more than 24 hours 87%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 71%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Write preadmission orders for preoperative medications. Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs. Reexamine patient to make sure that physical findings have not changed and update H&P. Meet with patient and family to review planned procedure and post-operative management. Review informed consent with patient. Verify that all required instruments and supplies are available, including intraoperative imaging/fluoroscopy for documentation. An estimate of the appropriate size component is determined by templating of the joint with radiographs. Monitor/assist with patient positioning - position the patient on a radiolucent table for fluoroscopy or in the beach chair position with adequate room for portable x-ray. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Under anesthesia, the previous deltopectoral incision is opened from the mid-clavicle to the junction to the mid-third of the humerus. The deltopectoral interval is opened allowing identification of the conjoined tendon. Careful protection around neurovascular structures during the case including the axillary and musculocutaneous nerve is accomplished. The subscapularis tendon is divided, tagged and mobilized. A wide capsular release is performed for exposure and mobilization of the proximal humerus. Synovial fluid and soft tissue specimens are sent for gram stain, culture, and pathology. Dislocation of the shoulder is performed with intra-operative inspection and assessment of the humeral component and glenoid articular cartilage. Extensive scar tissue is excised. Extraction instruments are used to remove the humeral component. Meticulous preparation and cleaning of the humeral canal, including removal of the fibrous membrane and all of the cement is performed. Bone specimens are sent for culture and pathology. The joint is debrided and the hypertrophic synovium is excised. The wound is irrigated with liters of antibiotic fluid. The subscapularis is repaired. The deltopectoral groove is closed, followed by closure of the subcutaneous tissues and skin.

Description of Post-Service Work: Hospital - through discharge from recovery room: The shoulder is immobilized at the patient's side. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Monitor patient stabilization in the recovery room, with a careful neurologic examination of the extremity to ensure that no brachial plexus injury has occurred during surgery. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled analgesia. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to orthopaedic floor and discuss ongoing care with floor nurses.

Hospital visits: Review interval chart notes. Discuss ongoing care with floor nurses. Examine patient, assess neurologic status, check wounds, and change dressings. Monitor physiotherapy and assess range of motion progress. Assess opposite extremity for comparison. Write orders assistive exercise, indicating avoidance of passive stretching of the shoulder. Educate the patient regarding arm movements to prevent possible dislocation of the prosthetic shoulder. Write orders for progression to active exercise depending on the quality of the rotator cuff tissues and the adequacy of the rotator cuff repair. Assess pain scores and adequacy of analgesia. Review nursing/other staff patient chart notes. Write orders for films and continued antibiotic medications, as necessary. Chart patient progress notes. Answer patient and family questions. Answer nursing/other staff questions.

Hospital Discharge Management: Review interval chart notes. Examine patient, assess neurologic status and check wounds. Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy. Write prescriptions for medications needed post-discharge. Home restrictions and activity levels are discussed with the patient, family members and discharging nurse. All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

Post-op Office Visits: Review interval chart notes. Examine and talk with patient. Assess surgical wound. Remove staples or sutures, when appropriate. Assess neurovascular status, ROM, circulation, sensation, and motor function of the operated extremity. Assess opposite extremity for comparison. Review activity and restrictions. Order occupational therapy. Supervise rehabilitation. Order radiographs, as necessary. Discuss progress with PCP (verbal and written). Assess pain scores and adequacy of analgesia. Dictate progress notes for medical chart.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	01/2013				
<b>Presenter(s):</b>	William Creevy, MD; John Heiner, MD; Anne Miller, MD				
<b>Specialty(s):</b>	orthopaedic surgery; hand surgery				
<b>CPT Code:</b>	23334				
<b>Sample Size:</b>	300	<b>Resp N:</b>	31	<b>Response:</b> 10.3 %	
<b>Sample Type:</b>	Random <b>Additional Sample Information:</b> 300 members from AAOS and ASSH were randomly selected.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	1.00	<b>4.00</b>	9.00	30.00
<b>Survey RVW:</b>	10.00	15.50	<b>20.00</b>	22.30	26.00
<b>Pre-Service Evaluation Time:</b>			<b>60.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>20.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>20.00</b>		
<b>Intra-Service Time:</b>	60.00	90.00	<b>120.00</b>	180.00	240.00
<b>Immediate Post Service-Time:</b>	<b>20.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00    99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>80.00</b>	99231x 0.00    99232x 2.00    99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>38.00</b>	99238x 1.00    99239x 0.00    99217x 0.00			
<b>Office time/visit(s):</b>	<b>85.00</b>	99211x 0.00 12x 1.00 13x 3.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00    55x 0.00    56x 0.00    57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00    99225x 0.00    99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

4 - FAC Difficult Patient/Difficult Procedure

<b>CPT Code:</b>	23334	<b>Recommended Physician Work RVU: 18.89</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		40.00	40.00	0.00
<b>Pre-Service Positioning Time:</b>		15.00	3.00	12.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		20.00	20.00	0.00
<b>Intra-Service Time:</b>		120.00		
<b>Immediate Post Service-Time:</b>	<b>20.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00    99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>80.00</b>	99231x 0.00    99232x 2.00    99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>38.00</b>	99238x 1.0    99239x 0.0    99217x 0.00		
<b>Office time/visit(s):</b>	<b>85.00</b>	99211x 0.00 12x 1.00 13x 3.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00    55x 0.00    56x 0.00    57x 0.00		
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00    99225x 0.00    99226x 0.00		

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
27269	090	18.89	RUC Time

CPT Descriptor Open treatment of femoral fracture, proximal end, head, includes internal fixation, when performed**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
37215	090	19.68	RUC Time	8,472

CPT Descriptor 1 Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
24363	090	22.00	RUC Time	1,006

CPT Descriptor 2 Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
	090		RUC Time

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 8      % of respondents: 25.8 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 23334</b>	<b>Key Reference CPT Code: 27269</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	75.00	60.00	
Median Intra-Service Time	120.00	125.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	80.0	80.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	85.0	71.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

<b>Median Total Time</b>	<b>418.00</b>	<b>404.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.63	3.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.13	3.75
Urgency of medical decision making	3.50	3.38

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.25	3.88
Physical effort required	4.25	3.88

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.88	3.50
Outcome depends on the skill and judgment of physician	4.38	4.00
Estimated risk of malpractice suit with poor outcome	3.75	3.63

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.75	3.75
Intra-Service intensity/complexity	4.38	4.00
Post-Service intensity/complexity	3.75	3.63

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background – 23333, 23334, 23335**

At the April 2012 RUC meeting, codes 23331, Removal of foreign body, shoulder; deep (eg, Neer hemiarthroplasty removal) and 23332, Removal of foreign body, shoulder; complicated (eg, total shoulder) were surveyed as family member codes in conjunction with the survey of new CPT codes 23473 and 23474 (revision shoulder arthroplasty). However, during facilitation, RUC members determined that the descriptor for 23331 at the time was problematic because it stated “foreign body removal” as opposed to “prosthetic removal.” It was believed that a surgeon removing any foreign body from the shoulder could have reported 23331. The RUC referred code 23331 to CPT for better delineation between the removal of a prosthesis and other types of foreign bodies.

In October 2012, the CPT Editorial Panel approved revised and renumbered code descriptors for 23331 and 23332 and added a new code for removal of a foreign body – other than hardware or prosthesis:

23333 Removal of foreign body, shoulder; deep (subfascial or intramuscular)

23334 Removal of prosthesis; humeral or glenoid component

23335 Removal of prosthesis; humeral and glenoid component

For removal of hardware other than prosthesis, new guidelines direct codes to use current codes 20670, Removal of implant; superficial (eg, buried wire, pin or rod) (separate procedure) and 20680, Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate).

### **23334 – Compelling Evidence for Change in Work RVU**

1. *Evidence that incorrect assumptions were made in the previous valuation of the service, such as a misleading vignette, survey and/or crosswalk assumptions in a previous evaluation.*
  - Code 23334 is a new code that replaces the current code 23331 which, as drafted, was intended to be used for the removal of a single component shoulder prosthesis. Harvard data indicate that only the intra-service time was surveyed (n=11), using the code descriptor as written in 1988 "Removal of foreign body, shoulder; deep (eg, Neer prosthesis removal)" as the Harvard survey vignette. Medicare frequency in 1993 was 215. In 1988, both Medicare and national frequency for single shoulder arthroplasty component removal would have been extremely low. In addition, there would not have been many surgeons familiar with shoulder arthroplasty removal of one or both components. We believe that the 11 general orthopaedic surgeons who participated in the Harvard review of intra-service time may not have been familiar with this procedure. Further, the consensus panel surgeons that Harvard used to review families of codes within and across specialties, would also not likely have been familiar with this procedure. This question of "fitness to rate" is compelling evidence that the Harvard time and visit data may be flawed.
2. *Change in physician work due to more than one of the following: technique, knowledge/technology, patient population, site-of-service, length of hospital stay, physician time.*
  - Technique and technology
    - Older versions of humeral prostheses were straight and smooth. Also, the humeral side was often uncemented and more easily removed. For those prostheses that were cemented, the cement was finger packed and removal was not complicated. Current cementing is very different; using pressurized cementing techniques (ie, vacuum mixed, centrifuge, pressurized, distal restrictor) that make removal more difficult.
    - For un-cemented components, current prosthesis design (eg, curved, metaphyseal fill, porous coated bone in growth) makes prosthesis removal difficult since the bone has attached to the stem.
    - Polyethylene wear with resultant osteolysis and bone loss makes prosthesis and cement removal more complicated, due to the risk of fracture and/or bone attached to the prosthesis.
    - Technical aspects of prosthesis and/or cement removal are more complex with the intent to limit bone loss or fracture and allow complete removal of cement to avoid infection. Specialized equipment is typically required (eg, special osteotomes, MidasRex, ultrasound).
  - Physician time and length of hospital stay

- There has been a clear increase in physician time, including significant increases in the intra-service time, as well as increased post-procedure visits – both number and level. Harvard data for 23331 implies an overnight stay (0.5x99231, 1.0x99238), which is not true now, nor was this true in 1988. This incorrect estimation of post-op work by algorithm for a low volume code resulted in an under estimation of total physician work.

### 23334 – Discussion and Recommendation

The AAOS and ASSH conducted a RUC survey and received 31 responses.

**We recommend the survey median RVW of 20.00.** This value compares well with the key reference service and MPC and other similar codes.

We recommend Pre-Time Package 4 with the following modification, crosswalked from similar major open shoulder procedures (eg, 23410-23420, 23472-23474)

- Evaluation: no change
- Positioning: Add 12 minutes (total positioning time=15). After induction of anesthesia in supine position, the patient will be repositioned in beach chair and slightly lateral to expose the shoulder, stabilize the patient's torso, and be certain there is adequate access to imaging equipment and electric instruments.
- Scrub/Dress/Wait: no change

### Comparison to Key Reference Service (27269)

Code 27269, *Open treatment of femoral fracture, proximal end, head, includes internal fixation, when performed* requires similar intra-time and similar total time compared with 23334, although there are differences in numbers and levels of post-op visits. Both procedures require dissection to a major joint and dislocation of the joint for repair. Survey code 23334 requires the additional complexity of extraction of the implant prior to repair and closure. The patient undergoing 23334 is more likely to be older with osteoporosis, compared with the typical patient undergoing 27269 (ie, trauma in an otherwise healthy individual). Follow-up therapy and ROM issues will also be greater in the patient undergoing 23334. Pre-service work for 27269 will typically be less than for 23334 because the typical patient is trauma/urgent. In summary, the recommended RVW of 20.00 is correctly greater than 27269.

CPT	RVW	IWPUT	total	eval	posit	sdw	intra	sd-post	99232	99231	99238	99213	99212
<b>23334</b>	<b>20.00</b>	<b>0.089</b>	<b>418</b>	<b>40</b>	<b>15</b>	<b>20</b>	<b>120</b>	<b>20</b>	<b>2</b>		<b>1</b>	<b>3</b>	<b>1</b>
<b>27269</b>	<b>18.89</b>	<b>0.084</b>	<b>404</b>	<b>25</b>	<b>15</b>	<b>20</b>	<b>125</b>	<b>30</b>	<b>1</b>	<b>2</b>	<b>1</b>	<b>1</b>	<b>3</b>

### Comparison to MPC and Other Codes

CPT		RVW	total	eval	posit	sdw	intra	sd-post	-32	-31	-38	-13	-12
<b>37215 MPC</b>	Transcath stent cca w/eps	<b>19.68</b>	<b>347</b>	<b>60</b>	<b>15</b>	<b>15</b>	<b>103</b>	<b>30</b>	<b>1</b>		<b>1</b>	<b>2</b>	
<b>23334</b>	Remove one part shoulder prosthesis	<b>20.00</b>	<b>418</b>	<b>40</b>	<b>15</b>	<b>20</b>	<b>120</b>	<b>20</b>	<b>2</b>		<b>1</b>	<b>3</b>	<b>1</b>
<b>23472 RUC-12</b>	Total shoulder arthroplasty	<b>22.13</b>	<b>448</b>	<b>40</b>	<b>15</b>	<b>20</b>	<b>140</b>	<b>30</b>	<b>1</b>	<b>2</b>	<b>1</b>	<b>3</b>	<b>1</b>

### SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

☐  
☐

The surveyed code is an add-on code or a base code expected to be reported with an add-on code.  
 Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.

- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 23331

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty orthopaedic surgery                      How often? Rarely

Specialty hand surgery                      How often? Rarely

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national frequency unknown

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 500

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We believe this will be rarely billed as it is an infrequently performed procedure, however, because it is a new code we have no historical data to reference.

Specialty orthopaedic surgery                      Frequency 470                      Percentage 94.00 %

Specialty hand surgery                      Frequency 30                      Percentage 6.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

## Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number



If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 23472

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 23335      Tracking Number P3      Original Specialty Recommended RVU: **23.00**  
 Presented Recommended RVU: **22.13**  
 Global Period: 090      RUC Recommended RVU: **22.13**

CPT Descriptor: Removal of prosthesis; humeral and glenoid component

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 72-year-old male is 3 years following a total shoulder arthroplasty for osteoarthritis. She presents with pain and decreased motion. The WBC is normal and inflammatory markers are elevated. Radiographs show minimal lucency at the bone cement interface of the humeral component. He undergoes removal of the humeral and glenoid components, removal of all the cement, with joint debridement and synovectomy.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 9% , Overnight stay-more than 24 hours 91%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 69%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Write preadmission orders for preoperative medications. Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs. Reexamine patient to make sure that physical findings have not changed and update H&P. Meet with patient and family to review planned procedure and post-operative management. Review informed consent with patient. Verify that all required instruments and supplies are available, including intraoperative imaging/fluoroscopy for documentation. An estimate of the appropriate size component is determined by templating of the joint with radiographs. Monitor/assist with patient positioning - position the patient on a radiolucent table for fluoroscopy or in the beach chair position with adequate room for portable x-ray. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Under anesthesia, a deltopectoral incision is made from the mid clavicle to the junction to the mid-third of the humerus. The deltopectoral interval is opened allowing identification of the conjoined tendon. Careful protection around neurovascular structures during the case including the axillary and musculocutaneous nerve is accomplished. The subscapularis tendon is divided, tagged and mobilized. A wide capsular release is performed for exposure and mobilization of the proximal humerus. Synovial fluid and soft tissue specimens and sent for gram stain, culture, and pathology. Dislocation of the shoulder components is performed with intraoperative inspection and assessment of the humeral and glenoid components. Extensive scar tissue is excised. Extraction instruments are used to remove the humeral and glenoid components. Meticulous preparation and cleaning of the humeral canal, including removal of the fibrous membrane and all of the cement is performed. Meticulous preparation and cleaning of the glenoid, including removal of the fibrous membrane and all of the cement is performed. Bone specimens are sent for culture and pathology. The joint is debrided and the hypertrophic synovium is excised. The wound is irrigated with liters of antibiotic fluid. The subscapularis is repaired. The deltopectoral groove is closed, followed by closure of the subcutaneous tissues and skin.

Description of Post-Service Work: Hospital - through discharge from recovery room: Apply sterile dressings. The shoulder is immobilized at the patient's side. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Monitor patient stabilization in the recovery room, with a careful neurologic examination of the extremity to ensure that no brachial plexus injury has occurred during surgery. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled analgesia. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to orthopaedic floor and discuss ongoing care with floor nurses.

Hospital visits: Review interval chart notes. Discuss ongoing care with floor nurses. Examine patient, assess neurologic status, check wounds, and change dressings. Monitor physiotherapy and assess range of motion progress. Assess opposite extremity for comparison. Write orders assistive exercise, indicating avoidance of passive stretching of the shoulder. Educate the patient regarding arm movements to prevent possible dislocation of the prosthetic shoulder. Write orders for progression to active exercise depending on the quality of the rotator cuff tissues and the adequacy of the rotator cuff repair. Assess pain scores and adequacy of analgesia. Review nursing/other staff patient chart notes. Write orders for films and continued antibiotic medications, as necessary. Chart patient progress notes. Answer patient and family questions. Answer nursing/other staff questions.

Hospital Discharge Management: Review interval chart notes. Examine patient, assess neurologic status, check wounds, and change dressings. Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy. Write prescriptions for medications needed post-discharge. Home restrictions and activity levels are discussed with the patient, family members and discharging nurse. All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

Post-op Office Visits: Review interval chart notes. Examine and talk with patient. Assess surgical wound. Remove staples or sutures, when appropriate. Assess neurovascular status, ROM, circulation, sensation, and motor function of the operated extremity. Assess opposite extremity for comparison. Redress wound. Review activity and restrictions. Order occupational therapy. Supervise rehabilitation. Order radiographs, as necessary. Discuss progress with PCP (verbal and written). Assess pain scores and adequacy of analgesia. Dictate progress notes for medical chart.

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)		01/2013			
Presenter(s):	William Creevy, MD; John Heiner, MD; Anne Miller, MD				
Specialty(s):	orthopaedic surgery; hand surgery				
CPT Code:	23335				
Sample Size:	300	Resp N:	32	Response: 10.6 %	
Sample Type:	Random randomly selected	Additional Sample Information: Members of AAOS and ASSH were			
		Low	25 <sup>th</sup> pctl	Median*	75 <sup>th</sup> pctl
Service Performance Rate		0.00	2.00	5.00	11.00
Survey RVW:		12.40	19.00	23.00	28.50
Pre-Service Evaluation Time:				60.00	
Pre-Service Positioning Time:				20.00	
Pre-Service Scrub, Dress, Wait Time:				20.00	
Intra-Service Time:		70.00	120.00	140.00	180.00
Immediate Post Service-Time:	30.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	80.00	99231x 0.00	99232x 2.00	99233x 0.00	
Discharge Day Mgmt:	38.00	99238x 1.00	99239x 0.00	99217x 0.00	
Office time/visit(s):	85.00	99211x 0.00	12x 1.00	13x 3.00	14x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	0.00	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	23335	Recommended Physician Work RVU: 22.13			
		Specialty Recommended Pre- Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:		40.00	40.00	0.00	
Pre-Service Positioning Time:		15.00	3.00	12.00	
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00	
Intra-Service Time:		140.00			
Immediate Post Service-Time:	<u>30.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>80.00</u>	99231x 0.00	99232x 2.00	99233x 0.00	
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>85.00</u>	99211x 0.00	12x 1.00	13x 3.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
23472	090	22.13	RUC Time

CPT Descriptor Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
24363	090	22.00	RUC Time	1,006

CPT Descriptor 1 Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
	090		RUC Time	

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
	090		RUC Time

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code:** 11      **% of respondents:** 34.3 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 23335</b>	<b>Key Reference CPT Code: 23472</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	75.00	75.00	
Median Intra-Service Time	140.00	140.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	80.0	80.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	85.0	85.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

<b>Median Total Time</b>	<b>448.00</b>	<b>448.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.64
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.27	3.55
Urgency of medical decision making	3.82	3.45

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.55	4.00
Physical effort required	4.45	4.00

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.45	3.91
Outcome depends on the skill and judgment of physician	4.45	4.09
Estimated risk of malpractice suit with poor outcome	4.09	4.00

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.27	3.73
Intra-Service intensity/complexity	4.36	4.00
Post-Service intensity/complexity	4.00	3.64

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background – 23333, 23334, 23335**

At the April 2012 RUC meeting, codes 23331, Removal of foreign body, shoulder; deep (eg, Neer hemiarthroplasty removal) and 23332, Removal of foreign body, shoulder; complicated (eg, total shoulder) were surveyed as family member codes in conjunction with the survey of new CPT codes 23473 and 23474 (revision shoulder arthroplasty). However, during facilitation, RUC members determined that the descriptor for 23331 at the time was problematic because it stated “foreign body removal” as opposed to “prosthetic removal.” It was believed that a surgeon removing any foreign body from the shoulder could have reported 23331. The RUC referred code 23331 to CPT for better delineation between the removal of a prosthesis and other types of foreign bodies.

In October 2012, the CPT Editorial Panel approved revised and renumbered code descriptors for 23331 and 23332 and added a new code for removal of a foreign body – other than hardware or prosthesis:

23333 Removal of foreign body, shoulder; deep (subfascial or intramuscular)

23334 Removal of prosthesis; humeral or glenoid component

23335 Removal of prosthesis; humeral and glenoid component

For removal of hardware other than prosthesis, new guidelines direct codes to use current codes 20670, Removal of implant; superficial (eg, buried wire, pin or rod) (separate procedure) and 20680, Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate).

### **23335 – Compelling Evidence for Change in Work RVU**

1. *Evidence that incorrect assumptions were made in the previous valuation of the service, such as a misleading vignette, survey and/or crosswalk assumptions in a previous evaluation.*
  - Code 23335 is a new code that replaces the current code 23332 which, as drafted, was intended to be used for the removal of both components of a shoulder prosthesis. Harvard data indicate that only the intra-service time was surveyed (n=10), using the code descriptor as written in 1988 "Removal of foreign body, shoulder; complicated, including 'total shoulder'" as the Harvard survey vignette. Medicare frequency in 1993 was 149. In 1988, both Medicare and national frequency for total shoulder arthroplasty removal would have been extremely low. In addition, there would not have been many surgeons familiar with shoulder arthroplasty removal of one or both components. We believe that the 10 general orthopaedic surgeons who participated in the Harvard review of intra-service time may not have been familiar with this procedure. Further, the consensus panel surgeons that Harvard used to review families of codes within and across specialties, would also not likely have been familiar with this procedure. This question of "fitness to rate" is compelling evidence that the physician work from the Harvard study may be flawed. In addition, since 23335 was only surveyed for intra-time and post time was calculated by algorithm and then visits were imputed by Dunn for practice expense purposes based on the calculated times, we believe there is compelling evidence that the total work does not reflect correct post-op work.
2. *Change in physician work due to more than one of the following: technique, knowledge/technology, patient population, site-of-service, length of hospital stay, physician time.*
  - Technique and technology
    - Older versions of humeral prostheses were straight and smooth. Also, the humeral side was often uncemented and more easily removed. For those prostheses that were cemented, the cement was finger packed and removal was not complicated. Current cementing is very different; using pressurized cementing techniques (ie, vacuum mixed, centrifuge, pressurized, distal restrictor) that make removal more difficult.
    - For un-cemented components, current prosthesis design (eg, curved, metaphyseal fill, porous coated bone in growth) makes prosthesis removal difficult since the bone has attached to the stem.
    - Polyethylene wear with resultant osteolysis and bone loss makes prosthesis and cement removal more complicated, due to the risk of fracture and/or bone attached to the prosthesis.
    - Technical aspects of prosthesis and/or cement removal are more complex with the intent to limit bone loss or fracture and allow complete removal of cement to avoid infection. Specialized equipment is typically required (eg, special osteotomes, MidasRex, ultrasound).

--Physician time

- There has been an increase in physician intra-time and intensity of follow-up visits. Harvard estimation of post-op work by algorithm for a low volume code resulted in an incorrect estimation of total physician work.

### 23335 – Discussion and Recommendation

The AAOS and ASSH conducted a RUC survey and received 32 responses.

**We recommend the survey median RVW of 23.00.** This value compares well with the key reference service and MPC and other similar codes.

We recommend Pre-Time Package 4 with the following modification, crosswalked from similar major open shoulder procedures (eg, 23410-23420, 23472-23474)

- Evaluation: no change
- Positioning: Add 12 minutes (total positioning time=15). After induction of anesthesia in supine position, the patient will be repositioned in beach chair and slightly lateral to expose the shoulder, stabilize the patient's torso, and be certain there is adequate access to imaging equipment and electric instruments.
- Scrub/Dress/Wait: no change

### Comparison to Key Reference Service (23472)

Code 23472, *Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))* requires the same intra-time and the same total time. The intra-operative complexity and intensity for 23335 will be greater than 23472 because significant attention is required to remove the prosthesis and all cement, but maintain as much bone as possible for subsequent reconstruction. Additional complexity is also performed related to altered surgical field and adhesions from the prior surgery, which may involve neurovascular structures. A recommendation of 23.00 places 23335 in correct rank order with 23472

CPT	RVW	IWPUT	total	eval	posit	sdw	intra	sd-post	99232	99231	99238	99213	99212
<b>23335</b>	<b>23.00</b>	<b>0.096</b>	<b>448</b>	<b>40</b>	<b>15</b>	<b>20</b>	<b>140</b>	<b>20</b>	<b>2</b>		<b>1</b>	<b>3</b>	<b>1</b>
<b>23472</b>	<b>22.13</b>	<b>0.089</b>	<b>448</b>	40	15	20	140	30	1	2	1	3	1

### Comparison to MPC and Other Codes

CPT		RVW	total	eval	posit	sdw	intra	sd-post	-32	-31	-38	-13	-12
<b>37215 MPC</b>	Transcath stent cca w/eps	<b>19.68</b>	<b>347</b>	<b>60</b>	<b>15</b>	<b>15</b>	<b>103</b>	<b>30</b>	<b>1</b>		<b>1</b>	<b>2</b>	
<b>24160</b>	<i>Remove total elbow prosthesis</i>	<b>20.50</b>	<b>405</b>	<b>40</b>	<b>12</b>	<b>20</b>	<b>120</b>	<b>30</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>3</b>	<b>1</b>
<b>24363 RUC-12</b>	Total elbow arthroplasty	<b>22.00</b>	<b>445</b>	40	12	20	140	30	1	2	1	3	1
<b>23472 RUC-12</b>	Total shoulder arthroplasty	<b>22.13</b>	<b>448</b>	40	15	20	140	30	1	2	1	3	1
<b>23335</b>	<i>Removal total shoulder prosthesis</i>	<b>23.00</b>	<b>448</b>	<b>40</b>	<b>15</b>	<b>20</b>	<b>140</b>	<b>30</b>	<b>2</b>		<b>1</b>	<b>3</b>	<b>1</b>

### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.



- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 23332

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty orthopaedic surgery                      How often? Rarely

Specialty hand surgery                      How often? Rarely

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national frequency unknown

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 500

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We believe this will be rarely billed as it is an infrequently performed procedure, however, because it is a new code we have no historical data to reference.

Specialty orthopaedic surgery                      Frequency 470                      Percentage 94.00 %

Specialty hand surgery                      Frequency 30                      Percentage 6.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

## Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 23472

ISSUE: Shoulder Prosthesis Removal

					RVW					TOT	PRE			INTRA			FAC-inpt/same day					OFFICE									
	CPT	DESC			Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	P-SD	33	32	31	38	39	15	14	13	12	11

REF	20680	Removal of implant; deep (eg, buried w	14	0.056		5.96		181	35	15	15		50		15		0.5	2					
	23333	new																					
SVY	23333	Removal of foreign body, shoulder; dee	33	0.066	5.00	6.00	7.00	7.50	9.00	194	30	15	15	20	30	45	60	60	15		0.5	1	2
REC	23333	Median RVW		0.054		6.00		178	33	12	15		45		15		0.5	1	1				

REF	27269	Open treatment of femoral fracture, pro	8	0.084			18.89			404	25	15	20			125			30		1	2.0	1.0				1	3
Hvd	23331	Removal of foreign body, shoulder; dee		0.032			7.63			273	25		25			88			23			1	1.0					4
SVY	23334	Removal of prosthesis; humeral or gler	31	0.085	10.00	15.50	20.00	22.30	26.00	443	60	20	20	60	90	120	180	240	20		2		1.0				3	1
REC	23334	Median RVW		0.080			18.89			418	40	15	20			120			20		2		1.0				3	1

REF	23472	Arthroplasty, glenohumeral joint; total s	11	0.089			22.13			448	40	15	20			140			30		1	2.0	1.0				3	1
Hvd	23332	Removal of foreign body, shoulder; cor		0.031			12.37			410	30	0	25			129			26			5	1.0					4.5
SVY	23335	Removal of prosthesis; humeral and gl	32	0.092	12.40	19.00	23.00	28.50	35.00	473	60	20	20	70	120	140	180	300	30		2		1.0				3	1
REC	23335	Median RVW		0.090			22.13			448	40	15	20			140			30		2		1.0				3	1

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor:

23333, Removal of foreign body, shoulder; deep (subfascial or intramuscular)

23334, Removal of prosthesis; humeral or glenoid component

23335, Removal of prosthesis; humeral and glenoid component

Global Period: 090

Meeting Date: 01/2013

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: A consensus expert panel committee was convened and reviewed the procedures under review. The consensus panel recommends standard 090 facility inputs for the codes.

If you have provided any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale: Consensus committee reviewed current PE details as comparison codes for both the existing and the new codes as these are the most relevant to the existing and new code descriptors.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Standard pre-service clinical labor activities for 090-day global facility codes

Intra-Service Clinical Labor Activities:

Standard intra-service clinical labor activities for 090-day global facility codes- half-day discharge for 23333 and full-day discharge for 23334 and 23335.

Post-Service Clinical Labor Activities:

Standard post-service clinical labor activities for 090-day global facility codes

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1				Survey Code		Reference Code		Survey Code		Reference Code		Survey Code		Reference Code	
2				23333		20680		23334		27269		23335		23473	
3	Meeting Date: January 2013 Tab: Tab 6 Specialty: AAOS, ASSH	CMS Code	Staff Type	Removal of foreign body, shoulder; deep (subfascial or intramuscular)		Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)		Removal of prosthesis; humeral or glenoid component		Open treatment of femoral fracture, proximal end, head, includes internal fixation, when performed		Removal of prosthesis; humeral and glenoid component		Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			090	090	090	090	090	090	090	090	090	090	090	090
6	TOTAL CLINICAL LABOR TIME		RN/LPN/MTA	N/A	129	N/A	120	N/A	207	N/A	189	N/A	207	N/A	207
7	TOTAL PRE-SERV CLINICAL LABOR TIME		RN/LPN/MTA	N/A	60	N/A	60	N/A	60	N/A	60	N/A	60	N/A	60
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		RN/LPN/MTA	N/A	6	N/A	6	N/A	12	N/A	12	N/A	12	N/A	12
9	TOTAL POST-SERV CLINICAL LABOR TIME		RN/LPN/MTA	N/A	63	N/A	54	N/A	135	N/A	117	N/A	135	N/A	135
10	PRE-SERVICE														
11	Start: Following visit when decision for surgery or procedure made														
12	Complete pre-service diagnostic & referral forms		RN/LPN/MTA		5		5		5		5		5		5
13	Coordinate pre-surgery services		RN/LPN/MTA		20		20		20		20		20		20
14	Schedule space and equipment in facility		RN/LPN/MTA		8		8		8		8		8		8
15	Provide pre-service education/obtain consent		RN/LPN/MTA		20		20		20		20		20		20
16	Follow-up phone calls & prescriptions		RN/LPN/MTA		7		7		7		7		7		7
18	End: When patient enters office/facility for surgery/procedure														
19	SERVICE PERIOD														
20	Start: When patient enters office/facility for surgery/procedure:														
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)		RN/LPN/MTA	n/a	6	n/a	6	n/a	12	n/a	12	n/a	12	n/a	12
42	End: Patient leaves office														
43	POST-SERVICE Period														
44	Start: Patient leaves office/facility														
46	Office visits: List Number and Level of Office Visits			# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits
47	99211 16 minutes		16												
48	99212 27 minutes		27		1		2		1		3		1		1
49	99213 36 minutes		36		1				3		1		3		3
50	99214 53 minutes		53												
51	99215 63 minutes		63												
52	Total Office Visit Time		RN/LPN/MTA	0	63	0	54	0	135	0	117	0	135	0	135
54	End: with last office visit before end of global period														
55	MEDICAL SUPPLIES			CODE	UNIT										
56	pack, minimum multi-specialty visit	SA048	pack		2		2		4		4		4		4
57	pack, post-op incision care (staple)	SA052	pack												
58	pack, post-op incision care (suture & staple)	SA053	pack		1		1		1		1		1		1
59	EQUIPMENT			CODE											
60	table, power	EF031	10		63		54		135		117		135		135
61	light, exam	EQ168	10		63		54		135		117		135		135

## AMA/Specialty Society RVS Update Committee Summary of Recommendations

January 2013

### Elbow Prosthesis Removal

In April 2012, the RUC referred CPT Code 24160 *Removal of prosthesis, includes debridement and synovectomy when performed; humeral and ulnar components* to the CPT Editorial Panel to revise the descriptor to clearly indicate “prosthetic removal”. At the October 2012 CPT meeting, the Editorial Panel revised the code descriptor for 24160 and 24164 *Removal of prosthesis, includes debridement and synovectomy when performed; humeral and ulnar component; radial head* to describe “prosthesis” versus “implant”.

Prior to valuing these procedures, the specialty societies presented compelling evidence to justify a change in the physician work value. The physician work and time components of CPT codes 24160 and 24164 were valued in the Harvard studies. Since that time, the technique and technology has changed. In the past, humeral prostheses were straight and smooth and the humeral side was typically not cemented, therefore, more easily removed. Cementing techniques have changed and are now pressurized and vacuum mixed and include the use of devices, such as a centrifuge and distal restrictor as opposed to hand mixed and finger packed. The new technique has made removal more difficult. For components that are not cemented, current design which includes metaphyseal fill, porous coated bone in growth also makes removal difficult since the bone has attached to the stem. In addition, polyethylene wear with resultant osteolysis and bone loss makes prosthesis and cement removal more complicated due to the increased risk of fracture and/or bone attached to the prosthesis. In order to avoid bone loss or fracture and allow complete removal of cement to avoid infection, specialized equipment such as special osteotomes, high-speed surgical drill and ultrasound are utilized. In addition, older versions of radial head implants were typically silastic and a single unit with a tapered stem. The flexible prosthesis made removal from the lateral elbow fairly straightforward. Current radial head prostheses are modular titanium implants with longer, wider and cylindrical stems. They are not flexible, thus, removal is a more difficult, complex and longer procedure. Additional soft tissue release is necessary to permit subluxation of the radius relative to the capitellum to allow extraction of the implant. The capsule and tendon insertion are then repaired back to the bone. Given this information, the RUC accepted compelling evidence that the current work RVU of 8.00 for 24160 and 6.43 for 24164 are potentially misvalued.

#### ***24160 Removal of prosthesis, includes debridement and synovectomy when performed; humeral and ulnar components***

The RUC reviewed survey results from 30 orthopedic and hand surgeons and recommended the following physician time components: pre-service time of 72 minutes, intra-service time of 120 minutes and immediate post-service time of 30 minutes. The RUC agreed that 9 minutes of additional pre-service positioning time is warranted to either place the patient in the lateral decubitus position.

After review of the physician time, the RUC determined that a value of 18.63, the survey 25<sup>th</sup> percentile is appropriate. The RUC compared 24160 to key reference service 24363 *Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)* (work RVU=22.00) and determined that the reference code has an additional 40 minutes of total time, justifying the higher work RVU. The RUC also reviewed CPT codes 21242 *Arthroplasty, temporomandibular joint, with allograft* (work RVU=14.59), 24077 *Radical resection of tumor (eg, malignant neoplasm), soft tissue of upper arm or elbow area; less than 5 cm* (work RUV=15.72) and 23466 *Capsulorrhaphy, glenohumeral joint, any type multi-directional instability* (work RVU=15.80) and determined that 24160 is a more complex procedure. The typical patient is older and presents with pain and infection, typically resulting in cement removal and joint debridement. The RUC reviewed and discussed the appropriate number and level of post-operative visits and determined that two hospital visits, (1) 99231 and (1)99232, one discharge day (99238) and four office visits, (1) 99212 and (3) 99213 were appropriate. The specialty society confirmed that the first hospital visit is done on the day of surgery. The survey data confirmed that it is typical for the physician to perform an Evaluation and Management (E/M) service later on the same day of surgery to evaluate wound, complete neuromuscular exam and monitor any potential respiratory issues. The RUC noted that the typical patient is older and presents with pain, decreased motion and wound drainage. The surgeon is typically involved in intensive care coordination with the primary care provider and relating to physical and occupational therapy. In addition, the physician will complete a musculoskeletal exam on the entire extremity as well as a neurovascular exam. Determining a gait pattern for these patients is essential since the extremity will be considered non-weight bearing post-surgery. **The RUC recommends a work RVU of 18.63 for CPT code 24160.**

***24164 Removal of prosthesis, includes debridement and synovectomy when performed; humeral and ulnar component; radial head***

The RUC reviewed the survey results from orthopedic and hand surgeons and recommended the following physician time components: pre-service time of 60 minutes, intra-service time of 60 minutes and immediate post-service time of 20 minutes. The RUC agreed that 9 minutes of additional pre-service positioning time is warranted to either place the patient in the lateral decubitus position.

After review of the physician time, the RUC determined that a work RVU of 10.00, the survey 25<sup>th</sup> percentile, is appropriate. The RUC noted that this is a low volume procedure with 89 claims reported in 2011, which explains the low survey response. The RUC compared 24164 to key reference service 23430 *Tenodesis of long tendon of biceps* (work RVU=10.17) and determined that these two services should be valued similarly since the intra service time is the same with similar complexity. The RUC also reviewed MPC 60220 *Total thyroid lobectomy, unilateral; with or without isthmusectomy* (work RVU=11.19) and agreed that since this procedure requires more total time and complexity, it should be valued higher. The RUC reviewed and discussed the appropriate number and level of post-operative visits and determined that one half of a discharge day (99238) and three office visits (99213) were appropriate. The surgeon is typically involved in intensive care coordination with the primary care provider and relating to physical and occupational therapy. In addition, the physician will complete a musculoskeletal exam on the entire extremity as well as a neurovascular exam. Determining a gait pattern for these patients is essential since the extremity will be considered non-weight bearing post-surgery. The RUC also agreed that 9 minutes of additional pre-service positioning time is warranted to either place the patient in the lateral decubitus position. **The RUC recommends a work RVU of 10.00 for CPT code 24164.**

**Practice Expense:**

The direct practice expense inputs were accepted without modification as approved by the Practice Expense Subcommittee.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲24160	Q1	<p><del>Implant removal, elbow joint</del> Removal of prosthesis, includes debridement and synovectomy when performed; humeral and ulnar components</p> <p><u>(To report removal of foreign body, elbow, see 24200, 24201)</u></p> <p><u>(To report removal of hardware from the distal humerus or proximal ulna, other than humeral and ulnar prosthesis, use 20680)</u></p> <p>(Do not report 24160 in conjunction with 24370 or 24371 if a prosthesis [ie, humeral and/or ulnar component(s)] is being removed and replaced in the same elbow <u>during the same surgical session</u>)</p>	090	18.63
▲24164	Q2	<p>radial head</p> <p><u>(To report removal of foreign body, elbow, see 24200, 24201)</u></p> <p><u>(To report removal of hardware from proximal radius, other than radial head prosthesis, use 20680)</u></p>	090	10.00
<b>Repair, Revision, and/or Reconstruction</b>				



24360	Arthroplasty, elbow; with membrane (eg, fascial)
24361	with distal humeral prosthetic replacement
24362	with implant and fascia lata ligament reconstruction
24363	with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)
	(For revision of total elbow implant, see 24370, 24371)
24370	Revision of total elbow arthroplasty, including allograft when performed; humeral or ulnar component
24371	humeral and ulnar component
(Do not report 24370, 24371 in conjunction with 24160 if a prosthesis [ie, humeral and/or ulnar component(s)] is being removed and replaced in the same elbow)	

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 24160	Tracking Number Q1	Original Specialty Recommended RVU: <b>20.50</b>
		Presented Recommended RVU: <b>18.63</b>
Global Period: 090		RUC Recommended RVU: <b>18.63</b>

CPT Descriptor: Removal of prosthesis; humeral and ulnar components

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 73-year-old female is 8 months following a total elbow arthroplasty for rheumatoid arthritis. She presents with pain, decreased motion, and wound drainage. She undergoes removal of the humeral and ulnar components, removal of all the cement, with joint debridement and synovectomy.

Percentage of Survey Respondents who found Vignette to be Typical: 83%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 10% , Overnight stay-more than 24 hours 90%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 57%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Write preadmission orders for preoperative medications. Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs. Reexamine patient to make sure that physical findings have not changed and update H&P. Meet with patient and family to review planned procedure and post-operative management. Review informed consent with patient. Verify that all required instruments and supplies are available, including intraoperative imaging/fluoroscopy for documentation. Ensure that an array of implants is available for possible use in the operating room. An estimate of the appropriate size component is determined by templating of the joint with radiographs. Monitor/assist with patient positioning in a lateral decubitus position. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Under anesthesia, a posterior elbow incision is made. The ulnar nerve is identified for protection throughout the dissection. The triceps and extensor mechanism are released from their insertion on the ulna and then displaced in a radial direction. The elbow joint is exposed and scar tissue is excised and contractures released from the humerus and ulna for exposure and soft tissue balancing. Extraction instruments are used to remove the loose humeral and ulnar components, along with the fibrous membrane and all the cement. The wound is irrigated with liters of antibiotic fluid. The tourniquet is released, hemostasis is obtained, and the triceps tendon is re-approximated to the proximal ulna. The remainder of the extensor mechanism is approximated, subcutaneous tissue approximated, and the skin is closed.

Description of Post-Service Work: Hospital - through discharge from recovery room: Apply sterile dressings and splint. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Monitor patient stabilization in the recovery room, with a careful neurologic examination of the extremity. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled analgesia. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in

chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Call referring physician(s). Write orders for transferring to orthopaedic floor and discuss ongoing care with floor nurses.

Hospital visits: Review interval chart notes. Discuss ongoing care with floor nurses. Examine patient, assess neurologic status, check wounds, and change dressings. Monitor physiotherapy and assess range of motion progress. Assess opposite extremity for comparison. Write orders assistive exercise. Educate the patient regarding arm movements to prevent possible dislocation of the prosthetic elbow. Write orders for progression to active exercise. Assess pain scores and adequacy of analgesia. Review nursing/other staff patient chart notes. Write orders for films and continued antibiotic medications, as necessary. Chart patient progress notes. Answer patient and family questions. Answer nursing/other staff questions.

Hospital Discharge Management: Review interval chart notes. Examine patient, assess neurologic status, check wounds, and change dressings. Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy. Write prescriptions for medications needed post-discharge. Home restrictions and activity levels are discussed with the patient, family members and discharging nurse. All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

Post-op Office Visits: Review interval chart notes. Examine and talk with patient. Assess surgical wound. Remove staples and sutures, when appropriate. Assess neurovascular status, ROM, circulation, sensation, and motor function of the operated extremity. Assess opposite extremity for comparison. Redress wound. Review activity and restrictions. Order occupational therapy. Supervise rehabilitation. Order radiographs, as necessary. Discuss progress with PCP (verbal and written). Assess pain scores and adequacy of analgesia. Dictate progress notes for medical chart.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	01/2013				
<b>Presenter(s):</b>	William Creevy, MD; John Heiner, MD; Anne Miller, MD				
<b>Specialty(s):</b>	orthopaedic surgery; hand surgery				
<b>CPT Code:</b>	24160				
<b>Sample Size:</b>	300	<b>Resp N:</b>	30	<b>Response:</b> 10.0 %	
<b>Sample Type:</b>	Random <b>Additional Sample Information:</b> Members from AAOS and ASSH were randomly selected.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	1.00	<b>3.00</b>	4.00	20.00
<b>Survey RVW:</b>	15.00	18.63	<b>20.50</b>	24.00	25.50
<b>Pre-Service Evaluation Time:</b>			<b>60.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>20.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>20.00</b>		
<b>Intra-Service Time:</b>	70.00	90.00	<b>120.00</b>	180.00	300.00
<b>Immediate Post Service-Time:</b>	<b>30.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>60.00</b>	99231x 1.00	99232x 1.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>38.00</b>	99238x 1.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>85.00</b>	99211x 0.00	12x 1.00	13x 3.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

4 - FAC Difficult Patient/Difficult Procedure

<b>CPT Code:</b>	24160	<b>Recommended Physician Work RVU: 18.63</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>40.00</b>	<b>40.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>12.00</b>	<b>3.00</b>	<b>9.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>20.00</b>	<b>20.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>120.00</b>		
<b>Immediate Post Service-Time:</b>	<b>30.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>60.00</b>	99231x 1.00	99232x 1.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>38.00</b>	99238x 1.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>85.00</b>	99211x 0.00	12x 1.00	13x 3.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
24363	090	22.00	RUC Time

CPT Descriptor Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
37215	090	19.68	RUC Time	8,472

CPT Descriptor 1 Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
24363	090	22.00	RUC Time	1,006

CPT Descriptor 2 Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
	090		RUC Time

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 10      % of respondents: 33.3 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 24160</b>	<b>Key Reference CPT Code: 24363</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	72.00	72.00	
Median Intra-Service Time	120.00	140.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	60.0	80.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	85.0	85.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

<b>Median Total Time</b>	<b>405.00</b>	<b>445.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.30	4.10
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.40	4.00
Urgency of medical decision making	4.10	3.90

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.60	4.60
Physical effort required	4.50	4.30

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.80	4.60
Outcome depends on the skill and judgment of physician	4.80	4.60
Estimated risk of malpractice suit with poor outcome	4.40	4.30

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.50	4.30
Intra-Service intensity/complexity	4.70	4.70
Post-Service intensity/complexity	4.10	3.90

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background – 24160, 24164**

At the April 2012 RUC meeting, code 24160, Implant removal; elbow joint was surveyed as a family member code in conjunction with the survey of new CPT codes 24370 and 24371 (revision elbow arthroplasty). However, during facilitation, RUC members determined that the descriptor for 24160 at the time was problematic because it stated “implant removal” as opposed to “prosthetic removal.” It was believed that a surgeon removing any hardware or prosthetic component from the shoulder could have reported 24160. The RUC referred code 24160 to CPT for better delineation between the removal of a prosthesis and other types of implants. The AAOS and ASSH added 24164, Implant removal; radial head to the CPT proposal for revised descriptors.

In October 2012, the CPT Editorial Panel approved revised code descriptors for 24160 and 24164:

24160 Removal of prosthesis; humeral **and** ulnar components

24164 Removal of prosthesis; radial head

For removal of hardware other than prosthesis, new guidelines direct codes to use current codes 20670, Removal of implant; superficial (eg, buried wire, pin or rod) (separate procedure) and 20680, Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate).

### 24160 – Compelling Evidence for Change in Work RVU

1. *Evidence that incorrect assumptions were made in the previous valuation of the service, such as a misleading vignette, survey and/or crosswalk assumptions in a previous evaluation.*
  - Code 24160, as drafted, was intended to be used for the removal of a total elbow prosthesis. Harvard data indicate that only the intra-service time was surveyed (n=12), using the code descriptor as written in 1988 "Implant removal, elbow joint" as the Harvard survey vignette. Medicare frequency in 1993 was 108. In 1988, both Medicare and national frequency for total elbow arthroplasty removal would have been extremely low. In addition, there would not have been many surgeons familiar with total elbow arthroplasty removal. We believe that the 12 general orthopaedic surgeons who participated in the Harvard review of intra-service time may not have been familiar with this procedure. Further, the consensus panel surgeons that Harvard used to review families of codes within and across specialties, would also not likely have been familiar with this procedure. This question of "fitness to rate" is compelling evidence that the Harvard time and visit data may be flawed.
2. *Change in physician work due to more than one of the following: technique, knowledge/technology, patient population, site-of-service, length of hospital stay, physician time.*
  - Technique and technology
    - Older versions of total elbow prostheses were most often straight and smooth. For those prostheses that were cemented, the cement was finger packed and removal was less complicated. Current cement fixation is different; pressurized cementing techniques (ie, vacuum mixed, centrifuge, pressurized, distal restrictor) make removal more difficult.
    - When cement fixation is not used, current prosthesis design (eg, curved, metaphyseal fill, porous coated bone in growth) makes prosthesis removal difficult since the bone has attached to the stem.
    - Polyethylene wear with resultant osteolysis and bone loss makes prosthesis and cement removal more complicated due to the risk of fracture and/or bone attached to the prosthesis.
    - Technical aspects of prosthesis and/or cement removal are more complex with the intent to limit bone loss or fracture and allow complete removal of cement to avoid infection. Specialized equipment is typically required (eg, special osteotomes, MidasRex, ultrasound).
  - Physician time and length of hospital stay
    - There has been a clear increase in physician time, including significant increases in the intra-service time, as well as additional post-procedure visits – both number and level. Harvard data for 24160 implies same day discharge with no additional hospital visits (1.0x99238), which is not true now, nor was this true in 1988. This

incorrect estimation of post-op work by algorithm for a very low volume code resulted in a incorrect value for total physician work.

### 24160 – Discussion and Recommendation

The AAOS and ASSH conducted a RUC survey and received 30 responses. We believe the Harvard review of 24160 intra-service time (Hvd N=12) and incorrect estimation of post-op work resulted in an underestimation of total physician work. The CMS website 2011 Medicare utilization file indicates 397 cases. Of this total, 175 cases or 44% included an assistant at surgery.

**We recommend the survey median RVW of 20.50.** This value compares well with the key reference service and MPC and other similar codes.

We recommend Pre-Time Package 4 with the following modification, crosswalked from similar major open elbow procedures (eg, 24363, 24370, 24371)

- Evaluation: no change
- Positioning: Add 9 minutes (total positioning time=12). After induction of anesthesia in supine position, the patient will be repositioned lateral and stabilized.
- Scrub/Dress/Wait: no change

### Comparison to Key Reference Service (24363)

Code 24363, *Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)* requires slightly more intra-time and slightly more total time compared with 24160. Although code 24363 requires more intra-operative time, survey code 24160 requires additional complexity related to extraction of the prosthesis with retention of as much bone as possible, plus the extra work related to scarring and adhesions from prior surgery. In summary, the recommended RVW of 20.50 is appropriately less than 24363.

CPT	RVW	IWPUT	total	eval	posit	sdw	intra	sd-post	99232	99231	99238	99213	99212
<b>24160</b>	<b>20.50</b>	<b>0.097</b>	<b>405</b>	<b>40</b>	<b>12</b>	<b>20</b>	<b>120</b>	<b>30</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>3</b>	<b>1</b>
<b>24363</b>	<b>22.00</b>	<b>0.089</b>	<b>445</b>	40	12	20	140	30	1	2	1	3	1

### Comparison to MPC and Other Codes

CPT		RVW	total	eval	posit	sdw	intra	sd-post	-32	-31	-38	-13	-12
<b>37215 MPC</b>	Transcath stent cca w/eps	19.68	347	60	15	15	103	30	1		1	2	
<b>24160</b>	<i>Remove total elbow prosthesis</i>	<b>20.50</b>	<b>405</b>	<b>40</b>	<b>12</b>	<b>20</b>	<b>120</b>	<b>30</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>3</b>	<b>1</b>
<b>24363 RUC-12</b>	Total elbow arthroplasty	<b>22.00</b>	<b>445</b>	40	12	20	140	30	1	2	1	3	1
<b>23472 RUC-12</b>	Total shoulder arthroplasty	<b>22.13</b>	<b>448</b>	40	15	20	140	30	1	2	1	3	1
<b>233X3</b>	<i>Removal total shoulder prosthesis</i>	<b>23.00</b>	<b>448</b>	<b>40</b>	<b>15</b>	<b>20</b>	<b>140</b>	<b>30</b>	<b>2</b>		<b>1</b>	<b>3</b>	<b>1</b>

### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.



- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.  
☐ Multiple codes are used to maintain consistency with similar codes.  
☐ Historical precedents.  
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 24160

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
 If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty orthopaedic surgery                      How often? Rarely

Specialty hand surgery                      How often? Rarely

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national frequency unknown

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 100

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. CMS Website: 2011 Medicare final utilization for 24160 subtracting the total number of total elbow arthroplasty revision codes we are assuming, starting in FY 2013, will be performed which is roughly 160 (243X1 and 243X2) because those will no longer will be billed under 24160 leaving approximately 100 implant removals done stand-alone.

Specialty orthopaedic surgery                      Frequency 78                      Percentage 78.00 %

Specialty hand surgery                      Frequency 21                      Percentage 21.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

## Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 24363

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 24164	Tracking Number Q2	Original Specialty Recommended RVU: <b>10.00</b>
		Presented Recommended RVU: <b>10.00</b>
Global Period: 090		RUC Recommended RVU: <b>10.00</b>

CPT Descriptor: Removal of prosthesis; radial head

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 47-year-old male is 4 years following a radial head replacement for a radial head fracture and elbow dislocation. He presents with lateral elbow pain and slight decreased motion. Radiographs show loosening around the implant stem, with narrowing of the joint space between the implant and capitellum. He undergoes removal of the radial head prosthesis, joint debridement, and synovectomy.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 30% , In the ASC 70%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 50% , Overnight stay-less than 24 hours 33% , Overnight stay-more than 24 hours 17%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 5%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Write preadmission orders for preoperative medications. Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs. Reexamine patient to make sure that physical findings have not changed and update H&P. Meet with patient and family to review planned procedure and post-operative management. Review informed consent with patient. Verify that all required instruments and supplies are available, including intraoperative imaging/fluoroscopy for documentation. Ensure that an array of implants is available for possible use in the operating room. An estimate of the appropriate size component is determined by templating of the joint with radiographs. Monitor/assist with patient positioning in a lateral decubitus position. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Under anesthesia, an incision is made over the anterolateral aspect of the elbow. The dissection is brought through the subcutaneous tissue. The interval between the anconeus and extensors is divided. The capsule is incised over the lateral aspect of the elbow. Synovial fluid and soft tissue are sent for gram stain, culture and pathology. Dissection is made around the radial head implant and proximal radial shaft. The implant is removed. The medullary canal of the radius is debrided. The capitellum is exposed and the joint debrided; hypertrophic synovium is excised. The elbow is tested for stability. The joint is irrigated. The tourniquet is released and hemostasis obtained. The capsule, fascia, subcutaneous tissue and skin are closed.

Description of Post-Service Work: Hospital - through discharge: Apply sterile dressings. The shoulder is immobilized at the patient's side. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Monitor patient stabilization in the recovery room, with a careful neurologic examination of the extremity. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled

analgesia. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Write orders for follow-up, post-discharge labs, x-rays, home care, and physical therapy. Write prescriptions for medications needed post-discharge. Home restrictions and activity levels are discussed with the patient, family members and discharging nurse. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-op Office Visits: Review interval chart notes. Examine and talk with patient. Assess surgical wound. Remove staples or sutures, when appropriate. Assess neurovascular status, ROM, circulation, sensation, and motor function of the operated extremity. Assess opposite extremity for comparison. Redress wound. Review activity and restrictions. Order occupational therapy. Supervise rehabilitation. Order radiographs, as necessary. Discuss progress with PCP (verbal and written). Assess pain scores and adequacy of analgesia. Dictate progress notes for medical chart.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	01/2013				
<b>Presenter(s):</b>	William Creevy, MD; John Heiner, MD; Anne Miller, MD				
<b>Specialty(s):</b>	orthopaedic surgery; hand surgery				
<b>CPT Code:</b>	24164				
<b>Sample Size:</b>	300	<b>Resp N:</b>	20	<b>Response:</b> 6.6 %	
<b>Sample Type:</b>	Random <b>Additional Sample Information:</b> Members from AAOS and ASSH were randomly selected.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	1.00	<b>2.00</b>	2.00	6.00
<b>Survey RVW:</b>	8.00	10.00	<b>11.50</b>	13.25	15.00
<b>Pre-Service Evaluation Time:</b>			<b>45.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>15.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>15.00</b>		
<b>Intra-Service Time:</b>	40.00	45.00	<b>60.00</b>	68.00	120.00
<b>Immediate Post Service-Time:</b>	<b>20.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>19.00</b>	99238x 0.50	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>69.00</b>	99211x 0.00	12x 0.00	13x 3.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

**Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:** 3 -FAC Straightforward Patient/Difficult Procedure

<b>CPT Code:</b>	24164	<b>Recommended Physician Work RVU: 10.00</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>33.00</b>	<b>33.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>12.00</b>	<b>3.00</b>	<b>9.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>15.00</b>	<b>15.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>60.00</b>		
<b>Immediate Post Service-Time:</b>	<b>20.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>19.00</b>	99238x 0.5	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>69.00</b>	99211x 0.00	12x 0.00	13x 3.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
23430	090	10.17	RUC Time

CPT Descriptor Tenodesis of long tendon of biceps**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
14060	090	9.23	RUC Time	95,046

CPT Descriptor 1 Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
60220	090	11.19	RUC Time	8,829

CPT Descriptor 2 Total thyroid lobectomy, unilateral; with or without isthmusectomy

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
	090		RUC Time

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 7      % of respondents: 35.0 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 24164</b>	<b>Key Reference CPT Code: 23430</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	60.00	60.00	
Median Intra-Service Time	60.00	60.00	
Median Immediate Post-service Time	20.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	69.0	78.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
<b>Median Total Time</b>	<b>228.00</b>	<b>237.00</b>	

Other time if appropriate		
---------------------------	--	--

**INTENSITY/COMPLEXITY MEASURES (Mean)**(of those that selected Key  
Reference code)**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.71	2.71
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.71	2.71
--	------	------

Urgency of medical decision making	2.43	2.43
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.86	3.14
--------------------------	------	------

Physical effort required	2.71	3.00
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.00	2.71
---	------	------

Outcome depends on the skill and judgment of physician	2.86	3.14
--	------	------

Estimated risk of malpractice suit with poor outcome	3.00	2.86
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.57	2.71
----------------------------------	------	------

Intra-Service intensity/complexity	2.86	2.86
------------------------------------	------	------

Post-Service intensity/complexity	3.00	2.29
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background – 24160, 24164**

At the April 2012 RUC meeting, code 24160, *Implant removal; elbow joint* was surveyed as a family member code in conjunction with the survey of new CPT codes 24370 and 24371 (revision elbow arthroplasty). However, during

facilitation, RUC members determined that the descriptor for 24160 at the time was problematic because it stated “implant removal” as opposed to “prosthetic removal.” It was believed that a surgeon removing any hardware or prosthetic component from the shoulder could have reported 24160. The RUC referred code 24160 to CPT for better delineation between the removal of a prosthesis and other types of implants. The AAOS and ASSH added 24164, Implant removal; radial head to the CPT proposal for revised descriptors.

In October 2012, the CPT Editorial Panel approved revised code descriptors for 24160 and 24164:

24160 Removal of prosthesis; humeral **and** ulnar components

24164 Removal of prosthesis; radial head

For removal of hardware other than prosthesis, new guidelines direct codes to use current codes 20670, Removal of implant; superficial (eg, buried wire, pin or rod) (separate procedure) and 20680, Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate).

### **24164 – Compelling Evidence for Change in Work RVU**

1. *Evidence that incorrect assumptions were made in the previous valuation of the service, such as a misleading vignette, survey and/or crosswalk assumptions in a previous evaluation.*
  - Code 24164, as drafted, was intended to be used for the removal of a radial head prosthesis. Harvard data indicate that only the intra-service time was surveyed (n=14), using the code descriptor as written in 1988 "Implant removal, radial head" as the Harvard survey vignette. Medicare frequency in 1993 was 30. In 1988, both Medicare and national frequency for radial head prosthesis removal would have been extremely low. In addition, there would not have been many surgeons familiar with radial head prosthesis removal. We believe that the 14 general orthopaedic surgeons who participated in the Harvard review of intra-service time may not have been familiar with this procedure. Further, the consensus panel surgeons that Harvard used to review families of codes within and across specialties, would also not likely have been familiar with this procedure. This question of "fitness to rate" is compelling evidence that the Harvard time and visit data may be flawed.
2. *Change in physician work due to more than one of the following: technique, knowledge/technology, patient population, site-of-service, length of hospital stay, physician time.*

#### **--Technique and technology**

- Older versions of radial head implants were typically silastic and a single unit with a tapered stem; removal was fairly straightforward because the flexible prosthesis was easily removed from the lateral elbow.
- Current radial head prostheses are modular metallic (e.g. titanium) implants with longer, wider and cylindrical stems. They are not flexible. Thus removal of the prosthesis is more a difficult, complex and longer procedure; more extensive soft tissue release (capsule and extensor origin) is necessary to permit subluxation of the radius relative to the capitellum to allow extraction of the implant. The capsule and tendon insertion are then repaired back to the bone.

#### **--Physician time and length of hospital stay**

- There has been a clear increase in physician intra-time from the Harvard estimation. Harvard data for 24164 implies an overnight stay (0.5x99231, 1.0x99238), which is now described as "outpatient" and assigned 0.5x99238 per CMS policy. The incorrect estimation of post-op office work by algorithm along with incorrect estimation of intra-time for a very low volume code resulted in an incorrect estimation of total physician work.

### **24164 – Discussion and Recommendation**

The AAOS and ASSH conducted a RUC survey and received 20 responses. We believe the Harvard review of 24164 intra-service time (Hvd N=14) and misestimation of post-op work resulted in an underestimation of total physician work.



**We recommend the survey 25<sup>th</sup> percentile RVW of 10.00.** This value compares well with the key reference service and MPC and other similar codes.

We recommend Pre-Time Package 3 with the following modification, crosswalked from similar open elbow procedures (eg, 23430, 24071, 24152)

- Evaluation: no change
- Positioning: Add 9 minutes (total positioning time=12). After induction of anesthesia in supine position, the patient will be repositioned lateral and stabilized. A tourniquet is applied.
- Scrub/Dress/Wait: no change

### Comparison to Key Reference Service (23430)

Code 23430, *Tenodesis of long tendon of biceps* requires the same intra-time and similar total time compared with 24164. Both procedures are typically performed on non-elderly patients. Post-op work for the elbow procedure will include less visits, but at a higher level because the patient requires more attention to therapy and range of motion compared with the shoulder procedure. In summary, the recommended RVW of 10.00 is appropriately similar to 23430.

CPT	RVW	IWPUT	total	eval	posit	sdw	intra	sd-post	99238	99213	99212
<b>24164</b>	<b>10.00</b>	<b>0.081</b>	<b>228</b>	<b>33</b>	<b>12</b>	<b>15</b>	<b>60</b>	<b>20</b>	<b>0.5</b>	<b>3</b>	
<b>23430</b>	<b>10.17</b>	<b>0.084</b>	<b>237</b>	<b>33</b>	<b>12</b>	<b>15</b>	<b>60</b>	<b>20</b>	<b>0.5</b>	<b>2</b>	<b>2</b>

### Comparison to MPC Codes

CPT	DESC	RVW	total	eval	posit	sdw	intra	sd-post	-38	-13	-12
<b>14060 MPC</b>	Adjacent tissue transfer	<b>9.23</b>	<b>183</b>	<b>15</b>	<b>10</b>	<b>5</b>	<b>60</b>	<b>15</b>		<b>2</b>	<b>2</b>
<b>24164</b>	<i>Remove radial head prosthesis</i>	<b>10.00</b>	<b>228</b>	<b>33</b>	<b>12</b>	<b>15</b>	<b>60</b>	<b>20</b>	<b>0.5</b>	<b>3</b>	
<b>60220 MPC</b>	Partial removal of thyroid	<b>11.19</b>	<b>267</b>	<b>40</b>	<b>12</b>	<b>20</b>	<b>90</b>	<b>40</b>	<b>0.5</b>	<b>2</b>	

### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.  
☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.  
☐ Multiple codes allow flexibility to describe exactly what components the procedure included.  
☐ Multiple codes are used to maintain consistency with similar codes.  
☐ Historical precedents.  
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

---

### FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 24164

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty orthopaedic surgery                      How often? Rarely

Specialty hand surgery                      How often? Rarely

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national frequency unknown

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 92 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. CMS Website: 2011 Medicare final utilization for 24164.

Specialty orthopaedic surgery                      Frequency 68                      Percentage 73.91 %

Specialty hand surgery                      Frequency 24                      Percentage 26.08 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 23430

ISSUE: Elbow Prosthesis Removal

						RVW					TOT	PRE			INTRA			FAC-inpt/same day					OFFICE						
	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	P-SD	33	32	31	38	39	15	14	13	12	11

REF	24363	Arthroplasty, elbow; with distal humeru	10	0.089		22.00		445	40	12	20		140		30	1	2.0	1.0		3	1					
	24160	Implant removal; elbow joint		0.049		8.00		242	24		25		78		21			1.0			3.5					
SVY	24160	Removal of prosthesis; humeral and ul	30	0.092	15.00	18.63	20.50	24.00	25.50	433	60	20	20	70	90	120	180	300	30		1	1	1.0		3	1
REC		25th RVW		0.082		18.63		405	40	12	20		120		30	1	1	1.0			3	1				

REF	23430	Tenodesis of long tendon of biceps	7	0.084		10.17		237	33	12	15		60		20		0.5	2	2					
Hvd	24164	Implant removal; radial head		0.051		6.43		203	19		25		45		18	1	1.0		3					
SVY	24164	Removal of prosthesis; radial head	20	0.101	8.00	10.00	11.50	13.25	15.00	243	45	15	15	40	45	60	68	120	20		0.5			3
REC		25th RVW		0.081		10.00		228	33	12	15		60		20		0.5		3					

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor:

24160, Removal of prosthesis; humeral and ulnar components

24164, Removal of prosthesis; radial head

Global Period: 090

Meeting Date: 01/2013

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: A consensus expert panel committee was convened and reviewed the procedures under review. The consensus panel compared the current PE details for 24160, and 24164 and determined no changes beyond changes in post-operative service time where the level and/or number of post-operative office visits were warranted. Otherwise, standard 090 facility inputs were used.

If you have provided any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale: Consensus committee reviewed current PE details as comparison codes for both the existing and the new codes as these are the most relevant to the existing and new code descriptors.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Standard pre-service clinical labor activities for 090-day global facility codes

Intra-Service Clinical Labor Activities:

Standard intra-service clinical labor activities for 090-day global facility codes- half-day discharge for 24164 and full-day discharge for 24160.

Post-Service Clinical Labor Activities:

Standard post-service clinical labor activities for 090-day global facility codes

	A	B	C	D	E	F	G	H	I	J	K
1				Survey Code		Reference Code		Survey Code		Reference Code	
2				24160		24160 PEAC 2002		24164		24164 PEAC 2002	
3	Meeting Date: January 2013 Tab: 7 Specialty: AAOS, ASSH	CMS Code	Staff Type	Removal of prosthesis; humeral and ulnar components		Implant removal; elbow joint		Removal of prosthesis; radial head		Implant removal; radial head	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			090	090	090	090	090	090	090	090
6	TOTAL CLINICAL LABOR TIME		RN/LPN/MTA	N/A	207	N/A	167	N/A	174	N/A	147
7	TOTAL PRE-SERV CLINICAL LABOR TIME		RN/LPN/MTA	N/A	60	N/A	60	N/A	60	N/A	60
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		RN/LPN/MTA	N/A	12	N/A	12	N/A	6	N/A	6
9	TOTAL POST-SERV CLINICAL LABOR TIME		RN/LPN/MTA	N/A	135	N/A	95	N/A	108	N/A	81
10	PRE-SERVICE										
11	Start: Following visit when decision for surgery or procedure made										
12	Complete pre-service diagnostic & referral forms		RN/LPN/MTA		5		5		5		5
13	Coordinate pre-surgery services		RN/LPN/MTA		20		20		20		20
14	Schedule space and equipment in facility		RN/LPN/MTA		8		8		8		8
15	Provide pre-service education/obtain consent		RN/LPN/MTA		20		20		20		20
16	Follow-up phone calls & prescriptions		RN/LPN/MTA		7		7		7		7
18	End: When patient enters office/facility for surgery/procedure										
19	SERVICE PERIOD										
20	Start: When patient enters office/facility for surgery/procedure:										
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)		RN/LPN/MTA	n/a	12	n/a	12	n/a	6	n/a	6
42	End: Patient leaves office										
43	POST-SERVICE Period										
44	Start: Patient leaves office/facility										
46	Office visits: List Number and Level of Office Visits			# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits
47	99211 16 minutes		16								
48	99212 27 minutes		27		1		3.5				3
49	99213 36 minutes		36		3				3		
50	99214 53 minutes		53								
51	99215 63 minutes		63								
52	Total Office Visit Time		RN/LPN/MTA	0	135	0	95	0	108	0	81
54	End: with last office visit before end of global period										
55	MEDICAL SUPPLIES			CODE	UNIT						
56	pack, minimum multi-specialty visit	SA048	pack		4		4		3		3
57	pack, post-op incision care (staple)	SA052	pack				1				
58	pack, post-op incision care (suture & staple)	SA053	pack		1				1		1
59	EQUIPMENT			CODE							
60	table, power	EF031	10		135		95		108		81
61	light, exam	EQ168	10		135				108		81

## AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2013

### Transcatheter Aortic Valve Replacement

In February 2012, the CPT Editorial Panel deleted four Category III code (0256T-0259T) and approved nine codes to report transcatheter aortic valve replacement procedures.

In April 2012, the RUC thoroughly discussed the unique nature of these services to understand and assign the appropriate valuation. First, the members noted that these services require two physicians, an interventional cardiologist and a cardiothoracic surgeon, be actively working on the patient during these procedures. Each operator has distinctly required work, which are specific to the operator's skill set, and are not duplicative between the two. For these reasons, the CMS National Coverage Determination (NCD) mandates that two physicians be present for this procedure to be completed. Second, the RUC recognized the intense nature of these procedures. Patients eligible for these procedures have previously been turned down for aortic valve replacement surgery and are receiving these procedures as a last resort. The NCD further mandates this patient population and there are currently no indications that these procedures will be approved for otherwise operable patients in the future. Finally, the RUC noted that the recommendations made by the Committee will value the total work of the service. Physician time includes the clock time of the procedure and does not constitute the addition of each physician's time. Payment policy issues, related to the co-surgery modifier and resulting payment modifications, were not determined, as it is outside the purview of the RUC. The RUC understands that CMS will consider these issues when implementing the new code family.

Prior to surveying, the specialty societies obtained approval from the Research Subcommittee to conduct an alternative methodology for surveying these services. To ensure the complete work of both physicians was captured, each survey was conducted concurrently by a thoracic surgeon and an interventional cardiologist.

In April 2012 the RUC reviewed and recommended a work RVU of 40.00 for CPT code 33366 *Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical approach (eg, left thoracotomy)*. However, this service did not receive FDA approval prior to publication of CPT and it was carrier priced and published in CPT 2013 as Category III CPT code 0318T *Implantation of catheter-delivered prosthetic aortic heart valve, open thoracic approach, (eg, transapical, other transaortic)*. FDA approval was received in November 2012 as a result, the Society of Thoracic Surgeons (STS), the American College of Cardiology (ACC) and the Society for Cardiac Angiography and Interventions (SCAI) submitted a coding proposal to CPT to convert Category III code 0318T to a Category I code, 33366 for CPT 2014. CPT code 33366 has the same descriptor, vignette and work descriptions that were surveyed and reviewed by the RUC at the April 2012 meeting. **In April 2013, the RUC reaffirmed its April 2012 recommendation of 40.00 work RVUs for CPT code 33366.**

April 2012 RUC Recommendation:

**33366 Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical approach (eg, left thoracotomy)**

The RUC reviewed the survey data from 31 thoracic surgeons and cardiologists and agreed with the specialty that the appropriate physician time components for this procedure are as follows: pre-service time = 85 minutes, intra-service time = 195 minutes and post-service time = 45 minutes. This time represents the procedure time and does not duplicate the time spent by each physician. Agreed with the addition of 22 minutes of pre-service time to account for the time each physician spends separately obtaining consent and reviewing the procedure with the patient. Additionally, there is greater positioning time because the patient must be positioned for each contingency of the procedure. The RUC also assigned one critical care code (99291) to this 000 day global service as the patient is cared for in the inpatient setting. This critical care visit covers the time that both physicians spend with the patient directly related to the procedure.

The RUC reviewed the survey respondents' estimated physician work value for this procedure and agreed with the specialty that 40.00, the survey median, is an appropriate work RVU for this service. To justify this value, the RUC reviewed the key reference service code 33979 *Insertion of ventricular assist device, implantable intracorporeal, single ventricle* (work RVU= 37.50) and agreed that while 33979 has more intra-service time compared to the surveyed code, 0318T should be valued slightly higher due to greater intensity, as seen in the intensity complexity measures. The RUC also reviewed CPT code 33880 *Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin* (work RVU= 27.28, valued as a 000 day global) and agreed that while the reference code has greater total physician time, 0318T is a much more intense procedure. In addition, 33366, as described above, is a unique procedure involving two physicians and is a much more complicated and involved procedure compared to the reference code. The RUC also reviewed 33366 in comparison to 33361 and agreed that the increase complexity was accurately reflected with the increase work RVU of 10.50 and increased time of 60 minutes. **The RUC recommends a work RVU of 40.00 for CPT code 33366.**

**Practice Expense**

The RUC reviewed and approved the practice expense at the April 2012 RUC meeting.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<b>Category I</b> <b>Surgery</b> <b>Cardiovascular System</b> <b>Cardiac Valves</b> <b>Aortic Valve</b>				
<p>Codes <del>33361-33365, 0318T</del>, 33366, 33362, 33363, 33364, 33365 are used to report transcatheter aortic valve replacement (TAVR)/ transcatheter aortic valve implantation (TAVI). TAVR/ TAVI requires two physician operators and all components of the procedure are reported using modifier 62.</p> <p>Codes <del>33361-33365, 0318T</del>, 33366, 33362, 33363, 33364, 33365 include the work, when performed, of percutaneous access, placing the access sheath, balloon aortic valvuloplasty, advancing the valve delivery system into position, repositioning the valve as needed, deploying the valve, temporary pacemaker insertion for rapid pacing (33210), and closure of the arteriotomy when performed. Codes <del>33361-33365, 0318T</del>, 33366, 33362, 33363, 33364, 33365 include open arterial or cardiac approach.</p> <p>Angiography, radiological supervision, and interpretation performed to guide TAVR/TAVI (eg, guiding valve placement, documenting completion of the intervention, assessing the vascular access site for closure) are included in these codes.</p> <p>Diagnostic left heart catheterization codes (93452, 93453, 93458-93461) and the supraaortic aortography code (93567) should <b>not</b> be used with TAVR/TAVI services (<del>33361-33365, 0318T</del>, 33366, 33362, 33363, 33364, 33365) to report:</p>				



1. Contrast injections, angiography, roadmapping, and/or fluoroscopic guidance for the TAVR/TAVI,
2. Aorta/left ventricular outflow tract measurement for the TAVR/TAVI, or
3. Post-TAVR/TAVI aortic or left ventricular angiography, as this work is captured in the TAVR/TAVI services codes (33361-~~33365~~, ~~0318T~~, 33366, 33362, 33363, 33364, 33365).

Diagnostic coronary angiography performed at the time of TAVR/TAVI may be separately reportable if:

1. No prior catheter-based coronary angiography study is available and a full diagnostic study is performed, or
2. A prior study is available, but as documented in the medical record:
  - a. The patient's condition with respect to the clinical indication has changed since the prior study, or
  - b. There is inadequate visualization of the anatomy and/or pathology, or
  - c. There is a clinical change during the procedure that requires new evaluation.
  - d. For same session/same day diagnostic coronary angiography services, report the appropriate diagnostic cardiac catheterization code(s) appended with modifier 59 indicating separate and distinct procedural service from TAVR/TAVI.

Diagnostic coronary angiography performed at a separate session from an interventional procedure may be separately reportable.

Other cardiac catheterization services may be reported separately when performed for diagnostic purposes not intrinsic to TAVR/TAVI.

Percutaneous coronary interventional procedures may be reported separately, when performed.

When transcatheter ventricular support is required in conjunction with TAVR/TAVI, the appropriate code should be reported with the appropriate ventricular assist device (VAD) procedure code (33990-33993, 33975, 33976, 33999) or balloon pump insertion code (33967, 33970, 33973).

The TAVR/TAVI cardiovascular access and delivery procedures are reported with 33361-~~33365~~, ~~0318T~~, 33366, 33362, 33363, 33364, 33365. When cardiopulmonary bypass is performed in conjunction with TAVR/TAVI, codes 33361-~~33365~~, ~~0318T~~, 33366, 33362, 33363, 33364, 33365 should be reported with the appropriate add-on code for percutaneous peripheral bypass (33367), open peripheral bypass (33368), or central bypass (33369).

33361	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach
33362	open femoral artery approach

33363	open axillary artery approach			
33364	open iliac artery approach			
33365 transaortic approach (eg, median sternotomy, mediastinotomy)				
●33366	BB1	transapical exposure (eg, left thoracotomy)	000	40.00
<b>✚33367</b> cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels) (List separately in addition to code for primary procedure) (Use 33367 in conjunction with 33361– <del>33365, 0318T</del> , <u>33366, 33362, 33363, 33364, 33365</u> ) (Do not report 33367 in conjunction with 33368, 33369)				
<b>✚33368</b> cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels) (List separately in addition to code for primary procedure) (Use 33368 in conjunction with 33361– <del>33365, 0318T</del> , <u>33366, 33362, 33363, 33364, 33365</u> ) (Do not report 33368 in conjunction with 33367, 33369)				
<b>✚33369</b> cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary artery) (List separately in addition to code for primary procedure) (Use 33369 in conjunction with 33361– <del>33365, 0318T</del> , <u>33366, 33362, 33363, 33364, 33365</u> ) (Do not report 33369 in conjunction with 33367, 33368)				
<b>Category III</b>				
0254T	Endovascular repair of iliac artery bifurcation (eg, aneurysm, pseudoaneurysm, arteriovenous malformation, trauma) using bifurcated endoprosthesis from the common iliac artery into both the external and internal iliac artery, unilateral;			
0255T	radiological supervision and interpretation (0256T has been deleted. To report, see 33361, <u>33362, 33363, 33364</u> ) (0257T has been deleted. To report, see <del>33365, 0318T</del> , <u>33366</u> )			

<p>(0258T has been deleted. To report, see 33365, <del>33366</del><u>33366</u>)</p> <p>(0259T has been deleted. To report, see 33365-,<u>33367</u>, <u>33368</u>, 33369)</p>				
D0318T		<p><del>Implantation of catheter delivered prosthetic aortic heart valve, open thoracic approach, (eg, transapical, other than transaortic)</del></p> <p><del>(For percutaneous femoral artery, open femoral artery, open axillary artery, open iliac artery, or transaortic approach, see 33361-33365)</del></p> <p><del>(To report cardiopulmonary bypass in conjunction with 0318T, see 33367, 33368, or 33369)</del></p> <p><u>(0318T has been deleted. To report, see 33366)</u></p>	YYY	N/A

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 33366      Tracking Number   GG6

Original Specialty Recommended RVU: **40.00**Presented Recommended RVU: **40.00**

Global Period: 000

RUC Recommended RVU: **40.00**

CPT Descriptor: Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical approach (eg, left thoracotomy)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: An 83 y/o male with aortic stenosis, coronary artery disease, and Class III-IV heart failure. The aortic stenosis is life-limiting and severely symptomatic, and is characterized as critical with a documented aortic valve orifice area of 0.6 cm<sup>2</sup>. He has multiple additional co-morbidities that make his risk of mortality with conventional open heart aortic valve replacement greater than 10% by objective predictive criteria. He is evaluated by the valve-team comprised of a cardiac surgeon and an interventional cardiologist who agree that the operative risks outweigh the benefit. The team therefore recommends transcatheter aortic valve replacement. Because of severe peripheral vascular disease, including severe aortoiliac, femoral axillary artery disease, and the presence of a porcelain aorta, a transapical approach is recommended.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 100%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 6%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The patient's history, records, laboratory and diagnostic tests, including CT angiogram, coronary and ilio-femoral contrast angiogram, transthoracic echocardiogram, transesophageal echocardiogram are reviewed. This includes review of the primary CT and angiographic images from prior studies. Physical examination is conducted. A clinical note is generated summarizing the clinical information if a recent note is not available. The patient is prepared for the procedure with careful documentation of baseline clinical findings such as vital signs, arterial pulses, allergies, electrocardiographic findings, laboratory results, family contact information, and other data. Appropriate antiplatelet and other pharmacologic therapy important for patient safety is ensured. Additional pre-procedure functions include writing orders for adequate sedation and patient support, and a review of study arrangements and procedures with technical, nursing and other assisting personnel. Appropriate communication is conducted with the patient and family as well as other medical professionals as needed. The procedure is reviewed with the patient and family. The risks and benefits of the procedure are presented, as well as the alternatives. Informed consent is obtained. Necessary equipment, instruments and supplies for the procedure are confirmed to be available and operational. Hair is removed from the potential access sites. Instruments and supplies for the procedure are pulled. The patient is transported to the procedure suite, positioned on the procedural table, attached to cardiac electrodes and an oxygen saturation monitor. General anesthesia is induced by the anesthesiology team. External defibrillator pads are placed on the anterior and posterior chest. A sterile table is prepared. All cardiopulmonary bypass equipment and specialized instruments/supplies are assembled on

the operative field. Critical personnel, including surgeons, interventional cardiologists, nurses, technicians, and perfusionists are also positioned at the operative field. In addition, all other personnel including anesthesiologists, circulating nurses, respiratory therapists, echocardiologists and echo technicians are in place, performing their specialized duties. The patient is prepped and draped for all possible alternative access sites and possible open surgical approaches. The injection manifold and hemodynamic monitoring tubes and cables are set up. The patient's information is loaded in the hemodynamic monitoring equipment and into the angiographic digital archive in order to retain the data from the upcoming study.

A "Time Out" occurs during which confirmation of critical information is ensured, such as the patient's identity, planned procedure, access route, allergies, signed consent, availability of proper equipment, and any unusual circumstances which might influence the procedure.

**Description of Intra-Service Work:** A temporary transvenous pacemaker electrode is advanced into apex of the right ventricle and tested for proper electrical capture.

Arterial access (eg, femoral, radial, or brachial) for the reference pigtail catheter is obtained by needle puncture (Seldinger technique), followed by passage of a standard guide wire and pigtail angiographic catheter. The catheter is positioned within the aortic root using fluoroscopy. A root aortogram(s) is/are obtained using power contrast injection and cine angiography to determine the optimal angiographic angle relative to the native aortic valve.

The heart is exposed through a left anterior thoracotomy in the fifth or sixth intercostal space. Single lung ventilation is initiated and the left lung is collapsed. A pericardiotomy is performed, and pacing wires are affixed to the ventricular muscle. Two circumferential pledgeted pursestring sutures are placed in the apex of the left ventricle. Anticoagulant therapy is administered to achieve therapeutic anticoagulation levels. A sheath is introduced into the left ventricle, and a pigtail catheter advanced over a guidewire into the ascending aorta using fluoroscopy. A root aortogram(s) is/are obtained using power contrast injection and cine angiography to determine the optimal angiographic angle relative to the native aortic valve. Typically, several aortograms in different angles are required

Under fluoroscopic guidance, access across the native aortic valve is obtained using a guidewire and catheter of the physician's choice. This typically requires multiple attempts and multiple angiographic views due to the severe aortic valve stenosis. Once the guidewire is across the aortic valve and positioned in the aorta, a small catheter is advanced over the wire and the wire is exchanged for a stiff guide wire. A large balloon catheter is passed over the guide wire and positioned within the native aortic valve. Rapid pacing is initiated to minimize balloon movement and balloon aortic valvuloplasty is performed: the balloon is inflated by one physician while another physician continuously adjusts the balloon catheter position to minimize any potential movement and resultant left ventricular trauma/perforation. Typically, this results in hypotension and ventricular ectopy. The balloon is then rapidly deflated and the patient is monitored for hemodynamic recovery. Supravalvular aortography is performed to assess the aorta and ventricle for trauma and to assess for aortic insufficiency. Concurrently, the prosthetic valve is loaded into or onto the delivery catheter. Correct orientation of the valve on the delivery catheter is confirmed by the physician, before inserting the valve-delivery catheter system into the introducer sheath. The valvuloplasty catheter is exchanged for the prosthetic delivery catheter over the previously positioned stiff guidewire while maintaining access across the native aortic valve. The delivery catheter is advanced across the native aortic valve annulus to the aortic root and positioned under fluoroscopic guidance. In addition, transesophageal echocardiography may be used to position the prosthesis within the aortic annulus (if performed, TEE is separately reported). Multiple supravalvular aortograms may be performed to facilitate placement before a satisfactory valve position is chosen. The prosthesis is then deployed within the native aortic valve, typically during rapid ventricular pacing.

After confirming satisfactory position and function of the valve, as well as assessing the degree of any paravalvular regurgitation or presence of mechanical complications that might require open, urgent surgical intervention or coronary compromise requiring percutaneous coronary intervention, the delivery catheter and guide wire are removed from the patient.

The LV apical sheath is removed and the pursestring sutures are tied. Hemostasis is assured. Protamine is given to reverse the heparin. Chest tube(s) are placed. Double lung ventilation is resumed. The incision is closed in layers and dressings are placed.

**Description of Post-Service Work:** The physicians confirm the patient hemodynamic status, including systemic arterial pressure, pulmonary artery pressure and the patient's heart rhythm, prior to removing the patient from the operating room and committing the patient to ICU transfer. A focused vascular examination of the at-risk extremities is performed

assessing for adequate limb perfusion. Post operative orders are written. A detailed “hand-off” process is initiated in which procedure results are reviewed with the accepting nursing staff and other physicians, as well as with other members of the health care team. The patient’s fluoroscopic exposure time and total contrast volume administered are reviewed and recorded. Procedure notes are dictated, reviewed, revised as necessary to provide an accurate accounting of the procedure performed as well as any possible complications or events that would require special attention by the post operative care givers. The dictated summary is signed. Data relating to the patient and the procedure performed are immediately entered into the mandatory TAVR registry by the two procedural physicians.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2012				
<b>Presenter(s):</b>	Jim Levett, MD; Stephen Lahey, MD; Jeff Jacobs, MD; Richard Wright, MD; Clifford Kavinsky, MD					
<b>Specialty(s):</b>	STS, ACC					
<b>CPT Code:</b>	33366					
<b>Sample Size:</b>	70	<b>Resp N:</b>	31	<b>Response:</b> 44.2 %		
<b>Description of Sample:</b>	Targeted. As approved by the Research subcommittee, the STS and ACC sent the survey to physicians who participated in a TAVR trial. This sample represented 70 sites and 180 physicians. The survey was sent to the cardiologist and cardiothoracic surgeon at each instution and asked to complete the survey jointly.					
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Service Performance Rate</b>		0.00	0.00	<b>0.00</b>	11.00	60.00
<b>Survey RVW:</b>		22.21	32.00	<b>40.00</b>	43.13	56.00
<b>Pre-Service Evaluation Time:</b>				<b>60.00</b>		
<b>Pre-Service Positioning Time:</b>				<b>30.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>30.00</b>		
<b>Intra-Service Time:</b>		75.00	173.00	<b>195.00</b>	225.00	340.00
<b>Immediate Post Service-Time:</b>	<b>45.00</b>					
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>				
<b>Critical Care time/visit(s):</b>	<b>70.00</b>	99291x 1.00	99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00	15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00	
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00		

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	33366	Recommended Physician Work RVU: 40.00					
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package		Adjustments/Recommended Pre-Service Time		
Pre-Service Evaluation Time:		50.00	40.00		10.00		
Pre-Service Positioning Time:		15.00	3.00		12.00		
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00		0.00		
Intra-Service Time:		195.00					
Immediate Post Service-Time:	45.00						
Post Operative Visits	Total Min**	CPT Code and Number of Visits					
Critical Care time/visit(s):	70.00	99291x 1.00	99292x 0.00				
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.0	99239x 0.0	99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00	15x 0.00	

<b>Prolonged Services:</b>	<u><b>0.00</b></u>	99354x <b>0.00</b>	55x <b>0.00</b>	56x <b>0.00</b>	57x <b>0.00</b>
<b>Sub Obs Care:</b>	<u><b>0.00</b></u>	99224x <b>0.00</b>	99225x <b>0.00</b>	99226x <b>0.00</b>	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? Yes

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
33979	ZZZ	37.50	RUC Time

CPT Descriptor Insertion of ventricular assist device, implantable intracorporeal, single ventricle**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1 see separate table for MPC references

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
33880	000	27.28	RUC Time

CPT Descriptor Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin

\*Code global and RVU has been adjusted to represent a 000 day global value per approval of research subcommittee for use on RSL for code

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.****Number of respondents who choose Key Reference Code:** 18      **% of respondents:** 58.0 %**TIME ESTIMATES (Median)**

	<b>CPT Code:</b> <b>33366</b>	<b>Key Reference CPT Code:</b> <b>33979</b>	<b>Source of Time</b> <b>RUC Time</b>
Median Pre-Service Time	85.00	95.00	
Median Intra-Service Time	195.00	280.00	
Median Immediate Post-service Time	45.00	120.00	
Median Critical Care Time	70.0	0.00	



Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>395.00</b>	<b>495.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.35	3.94
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.41	4.00
Urgency of medical decision making	4.06	3.82

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.41	4.06
Physical effort required	4.35	4.00

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.41	4.00
Outcome depends on the skill and judgment of physician	4.41	4.06
Estimated risk of malpractice suit with poor outcome	3.76	3.53

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.35	3.88
Intra-Service intensity/complexity	4.41	4.12
Post-Service intensity/complexity	3.88	4.00

---

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An Expert Panel with representatives from the American College of Cardiology, Society of Thoracic Surgeons and the Society for Cardiac Angiography and Interventions was convened to review the survey results and finalize the recommendations. The survey response rate was excellent and the results were internally consistent. All survey respondents were members of teams of co-operators who participated in clinical trials of these new devices.

#### JOINT OPERATORS FOR THE PROCEDURES

There are nine codes included in the transcatheter aortic valve replacement (TAVR) procedures. Six codes represent the various approaches and insertion of the TAVR. Each of the six insertion codes were surveyed jointly by the cardiologist and the cardiac surgeon from institutions that were/are involved with clinical trials for the TAVR procedures. The survey was distributed to 70 institutions and over 140 physicians. There are three add-on codes to report when cardiopulmonary bypass is employed to support the patient during the procedure.

For the TAVR insertion procedures there are always two physicians (a cardiologist and a cardiac surgeon) that participate in the case and both physicians utilize their specialty specific expertise and collaborate for the entire procedure.

Medicare's proposed National Coverage Decision, and the joint statements of the American College of Cardiology and the Society of Thoracic Surgeons mandate the performance of these procedures by two physicians. The relevant section is as follows:

4. The procedure is performed by physicians with the following qualifications and experience:

a. Surgeon requirements:

- i. Board Certified/Eligible in Cardiovascular Surgery;
- ii. Professional experience with:
  1.  $\geq 100$  AVR/career including 10 high risk patients; OR
  2.  $\geq 25$  AVR/year or 50 AVR in 2 years; AND
  3.  $\geq 20$  in the last year prior to TAVR.

b. Interventionalist requirements:

- . Operators must be Board Certified/Eligible in Interventional Cardiology
- i. Professional experience with 50 structural heart disease procedures

This will result in the **required use of the -62 modifier** for 33361-33366 and result in each physician being allocated 62.5% of the physician work (and therefore total physician payment) described in the codes. Based upon this, the following describes the individual IWPUT for the proposed work values:

IWPUT Calculator				
<b>33366</b>	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical approach (eg, left thoracotomy)			
<b>Building Block Method</b>			<b>RVW</b>	<b>-62 Mod RVW</b>
<b>Proposed RVW</b>			<b>40.00</b>	<b>25.00</b>
<b>Pre-service</b>	<b>Time</b>	<b>Intensity</b>	<b>-62 Mod Intensity</b>	(=time x intensity)
Pre Evaluation	50	0.0224	0.0140	0.70
Pre Positioning	15	0.0224	0.0140	0.21
Scrub, prep	20	0.0081	0.0051	0.10
<b>Pre-service total</b>				<b>1.01</b>
<b>Post-service</b>	<b>Time</b>	<b>Intensity</b>	<b>-62 Mod Intensity</b>	
Immediate post	45	0.0224	0.0140	0.63
Subsequent visits:	<b>Visit n</b>	<b>E/M RVU</b>	<b>-62 ModE/M RVU</b>	(=n x E/M RVU)
ICU 99291	1.0	4.50	2.81	2.81
ICU 99292	0.0	2.25	1.41	0.00
99233	0.0	2.00	1.25	0.00
99232	0.0	1.39	0.87	0.00
99231	0.0	0.76	0.48	0.00
Discharge Day Mgmt				
99238	0.0	1.28	0.80	0.00
99239		1.90	1.19	0.00
Office Visits				
99215	0.0	2.11	1.32	0.00
99214	0.0	1.50	0.94	0.00
99213	0.0	0.97	0.61	0.00
99212	0.0	0.48	0.30	0.00
99211	0.0	0.18	0.11	0.00
Subsequent Obs Care				
99224	0.0	0.540	0.34	0.00
99225	0.0	0.960	0.60	0.00
99226	0.0	1.440	0.90	0.00
Prolonged Services				
99354	0.0	1.77	1.11	0.00
99355	0.0	1.77	1.11	0.00
99356	0.0	1.71	1.07	0.00
99357	0.0	1.71	1.07	0.00
<b>Post-service total</b>				<b>3.44</b>
	<b>Time</b>		<b>IWPUT</b>	

Intra-service	195	0.1054	20.54625
---------------	-----	--------	----------

These intensities are well within the typical range for similar procedures provided by these and other specialties. A separate file has been provided for comparative review, including many codes from the current MPC list.

#### PRE-TIME CHANGES

The Expert Panel selected pre-service time package 4 representing a difficult patient and difficult procedure done in a facility under anesthesia. The Expert Panel is recommending increases in time for the evaluation of the patient and for the positioning of the patient for all nine TAVR procedure codes.

#### ADDITIONAL EVALUATION TIME

For the evaluation the Expert Panel is recommending a 10-minute increase in time over the package for a total evaluation time of 50 minutes. This is supported by the survey data for four of the six codes. The total evaluation time accounts for the combined review of the patient by the physicians and the collaborative efforts that go into each case. The additional evaluation time of 10 minutes accounts for the time each physician would spend separately with the patient obtaining consent, reviewing the procedure and explaining the various aspects of the procedure from their specialty specific aspect. The Expert Panel felt that adding 10 minutes of evaluation time to package 4 was reasonable and would cover all aspects of the same day pre-service work involved with the procedure by both physicians. In addition, the Expert Panel feels that a uniform pre-time representation for each of the various approaches is reasonable. This change is further supported by the survey, where evaluation times ranged from 45-60 minutes.

RUC reviewed codes that were valued after the implantation of the pre-service time package that have additional evaluation time above the 40 minutes represented in pre-service time package 4 include the following:

Code	Descriptor	pre-time package	pre-evaluation time	global
33977	Removal of ventricular assist device; extracorporeal, single ventricle	4	60 mins	XXX
33978	Removal of ventricular assist device; extracorporeal, biventricular	4	60 mins	XXX
33980	Removal of ventricular assist device, implantable intracorporeal, single ventricle	4	60 mins	XXX

#### ADDITIONAL POSITIONING TIME

For the positioning, an additional 12 minutes was added to each case. The codes represent hybrid procedures each with the possibility of emergency bypass. The positioning for these procedures is unique in that there is more equipment involved and that the surgeons need to plan and position for each contingency on the procedures. In addition, the patient has to be positioned for all of the approaches plus the induction of bypass for each of the bypass procedures.

#### SAME DAY IMMEDIATE POST TIME

The survey supported 45 minutes of immediate post time. There are numerous examples in the RUC database supporting this time.

**SAME DAY POST PROCEDURE VISIT**

For the six TAVR 000 day procedure codes the survey respondents replied 100% that the procedure was performed in the hospital, that the patient stayed overnight for more than 24 hours, and that a visit was provided the same day of surgery.

The survey respondents indicated that they spent over 40 minutes providing critical care services to the patient postop on the same day as the procedure once the patient is in the ICU. The critical care visit covers that time that both physicians spend with the patient directly related to the procedure providing critical care services. The survey supported a single critical care visit and the Expert Panel agreed.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0257 T Implantation of catheter-delivered prosthetic aortic heart valve; open thoracic approach (eg, transapical, transventricular) and 0258T Transthoracic cardiac exposure (eg, sternotomy, thoracotomy, subxiphoid) for catheter-delivered aortic valve replacement; without cardiopulmonary bypass

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology and Cardiovascular Surgery

How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1190

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. It is estimated that 5000 minimally invasive aortic valve implantation procedures will be performed per year, with approximately 2/3 (3300) of these procedures believed to be from an endovascular approach (codes 33361- 33364 and 1/3 (1700) from an open thoracic approach (33365 -33366). The estimated percentage breakdown for each approach from the trials is as follows: Endovascular approaches (3300) 33361 ercutaneous 30%, 33362

femoral 52%, 33363 axillary 10%, 33364 iliac 8%; Open approach (1700 total) 33365 transaortic 30%, 33366 transapical 70%

Specialty Cardiology and Cardiovascular Surgery	Frequency 1190	Percentage 100.00 %
---	----------------	---------------------

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,130

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. It is estimated that 95% of the procedures will be performed on Medicare patients.

Specialty Cardiology and Cardiovascular Surgery	Frequency 1130	Percentage 100.00 %
---	----------------	---------------------

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 33979

## SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA
11	ISSUE:		Transcatheter Aortic Valve Replcement																								
12	TAB:		12																								
13	000 Day Global codes																										
14						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day						
15	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39
16	REF	33880	Endovascular repair of descending	14	0.096			27.21			455	90	20	20			225			45	1						
18	SVY	33361	Transcatheter aortic valve replacement	33	0.165	6.74	25.13	29.50	35.00	50.00	345	45	20	30	30	120	135	180	300	45	1						
19	REC	33361	Transcatheter aortic valve replacement		0.166	29.50					335	50	15	20			135			45	1						
20	62 modifier	33361	Transcatheter aortic valve replacement		0.104	18.44					335	50	15	20			135			45	1						
21																											
22	REF	33880	Endovascular repair of descending	19	0.096			27.21			455	90	20	20			225			45	1						
24	SVY	33362	open femoral artery approach	38	0.165	11.34	27.52	32.00	35.59	54.00	360	45	20	30	30	120	150	195	300	45	1						
25	REC	33362	open femoral artery approach		0.166	32.00					350	50	15	20			150			45	1						
26	62 modifier	33362	open femoral artery approach		0.104	20.00					350	50	15	20			150			45	1						
27																											
28	REF	33880	Endovascular repair of descending	13	0.096			27.21			455	90	20	20			225			45	1						
30	SVY- 0 performance	33363	open axillary artery approach	17	0.132	11.34	28.13	31.50	39.25	58.00	415	60	30	30	120	135	180	195	330	45	1						
31	SVY >0 performance	33363	open axillary artery approach	16	0.151	22.21	29.25	33.50	37.50	51.11	391	53	20	30	70	135	173	240	250	45	1						
32	SVY- Aggregate	33363	open axillary artery approach	33	0.139	11.34	28.50	33.00	37.50	58.00	423	60	30	30	70	130	180	200	330	53	1						
33	REC	33363	open axillary artery approach		0.144	33.00					380	50	15	20			180			45	1						
34	62 modifier	33363	open axillary artery approach		0.090	20.63					380	50	15	20			180			45	1						
35																											
36	REF	33880	Endovascular repair of descending	15	0.096			27.21			455	90	20	20			225			45	1						
38	SVY	33364	open iliac artery approach	31	0.152	8.80	30.00	34.87	39.74	65.00	403	53	25	30	70	150	180	240	330	45	1						
39	REC	33364	open iliac artery approach		0.154	34.87					380	50	15	20			180			45	1						
40	62 modifier	33364	open iliac artery approach		0.096	21.79					380	50	15	20			180			45	1						
41																											
42	REF	33979	Insertion of ventricular assist transaortic approach (eg. transaortic approach (eg. transaortic approach (eg.	15	0.117			37.50			495	60	20	15			280			120							
44	SVY	33365	transaortic approach (eg. transaortic approach (eg. transaortic approach (eg.	30	0.165	10.50	30.00	37.50	40.00	56.00	415	60	30	30	45	175	180	210	340	45	1						
45	REC	33365	transaortic approach (eg. transaortic approach (eg. transaortic approach (eg.		0.169	37.50					380	50	15	20			180			45	1						
46	62 modifier	33365	transaortic approach (eg. transaortic approach (eg. transaortic approach (eg.		0.105	23.44					380	50	15	20			180			45	1						
47																											
48	REF	33979	Insertion of ventricular assist transapical approach (eg. left transapical approach (eg. left transapical approach (eg. left	18	0.117			37.50			495	60	20	15			280			120							
50	SVY- 0 performance	33366	transapical approach (eg. left transapical approach (eg. left transapical approach (eg. left	19	0.192	27.21	37.50	42.00	45.06	56.00	403	53	25	30	100	148	180	213	320	45	1						
51	SVY >0 performance	33366	transapical approach (eg. left transapical approach (eg. left transapical approach (eg. left	12	0.125	22.21	28.91	33.00	37.75	46.75	443	60	30	30	75	180	200	250	340	53	1						
52	SVY- Aggregate	33366	transapical approach (eg. left transapical approach (eg. left transapical approach (eg. left	31	0.165	22.21	32.00	40.00	43.13	56.00	430	60	30	30	75	173	195	225	340	45	1						
53	REC	33366	transapical approach (eg. left transapical approach (eg. left transapical approach (eg. left		0.169	40.00					395	50	15	20			195			45	1						
54	62 modifier	33366	transapical approach (eg. left transapical approach (eg. left transapical approach (eg. left		0.105	25.00					395	50	15	20			195			45	1						
55	Reference code RVW and times have been adjusted to represent 000 day global procedures as used in RSL for survey and approved by Research Subcommittee																										
56																											
57	ZZZ Day Global codes																										
58	REF	37223	Revascularization, endovascular, open Transcatneter aortic valve replacement	7	0.094			4.21			45						45										
60	SVY	33367	Transcatheter aortic valve replacement	35	0.185	5.00	11.88	16.67	26.20	100.00	90				3	45	90	180	360								
61	REC	33367	Transcatheter aortic valve replacement		0.132	11.88					90						90										
62																											
63	REF	33960	Prolonged extracorporeal cardiopulmonary bypass support cardiopulmonary bypass support	7	0.080			10.59			133						133										
65	SVY	33368	cardiopulmonary bypass support cardiopulmonary bypass support	34	0.167	8.25	14.39	20.00	28.63	110.00	120				4	74	120	180	400								
66	REC	33368	cardiopulmonary bypass support cardiopulmonary bypass support		0.120	14.39					120						120										
67																											
68	REF	33305	Repair of cardiac wound: with cardiopulmonary bypass support cardiopulmonary bypass support	15	0.100			29.60			296						296										
70	SVY	33369	cardiopulmonary bypass support cardiopulmonary bypass support	35	0.175	10.00	19.00	27.95	32.88	120.00	160				5	90	160	240	420								
71	REC	33369	cardiopulmonary bypass support cardiopulmonary bypass support		0.119	19.00					160						160										
72	Reference code RVW and times have been adjusted to represent ZZZ global procedures as used in RSL for survey and approved by Research Subcommittee																										
73																											
74																											

**AMA/Specialty Society Update Process**  
**Practice Expense Summary of Recommendation**  
**Facility Direct Inputs**

CPT Long Descriptor:

- 33361 - Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach
- 33362 - open femoral artery approach
- 33363 - open axillary artery approach
- 33364 - open iliac artery approach
- 33365 - transaortic approach (eg, median sternotomy, mediastinotomy)
- 33366 - transapical approach (eg, left thoracotomy)

Global Period: 000 Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

Codes 33980 - Removal of ventricular assist device, implantable intracorporeal, single ventricle  
This code represents an XXX global procedure that was reviewed by the RUC and the Practice Expense Subcommittee at the February of 2011 RUC meeting. 33980 is a procedure that is performed in the facility setting 100% of the time and requires office staff time that would be typical of a 90-day global procedure performed in the facility setting. This code has an approved pre-facility clinical staff time of 60 minutes. Since cardiothoracic offices typically employ PAs, the cardiothoracic codes are typically assigned CMS code L051A and staff type RN.

The TAVR codes also represent procedures that will be performed in the facility 100% of the time and will require office staff time that would be typical for a 90-day global procedure performed in the facility setting. The main difference between the TAVR codes and the reference code is that the TAVR codes will be done jointly with the cardiologist and cardiovascular surgeon and requires additional scheduling and coordination of services because the cardiology office and the cardiovascular surgery office must both coordinate with the other specialists involved in the procedure which at a minimum include radiology, perfusionist and a specialized anesthesiologist. In addition the procedure requires a hybrid OR room requiring special equipment for the catheter-based, surgical, and imaging aspects of the procedure and the cardiopulmonary bypass equipment. Since the codes were jointly surveyed involving cardiology and cardiac surgeons, the specialty societies are recommending CMS Code L037D with a blended staff type of RN/ LP/ MTA rather than the RN staff type typical to the cardiothoracic surgery codes.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The clinical staff from both offices fill out the pre-service diagnostic and referral forms. They call the hospital



to schedule space and equipment needed in the facility. They will also coordinate with specialized anesthesiologist, the perfusionist, radiology and any other physician offices to set up the case. The clinical staff will also coordinate with the hospital to schedule the OR and the specialized equipment for the procedure. The operating room coordinating requires ensuring the needed hybrid equipment including the catheter-based equipment for the valve deployment, any instrumentation needed for an open approach or conversion to an open approach and cardiopulmonary bypass equipment as well as supporting imaging equipment for the procedure. The clinical staff will educate the patient on what they need to do to prepare for surgery. The staff ensures the patient and family fully understands the procedure and the recovery afterwards and obtains the operative consent. They make follow-up phone calls to the patient and the office of referring physicians and call in needed prescriptions.

	A	B	C	D	E	F	G	H	I	J
1				Reference Code						
2				33980	33361	33362	33363	33364	33365	33366
3	Meeting Date: April 2012 AMA/Specialty Society RVS Update Committee Recommendation	CMS Code	Staff Type	Removal of ventricular assist device, impantable intracorporeal, single ventricle (CMS Code is L015A staff type is RN)	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach	open femoral artery approach	open axillary artery approach	open iliac artery approach	transaortic approach (eg, median sternotomy, mediastinotomy )	transapical approach (eg, left thoracotomy)
4	LOCATION			Facility	Facility	Facility	Facility	Facility	Facility	Facility
5	GLOBAL PERIOD			XXX	000	000	000	000	000	000
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LP/MTA	60.0	80.0	80.0	80.0	80.0	80.0	60.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LP/MTA	60.0	80.0	80.0	80.0	80.0	80.0	60.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			0.0	0.0	0.0	0.0	0.0	0.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0	0.0	0.0	0.0
10	PRE-SERVICE									
11	Start: Following visit when decision for surgery or procedure made									
12	Complete pre-service diagnostic & referral forms	L037D	RN/LP/MTA	5	5	5	5	5	5	5
13	Coordinate pre-surgery services	L037D	RN/LP/MTA	20	40	40	40	40	40	20
14	Schedule space and equipment in facility	L037D	RN/LP/MTA	8	8	8	8	8	8	8
15	Provide pre-service education/obtain consent	L037D	RN/LP/MTA	20	20	20	20	20	20	20
16	Follow-up phone calls & prescriptions	L037D	RN/LP/MTA	7	7	7	7	7	7	7
17	Other Clinical Activity - specify:									
18	End: When patient enters office/facility for surgery/procedure									
19	SERVICE PERIOD									
43	POST-SERVICE Period									
55	MEDICAL SUPPLIES	CODE	UNIT							
62	EQUIPMENT	CODE								
63										
64										
65										
66										
67										

	A	B	C	D	E	F	G	H	I	J
1				Reference Code						
2				33980	33361	33362	33363	33364	33365	33366
3	Meeting Date: April 2012 AMA/Specialty Society RVS Update Committee Recommendation	CMS Code	Staff Type	Removal of ventricular assist device, impantable intracorporeal, single ventricle (CMS Code is L015A staff type is RN)	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach	open femoral artery approach	open axillary artery approach	open iliac artery approach	transaortic approach (eg, median sternotomy, mediastinotomy )	transapical approach (eg, left thoracotomy)
4	LOCATION			Facility	Facility	Facility	Facility	Facility	Facility	Facility
5	GLOBAL PERIOD			XXX	000	000	000	000	000	000
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LP/MTA	60.0	80.0	80.0	80.0	80.0	80.0	80.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LP/MTA	60.0	80.0	80.0	80.0	80.0	80.0	80.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			0.0	0.0	0.0	0.0	0.0	0.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0	0.0	0.0	0.0
10	PRE-SERVICE									
11	Start: Following visit when decision for surgery or procedure made									
12	Complete pre-service diagnostic & referral forms	L037D	RN/LP/MTA	5	5	5	5	5	5	5
13	Coordinate pre-surgery services	L037D	RN/LP/MTA	20	40	40	40	40	40	40
14	Schedule space and equipment in facility	L037D	RN/LP/MTA	8	8	8	8	8	8	8
15	Provide pre-service education/obtain consent	L037D	RN/LP/MTA	20	20	20	20	20	20	20
16	Follow-up phone calls & prescriptions	L037D	RN/LP/MTA	7	7	7	7	7	7	7
17	Other Clinical Activity - specify:									
18	End: When patient enters office/facility for surgery/procedure									
19	SERVICE PERIOD									
43	POST-SERVICE Period									
55	MEDICAL SUPPLIES	CODE	UNIT							
62	EQUIPMENT	CODE								
63										
64										
65										
66										
67										

## AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2013

### **Fenestrated Endovascular Repair (FEVAR)**

In February 2013, the CPT Editorial Panel converted four Category III codes and created eight Category I codes to report fenestrated endovascular repair of the visceral aorta bundled with radiological supervision and interpretation, as well as revised the introductory language for these services.

The Society for Vascular Surgery (SVS) indicated that the RUC survey data revealed extensive pre-service time (120-195 minutes) for these procedures. SVS confirmed that these procedures do require extensive pre-service work that is not otherwise reportable and some of the most intensive work occurs days to weeks before the defined 090-day global period. SVS indicated that each of the currently FDA-approved main aortic endograft bodies are custom made by the vendor because every patient has a different arrangement and relative orientation of the renal and visceral artery origins. Each fenestrated endograft is anatomically specific for each patient. Additionally, the physician must spend a minimum of two hours reviewing CT angiograms and 3D reconstructions, constructing procedure planning models and completing sizing sheets. Ultimately, the appropriate fenestrated device is ordered. The physician work is conducted over the course of several days or weeks prior to the date of surgery and is outside the guidelines for the 090-day global period.

**The RUC agreed with the specialty societies concerns and recommends that these services be carrier priced for CPT 2014 and that the specialty societies submit a coding proposal to describe the physician work provided prior to the 090-global period associated with these services.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<b>Category I</b> <b>Surgery</b> <b>Cardiovascular System</b> <b>Arteries and Veins</b> <b>Endovascular Repair of Abdominal Aortic Aneurysm</b>				
34800		<i>Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-aortic tube prosthesis</i>		
34802		<i>using modular bifurcated prosthesis (1 docking limb)</i>		
34803		<i>using modular bifurcated prosthesis (2 docking limbs)</i>		
		<del>(For endovascular repair of abdominal aortic aneurysm or dissection involving visceral vessels using a fenestrated modular bifurcated prosthesis (2 docking limbs), use Category III codes 0078T, 0079T)</del>		
34804		using unibody bifurcated prosthesis		
34805		using aorto-uniiliac or aorto-unifemoral prosthesis		
		<u>(For fenestrated endovascular repair of the visceral aorta, see 34841-34844. For fenestrated endovascular repair of the visceral aorta and concomitant infrarenal abdominal aorta, see 34845-34848)</u>		
		<u>(Do not report 34800, 34802, 34803, 34804, 34805 in conjunction with 34841-34848)</u>		

**Category I****Surgery****Cardiovascular System****Arteries and Veins****Fenestrated Endovascular Repair of the Visceral and Infrarenal Aorta**

The upper abdominal aorta that contains the celiac, superior mesenteric, and renal arteries is termed the visceral aorta. For reporting purposes, the thoracic aorta extends from the aortic valve to the aortic segment just proximal to the celiac artery. Codes 34841-34848 are used to report placement of a fenestrated endovascular graft in the visceral aorta, either alone or in combination with the infrarenal aorta for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption. The fenestrated main body endoprosthesis is deployed within the visceral aorta. Fenestrations within the fabric allow for selective catheterization of the visceral and/or renal arteries and subsequent placement of an endoprosthesis (ie, bare metal or covered stent) to maintain flow to the visceral artery.

Fenestrated aortic repair is reported based on the extent of aorta treated. Codes 34841-34844 describe repair using proximal endoprostheses that span from the visceral aortic component to one, two, three or four visceral artery origins and distal extent limited to the infrarenal aorta. These devices do not extend into the common iliac arteries. Codes 34845-34848 are used to report deployment of a fenestrated endoprosthesis that spans from the visceral aorta (including one, two, three, or four visceral artery origins) through the infrarenal aorta into the common iliac arteries. The infrarenal component may be a bifurcated unibody device, a modular bifurcated docking system with docking limb(s), or an aorto-uniliac or aorta-unifemoral device.-Codes 34845-34848 include placement of unilateral or bilateral docking limbs (depending on the device). Any additional stent graft extensions that terminate in the common iliac arteries are included in the work described by 34845-34848. Codes 34825 and 34826 may not be separately reported for proximal abdominal aortic extension prosthesis(s) or for distal extension prosthesis(s) that terminate in the aorta or the common iliac arteries. However, codes 34825 and 34826 may be reported for distal extension prosthesis(s) that terminate in the internal iliac, external iliac, or common femoral artery(s).

Codes 34841-34844 and 34845-34848 define the total number of visceral and/or renal arteries (ie, celiac, superior mesenteric, and/or unilateral or bilateral renal artery[s]) requiring placement of an endoprosthesis (ie, bare metal or covered stent) through an aortic endograft fenestration.

Introduction of guidewires and catheters in the aorta and visceral and/or renal arteries is included in the work of 34841-34848 and is not separately reportable. However, catheterization of the hypogastric artery(s) and/or arterial families outside the treatment zone of the graft may be separately reported. Balloon angioplasty within the target treatment zone of the endograft, either before or after endograft deployment, is not separately reportable. Fluoroscopic guidance and radiologic supervision and interpretation in conjunction with fenestrated endovascular aortic repair is not separately reportable and includes angiographic diagnostic imaging of the aorta and its branches prior to deployment of the fenestrated endovascular device, fluoroscopic guidance in the delivery of the fenestrated endovascular components, and intraoperative arterial angiography (eg, confirm position, detect endoleak, evaluate runoff) done at the time of the endovascular aortic repair.

Exposure of the access vessels (eg, 34812) may be reported separately. Extensive repair of an artery (eg, 35226, 35286) may be reported separately. For concomitant endovascular treatment of the descending thoracic aorta, report 33880-33886 and 75955-75959 with 34841-34848. Do not report descending thoracic aortic aneurysm repair extension placement for an extension that includes the visceral aorta. For isolated endovascular infrarenal abdominal aortic aneurysm repair that does not require placement of a fenestrated graft to preserve flow to the visceral branch(es), see 34800-34805.

Other interventional procedures performed at the time of fenestrated endovascular abdominal aortic aneurysm repair may be reported separately (eg, arterial embolization, intravascular ultrasound, balloon angioplasty or stenting of native artery[s] outside the endoprosthesis target zone, when done before or after deployment of endoprosthesis).

●34841	CC1	Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a fenestrated visceral aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including one visceral artery endoprosthesis (superior mesenteric, celiac or renal artery)	090	Carrier Price and Refer to CPT
●34842	CC2	including two visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])	090	Carrier Price and Refer to CPT
●34843	CC3	including three visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])	090	Carrier Price and Refer to CPT
●34844	CC4	including four or more visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])  <u>(Do not report 34841-34844 in conjunction with 34845-34848, 34800, 34802, 34803, 34804, 34805, 35081, 35102, 35452, 35472, 75952)</u>	090	Carrier Price and Refer to CPT

●34845	CC5	Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including one visceral artery endoprosthesis (superior mesenteric, celiac or renal artery)	090	Carrier Price and Refer to CPT
●34846	CC6	including two visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])	090	Carrier Price and Refer to CPT
●34847	CC7	including three visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])	090	Carrier Price and Refer to CPT
●34848	CC8	<p>including four or more visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])</p> <p><u>(Do not report 34845-34848 in conjunction with 34841-34844, 34800, 34802, 34803, 34804, 34805, 35081, 35102, 35452, 35472, 75952)</u></p> <p><u>(Do not report 34841-34848 in conjunction with 37236-37237 for bare metal or covered stents placed into the visceral branches within the endoprosthesis target zone)</u></p> <p><u>(For placement of distal extension prosthesis[s] terminating in the internal iliac, external iliac, or common femoral artery[s], see 34825-34826, 0254T-0255T, and 75953)</u></p> <p><u>(Use 34845-34848 in conjunction with 37220-37223 only when these procedures are performed outside the target treatment zone of the endoprosthesis)</u></p>	090	Carrier Price and Refer to CPT



**Category I****Surgery****Cardiovascular System****Endovascular Revascularization (Open or Percutaneous, Transcatheter)**

- ⊙37220      Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty
- ⊙37221      with transluminal stent placement(s), includes angioplasty within the same vessel, when performed  
(Use 37220, 37221 in conjunction with 34802-34805, 34825-34826, 34845-34848, 34900, 0254T only when these procedures are performed outside the target treatment zone of the endoprosthesis)
- ⊙ + 37222      Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)  
(Use 37222 in conjunction with 37220, 37221)
- ⊙ + 37223      with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)  
(Use 37223 in conjunction with 37221)  
(Use 37222, 37223 in conjunction with 34802-34805, 34825-34826, 34845-34848, 34900, 0254T only when these procedures are performed outside the target treatment zone of the endoprosthesis)

**Category I****Radiology****Diagnostic Radiology (Diagnostic Imaging)****Vascular Procedures****Transcatheter Procedures**

- 75952      Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation  
(For implantation of endovascular grafts, see 34800-34805)  
~~(For radiologic supervision and interpretation of endovascular repair of abdominal aortic aneurysm involving visceral vessels, see Category III codes 0080T, 0081T)~~  
(For radiologic supervision and interpretation of fenestrated endovascular repair of the visceral aorta with or without concomitant infrarenal abdominal aorta and common iliac artery[s], see 34841-34848)

<b>Category III Codes</b> (0078T-0081T should be reported in accordance with the Endovascular Abdominal Aneurysm Repair guidelines established for 34800-34826)				
D0078T		<del>Endovascular repair using prosthesis of abdominal aortic aneurysm, pseudoaneurysm or dissection, abdominal aorta involving visceral branches (superior mesenteric, celiac and/or renal artery[s])</del> (Do not report in 0078T in conjunction with 34800-34805, 35081, 35012, 35454, 35472) (Report 0078T in conjunction with 37205-37208, 37220-37223, only when these procedures are performed outside the target zone of the endoprosthesis)	XXX	N/A
D+0079T		<del>Placement of visceral extension prosthesis for endovascular repair of abdominal aortic aneurysm involving visceral vessels, each visceral branch (List separately in addition to code for primary procedure)</del> (Use 0079T in conjunction with 0078T)	XXX	N/A
D0080T		<del>Endovascular repair using prosthesis of abdominal aortic aneurysm, pseudoaneurysm or dissection, abdominal aorta involving visceral vessels (superior mesenteric, celiac and/or renal artery[s]); radiological supervision and interpretation</del> (Do not report 008T in conjunction with 34800-34805, 35801, 35102, 35452, 35472) (Report 008T in conjunction with 37205-37208, 37220-37223, only when these procedures are performed outside the target zone of the endoprosthesis)	XXX	N/A

D+0081T		<del>Placement of visceral extension prosthesis for endovascular repair of abdominal aortic aneurysm involving visceral vessels, each visceral branch, radiological supervision and interpretation (List separately in addition to code for primary procedure)</del> <del>(Use 0081T in conjunction with 0080T)</del> <del>(0078T-0081T have been deleted. To report, see 34841-34848)</del>	XXX	N/A
---------	--	--	-----	-----

April 2, 2013

Barbara Levy, MD  
Chair, RVS Update Committee  
American Medical Association  
515 N. State St.  
Chicago, IL 60610

Re: Tab 6 Fenestrated Endografting (FEVAR)

Dear Dr. Levy;

At their February 2013 meeting, the CPT Editorial Panel created eight new Category I codes to report fenestrated endograft repair of the upper abdominal aorta (FEVAR). The new codes 348XX1-348XX8 will be used to report placement of an endovascular graft in this visceral segment of the aorta, a procedure considered unimaginable just a few years ago. This endograft is different from all prior aortic endoprostheses in that there are pre-planned holes (fenestrations) in the fabric through which additional endograft limbs will extend into the origins of the renal and mesenteric arteries. Once the main body graft is placed, selective catheterization through the fenestrations is performed to bridge the gap between the main graft body and the renal arteries, superior mesenteric artery and/or celiac artery. With successful entry of wire and catheter through the fenestrations and into the main visceral arteries, covered stent grafts are advanced over the wire through the fenestrations, and into the native visceral arteries. When perfectly positioned, these additional covered endografts are deployed, thereby bridging the gap between main aortic endograft body and the visceral arteries. Thus, the new blood flow pathway is down the aorta, into the main body portion of the endograft, through the newly placed endograft branches and into the visceral arteries. This just-described deployment is performed either alone or in combination with repair of the entire infrarenal aorta, for arterial disorders including aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption. For the past several years these procedures have been reported by Category III codes (0078T, 0079T, 0080T, and 0081T). The application to convert to Category I codes was initiated by FDA-approval of the first such fenestrated aortic endograft. The Category I codes are substantially different than their Category III predecessors based on evolution of the investigational devices and procedures.

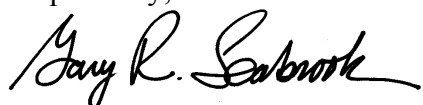
The task of recommending values for these eight new codes has been complicated by unanticipated hurdles as outlined below. As a result, we will be unable to submit RVU recommendations for these codes in April. We are recommending carrier pricing until several novel and complex issues are resolved.

RUC survey data revealed extensive pre-service time (120-195) for these procedures. The expert

consensus panel confirmed that these procedures do require extensive pre-service work that is not otherwise reportable, and in fact, some of the most intensive work occurs days to weeks before the defined 90-day global period begins (ie, the day before the procedure). Each of the currently FDA-approved main aortic endograft bodies are custom made by the vendor because every patient has a different arrangement and relative orientation of the renal and visceral artery origins. Thus, while the left and right renal arteries emanate from their respective sides of the aorta, one side may originate higher on the aorta than the other. In addition, the renal origins do not commonly exit from the normal 3 and 9 o'clock positions we envision on anatomic models. Finally, there is wide variation in how close the renal arteries are to the superior mesenteric origin. Each fenestrated endograft is anatomically specific for a patient depending on his or her anatomy. We now have learned that the physician must spend a minimum of 2 hours reviewing CT angiograms and 3D reconstructions, constructing procedure planning models and completing sizing sheets. Ultimately, the appropriate fenestrated device is ordered. This work is done over the course of several days or weeks prior to the date of surgery and is outside the guidelines for the 90-day global period. Additionally, this pre-service work is highly intense. If the surgeon errs in planning construction of the device, the intraoperative complications can be catastrophic, resulting in acute unresolvable renal failure, or acute and potentially fatal mesenteric ischemia should the fenestrations in the graft not align perfectly with the origins of the renal, superior mesenteric and celiac arteries. There is currently no means in RUC or CMS process to account for the degree, intensity and timing of two to three hours of physician work that occurs prior to initiation of the global period. This pre-service work is highly intense, and even if there were a means to artificially roll it forward into the 24 hours prior to surgery, the intensity is well beyond the standard 0.0224 IWP/UT used in CMS and RUC methodology.

We feel that it is crucial to correctly value these codes, but the limitations outlined above prevent us from making accurate recommendations. As such, SVS requests this Tab and these issues be referred to the Research Subcommittee to discuss specifically how to account for pre-service time and work that is 1) far in excess of any pre-service package, 2) vastly more intense than currently valued during pre-service, and 3) performed days to weeks prior to initiation of the traditional 90-day global period. We recommend that these eight new Category I CPT codes be Carrier priced until the Research Subcommittee and RUC formulate methodological recommendations.

Respectfully,



Gary Seabrook, MD  
The Society for Vascular Surgery (SVS)

cc: Sherry Smith  
Robert Zwolak, MD  
Matthew Sideman, MD  
Trisha Crishock

## AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2013

### **Retrograde Treatment Open Carotid Stent**

In February 2013, the CPT Editorial Panel established a new code, 37217 *Transcatheter placement of an intravascular stent(s), intrathoracic common carotid artery or innominate artery by retrograde treatment, via open ipsilateral cervical carotid artery exposure, including angioplasty, when performed, and radiological supervision and interpretation* to allow for reporting of open stent insertion. This procedure is currently reported using an unlisted code.

The RUC reviewed survey results from 32 vascular surgeons and neurosurgeons and agreed that a work RVU of 22.00, the survey median, appropriately accounts for the physician work. There was consensus among the RUC that the following physician time components are appropriate: pre-time of 74 minutes, intra service time of 120 minutes and post service time of 30 minutes. The RUC also agreed that an additional 11 minutes is appropriate to position the patient on the table in a beach chair position with the neck fully extended and rotated away from the operative side. In addition, the RUC agreed that time must be added to account for the placement of fluoroscopy compatible arm boards and safety restraints. To justify the work RVU, the RUC reviewed key reference code 37215 *Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection* (work RVU=19.68, intra service time=103 minutes) and agreed that 37217 is a more intense procedure requiring additional physician work. Specifically, CPT code 37217 includes surgical exploration of the neck, dissection of the carotid sheath, dissection of the common artery and closure of the wound, in addition to the work of stent placement and angiography. Therefore, 37217 should be valued higher. The RUC also reviewed CPT code 35606 *Bypass graft, with other than vein; carotid-subclavian* (work RVU=22.46, intra service time=145 minutes) and concluded that these two services should be valued similarly since they require analogous physician work and intensity. However, since 35606 requires slightly more time, it is appropriately valued higher. Further, the RUC compared 37217 to CPT code 33883 *Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); initial extension* (work RVU=21.09, intra service time=120 minutes) and noted that although these two require the same physician time, 37217 describes a slightly more intense procedure. **The RUC recommends a work RVU of 22.00 for CPT code 37217.**

### **Practice Expense**

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

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<b>Category I</b> <b>Surgery</b> <b>Cardiovascular System</b> <b>Arteries and Veins</b> <b>Transcatheter procedures</b>				
◎37215		Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection		
◎37216		without distal embolic protection		
<p>(37215 and 37216 include all ipsilateral selective carotid catheterization, all diagnostic imaging for ipsilateral, cervical and cerebral carotid arteriography, and all related radiological supervision and interpretation. When ipsilateral carotid arteriogram (including imaging and selective catheterization) confirms the need for carotid stenting, 37215 and 37216 are inclusive of these services. If carotid stenting is not indicated, then the appropriate codes for carotid catheterization and imaging should be reported in lieu of 37215 and 37216)</p> <p>(Do not report 37215, 37216 in conjunction with 36222-36224 for the treated carotid artery)</p> <p>(For <u>percutaneous</u> transcatheter placement of extracranial vertebral or intrathoracic carotid artery stent(s), see Category III codes 0075T, 0076T)</p> <p>(For <del>percutaneous transcatheter placement of intravascular stents other than coronary, carotid, or vertebral, see 37205, 37206</del>)</p>				

●37217	Y1	<p>Transcatheter placement of an intravascular stent(s), intrathoracic common carotid artery or innominate artery by retrograde treatment, via open ipsilateral cervical carotid artery exposure, including angioplasty, when performed, and radiological supervision and interpretation</p> <p><u>(37217 includes open vessel exposure and wound closure, all access and selective catheterization of the vessel, traversing the lesion, and any radiological supervision and interpretation directly related to the intervention performed when performed, standard closure of arteriotomy by suture, and imaging performed to document completion of the intervention in addition to the intervention(s) performed. Carotid artery revascularization services (eg, 33891, 35301, 35509, 35510, 35601, 35606) performed during the same session may be reported separately, when performed.)</u></p> <p><u>(Do not report 37217 in conjunction with 35201, 35458, 36221-36227, 35201, 35458, 75962 for ipsilateral services)</u></p> <p><u>(For percutaneous transcatheter placement of intravascular cervical carotid artery stent(s), see 37215, 37216)</u></p> <p><u>(For percutaneous transcatheter placement of intrathoracic common carotid artery stent(s), see 0075T, 0076T)</u></p> <p><u>(For transcatheter placement of intracranial stent(s), use 61635)</u></p>	090	22.00
<b>Radiology</b> <b>Diagnostic Radiology (Diagnostic Imaging)</b> <b>Transcatheter procedures</b>				



D75960		<p><del>Transcatheter introduction of intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity artery), percutaneous and/or open, radiological supervision and interpretation, each vessel</del></p> <p><del>(For stent placement, including radiological supervision and interpretation, in iliac, femoral, popliteal, and tibial/peroneal arteries, see 37221, 37223, 37226, 37227, 37230, 37231, 37234, 37235)</del></p> <p><del>(For procedure, see 37205–37208 )</del></p> <p><del>(For radiologic supervision and interpretation for transcatheter placement of extracranial vertebral or intrathoracic carotid artery stent(s), see Category III codes 0075T, 0076T)</del></p> <p><u>(75960 has been deleted. To report radiologic supervision for transcatheter placement of stent[s], see 37236-37238, 37221, 37223, 37226-37227, 37230-37231, 37234-37235, 37215-37216, 61635, 92928-92929, 92933-92934, 92937-92938, 92941, 92943-92944, 0075T-0076T, 37217)</u></p> <p>(75961 has been deleted. To report, use 37197)</p> <p>(For removal of a vena cava filter, use 37193)</p>	XXX	N/A
--------	--	--	-----	-----

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 37217	Tracking Number Y1	Original Specialty Recommended RVU: <b>22.00</b>
		Presented Recommended RVU: <b>22.00</b>
Global Period: 090		RUC Recommended RVU: <b>22.00</b>

CPT Descriptor: Transcatheter placement of an intravascular stent(s), intrathoracic common carotid artery or innominate artery by retrograde treatment, via open ipsilateral cervical carotid artery exposure, including angioplasty, when performed, and radiological supervision and interpretation

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 66-year-old male has recurrent episodes of transient left hemiparesis while on aspirin. Neurologic evaluation reveals no fixed neurological deficit. Diagnostic imaging demonstrates an irregular severe left common carotid origin stenosis and a widely patent carotid bifurcation. A common carotid stent is placed through an open retrograde approach.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 16% , Overnight stay-more than 24 hours 84%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 53%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Pre-service work begins after the decision to operate is made, from the day before surgery until the time of the procedure. This includes review of the hospital admission workup with special attention to cardiac comorbidity and development of any new embolic symptoms. Review results of preadmission testing, with special attention to anticoagulant or antiplatelet therapy, contrast allergy, CT scans, duplex ultrasound studies, arteriograms electrolytes, BUN, creatinine, and CBC to assure patient suitability for planned procedure; communication with referring physician, cardiologist, anesthesiologist and other health care professionals as necessary; review of indications, risks and benefits of surgery with patient and family; signature of informed consent; and preview of expected hospital course, pain management, discharge plans etc. with patient and family. Other pre-operative services including dressing, scrubbing, and waiting for surgery; supervision of patient positioning and skin preparation, and ensuring that necessary surgical instruments and supplies are available. Check OR or hybrid endovascular operating suite to ensure proper function and configuration of imaging equipment including compliance with radiation safety issues. The physician estimates the range of guiding catheters, selective catheters, sheaths, guidewires, balloons, and stents that may be required, and ensure availability. Ensure all technical personnel have been familiarized with the upcoming procedure and techniques and that they are fully familiar with all required devices. Ensure the patient is appropriately positioned on the table in a beach chair position with the neck extended and rotated to the right. Don radiation protection gear and ensure that all who will be in the suite do likewise. Supervise sterile prep of access site(s) and subsequent draping. Perform pre-procedural "time-out." Surgical presence is also required as the anesthesiology team proceeds with induction of general endotracheal anesthesia and insertion of an arterial pressure line.

Description of Intra-Service Work: Under anesthesia, the neck is incised along the anterior border of the sternocleidomastoid muscle and the soft tissue is dissected away from the carotid sheath. The common carotid artery is exposed, mobilized, and encircled taking care not to injure the vagus nerve or internal jugular vein. Systemic anticoagulation is administered and the distal artery is occluded. The common carotid artery is then punctured for retrograde catheter and guidewire manipulation through the occlusive disease into the aortic arch using fluoroscopic guidance. Roadmapping images are obtained for vessel sizing and to document anatomy. The area of stenosis/occlusion in the intrathoracic common carotid artery is crossed with a guidewire, and a sheath is advanced to or through the stenosis/occlusion. The lesion may be initially treated with balloon angioplasty for pre-dilatation to allow passage of the stent delivery system. An appropriately sized stent is selected and introduced to the lesion through the sheath. Using fluoroscopic guidance and appropriate road-mapping, the stent is positioned across the intended treatment zone, and is deployed. The stent may be seated or fully opened with additional balloon dilation. The stent delivery system and balloon are removed or pulled back over the wire, and follow-up images are obtained with contrast injection to determine if the stenosis has been adequately treated. Multiple balloon inflations may be required, or additional balloons with larger diameters may be used. If there are multiple segments of disease within the same vessel, these are also treated with appropriate-sized stent(s). Once a satisfactory result has been documented in the absence of extravasation, the sheath is removed, and hemostasis obtained with standard surgical closure of the arteriotomy. Vascular clamps are released with reinitiation of blood flow, and hemostasis of the suture line is achieved. The incision is closed in layers.

Description of Post-Service Work: Post-service work begins after skin closure in the operating room and includes application of sterile bandages, waiting for emergence from anesthesia, and confirmation that the patient has an intact neurologic status. Once this is assured, the patient is transferred to the recovery room where postoperative orders are written. The surgeon reviews ECG, blood gas, and other blood test results, and monitors neurologic status. The family, referring physician, and consultant physicians are contacted. In hospital post-service time includes all subsequent hospital visits, continued regulation of blood pressure, monitoring and care of the incision; monitoring, care and removal of all tubes and drains; and pain medication management. Discharge day management includes the surgeon's final examination of the patient, discussion of the likely post-hospital events, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge office visits for 90 days are part of the post-operative work. This includes removal of sutures, evaluation of periodic imaging studies and laboratory reports, and pain medication adjustments if necessary.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Gary Seabrook, MD, Robert Zwolak, MD, Matthew Sideman, MD, Micheal Sutherland, MD, Alex Mason, MD and John Ratliff, MD				
<b>Specialty(s):</b>	Vascular Surgery and Neurosurgery				
<b>CPT Code:</b>	37217				
<b>Sample Size:</b>	1800	<b>Resp N:</b>	32	<b>Response:</b> 1.7 %	
<b>Description of Sample:</b>	SVS - Random, 1400 AANS/CNS - Cerebrovascular Section, 400				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	1.00	2.00	2.00	4.00	15.00
<b>Survey RVW:</b>	17.88	20.38	22.00	24.00	28.00
<b>Pre-Service Evaluation Time:</b>			110.00		
<b>Pre-Service Positioning Time:</b>			15.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			20.00		
<b>Intra-Service Time:</b>	60.00	86.00	120.00	143.00	300.00
<b>Immediate Post Service-Time:</b>	<b>30.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>95.00</b>	99231x 0.00 99232x 1.00 99233x 1.00			
<b>Discharge Day Mgmt:</b>	<b>38.00</b>	99238x 1.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>46.00</b>	99211x 0.00 12x 0.00 13x 2.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

4 - FAC Difficult Patient/Difficult Procedure

<b>CPT Code:</b>	37217	<b>Recommended Physician Work RVU: 22.00</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		40.00	40.00	0.00
<b>Pre-Service Positioning Time:</b>		14.00	3.00	11.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		20.00	20.00	0.00
<b>Intra-Service Time:</b>		120.00		
<b>Immediate Post Service-Time:</b>	<b>30.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>95.00</b>	99231x 0.00 99232x 1.00 99233x 1.00		
<b>Discharge Day Mgmt:</b>	<b>38.00</b>	99238x 1.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>46.00</b>	99211x 0.00 12x 0.00 13x 2.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00
---------------	-------------	-------------	-------------	-------------

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
37215	090	19.68	RUC Time

CPT Descriptor Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
37215	090	19.68	RUC Time	8,988

CPT Descriptor 1 Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
35606	090	22.46	RUC Time

CPT Descriptor Bypass graft, with other than vein; carotid-subclavian**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 15      % of respondents: 46.8 %

**TIME ESTIMATES (Median)**

	<b>CPT Code:</b> 37217	<b>Key Reference CPT Code:</b> 37215	<b>Source of Time</b> RUC Time
Median Pre-Service Time	74.00	90.00	
Median Intra-Service Time	120.00	103.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	95.0	78.00	
Median Discharge Day Management Time	38.0	0.00	
Median Office Visit Time	46.0	46.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>403.00</b>	<b>347.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.67	3.40
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.80	3.67
--	------	------

Urgency of medical decision making	3.53	3.53
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.20	3.93
--------------------------	------	------

Physical effort required	3.67	3.20
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.33	4.27
---	------	------

Outcome depends on the skill and judgment of physician	4.40	4.13
--	------	------

Estimated risk of malpractice suit with poor outcome	4.47	4.33
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.67	3.67
----------------------------------	------	------

Intra-Service intensity/complexity	4.20	4.07
------------------------------------	------	------

Post-Service intensity/complexity	2.93	2.87
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

## **Why is this code being reviewed?**

CPT Code 37217 is a new code presented to and accepted by CPT to describe this procedure with no other code to appropriately describe this work. This procedure is currently being reported with 37799, unlisted procedure, vascular surgery.

## **Methodology**

An invitation to participate in a standard RUC survey for 37217 was sent to all active members of the Society of Vascular Surgery (SVS) and to 400 members of the AANS/CNS Cerebrovascular group through an email list-service. There were 32 respondents out of 1800 survey requests for a response rate of 1.7%. There was a high degree of concordance among the survey respondents with a tight distribution of recommendations. 88% of the respondents thought the vignette described the typical patient. All respondents had experience with this procedure and the median performance rate was 2 cases over the past 12 months.

## **Work RVU Recommendation**

We are recommending the median survey value of 22.00 RVU for 37217.

## **Pre-time**

Our expert panel recommends that Pre-time package 4 (facility- difficult patient/difficult procedure) is appropriate, with 11 additional minutes for positioning:

Evaluation: Survey respondents indicated a median evaluation time of 110 minutes to review multiple pre-operative tests, consultations and images for responsible pre-operative planning. The society expert panel recommends accepting the package 4 evaluation time of 40 minutes.

Positioning: Package 4 positioning time is 3 minutes. An additional 11 minutes (total=14) of pre-service positioning time for 37217 is necessary to accomplish special positioning. The patient must be positioned with the neck extended and rotated away from the operative side. This request is consistent with the 12 minutes of positioning approved for CPT code 60240. In that case 9 minutes (total=12) were added to account for “induction of anesthesia in supine position, assist with patient positioning with shoulder roll, head extended and stabilized. Assist with adjusting the OR table and anesthesia lines so that the operative site is assessable. Re-assess position of the extremities and head, adjust as needed. An additional 2 minutes of positioning time is recommended to account for placement of fluoro compatible arm boards and safety restraints to prevent patient from falling off narrow angiography table, and due to the need for orientation and test imaging of the angiographic field of interest. Radio-opaque material in the field must be repositioned prior to sterile draping. The society feels that these additional steps in positioning more than justify the additional minutes to the standard package. [Summary: 3 + 9 + 2 = 14]

Scrub, dress & wait: The survey respondents confirmed 20 minutes for pre-service scrub, dress, and wait time.

## **Comparison to Key Reference Code and MPC code**

### **Clinical Comparison**

The key reference code 37215 was chosen by the survey respondents 47% of the time with the next most frequent code being chosen by only 16% of the respondents. The key reference service, 37215(*Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection*), is on the MPC list and was reviewed by the RUC in April 2004. Key reference 37215 is similar to 37217 in the sense that they are both vascular operations on the carotid system. Both codes describe placement of a stent in the left carotid system with the risk of emboli to the brain and stroke. Survey code 37217 includes surgical exploration of the neck, dissection of the carotid sheath, dissection of the common carotid artery, and closure of the wound in addition to the work of stent placement and angiography.

### **Work Comparison with Key Reference/MPC Code**

Key reference code 37215 (*Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection*) involves percutaneous remote access to the carotid system, placement of an embolic protection device and delivery of a stent to the affected area. This percutaneous approach results in a shorter intra service procedure time and shorter hospitalization due to the absence of a neck wound and the pain and risk associated

with the surgical exposure required for 37217. The high risk of thromboembolic complications associated with both codes account for the similar range IWPUT. The shorter intraservice time, shorter hospitalization and higher risk of perioperative stroke account for the higher intensity of work seen in the key reference service code. Pre and Post service times are the similar between the two codes. The added time for surgical exposure, dissection and closure of the wound are reflected in the longer intra-service time seen in 37217. The post service times and office visit patterns are the same between the codes. The hospital visits reflect an additional day of hospitalization compared to the key reference service due to pain control, blood pressure control and recovery from open exploration required for 37217 which is not seen in the key reference code.

	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	Post	Hosp	office
37217	22.00	0.111	403	40	14	20	120	30	33,32,38	13,13
37215	19.68	0.122	347	60	15	15	103	30	32,38	13,13

## **Additional Comparison Code 35606**

### **Clinical Comparison**

The additional comparison code 35606 (*Bypass graft, with other than vein; carotid-subclavian*) reflects somewhat similar vascular surgery work in the same anatomic region as the survey code and was chosen by the respondents as the second most common key reference code with 16% of the respondents selecting it as the reference code. CPT Code 35606 (*Bypass graft, with other than vein; carotid-subclavian*) was reviewed by the RUC in September 2005. The comparison code 35606 is similar to 37217 in the sense that they are both vascular operations on the carotid artery system. Both codes describe surgical exploration of the neck, dissection of the carotid sheath, dissection of the common carotid artery, and closure of the wound. In addition the comparison code 35606 includes bypass of the common carotid artery to the subclavian artery with non autogenous conduit.

### **Work Comparison with Additional Comparison Code 35606**

The comparison code 35606 (*Bypass graft, with other than vein; carotid-subclavian*) involves bypass with a non autogenous conduit and two anastomoses which take longer than the closure of the single arteriotomy performed in 37217. The surgical incision and exposure are similar between the two procedures as is postoperative recovery and care. There is a high risk of thromboembolic complications associated with both codes. Pre time is slightly longer in 37217 due to the added preparation necessary for performance of a procedure involving angiography and operative interventions. The added time for performance of a second anastomosis is reflected in the longer intra-service time seen in 35606. The post service times, office visit, and hospital visit patterns are the same between the codes. While both services are very intense, the accurate intra-thoracic placement of a stent requires steep LAO imaging to achieve precise remote placement. It is entirely appropriate that the IWPUT of the new retrograde carotid stent of 0.111 is higher than the bypass graft 35606 (0.097), but lower than that of the percutaneous cervical carotid stent (0.122).

	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	Post	Hosp	office
37217	22.00	0.111	403	40	14	20	120	30	33,32,38	13,13
35606	22.46	0.097	414	30	15	15	145	30	33,32,38	13,13

## **Summary**

Based on comparisons to the key reference service / MPC code and the additional comparison code, we believe that our recommendation for the median survey value of 22.00 is appropriate for 37217.

## **SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No



Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 37799 Unlisted procedure, vascular surgery

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Vascular Surgery                      How often? Sometimes

Specialty Neuro Surgery                      How often? Rarely

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National data is not available.

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,000

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is an uncommon procedure. The specialty expert panel estimates 1000 cases per year.

Specialty Vascular Surgery	Frequency 950	Percentage 95.00 %
----------------------------	---------------	--------------------

Specialty Neuro Surgery	Frequency 50	Percentage 5.00 %
-------------------------	--------------	-------------------

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States? Yes

## Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 37660

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AF	AG	AH	AI	AJ
12	ISSUE: Retrograde Treatment Open Carotid Stent																															
13	TAB: 7																															
14						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day						Office					
15	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	15	14	13	12	11
16	REF	37215	Transcatheter pla	15	0.122			19.68			347	60	15	15			103			30	1					1.0		2				
17	CURRENT	37799	Unlisted procedure,	#DIV/0!							0																					
18	SVY	37217	Transcatheter pla	32	0.098	17.88	20.38	22.00	24.00	28.00	474	110	15	20	60	86	120	143	300	30	1 1					1.0		2				
19	REC				0.111	22.00					403	40	14	20			120			30	1 1					1.0		2				
20																																
21																																
22																																
23																																
24																																
25																																

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

**Global Period:** 090

**Meeting Date:** 04/2013

**CPT Long Descriptor:** *Transcatheter placement of an intravascular stent(s), intrathoracic common carotid artery or innominate artery by retrograde treatment, via open ipsilateral cervical carotid artery exposure, including angioplasty, when performed, and radiological supervision and interpretation*

**1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:**

A standard RUC survey was conducted for physician work. An expert panel reviewed the recommendations for physician work and makes the following practice expense recommendations.

**2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison. You must provide an explanation for the selection of reference codes. Reference Code Rationale:**

CPT Code 37215 *Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection* was included as the reference code for these practice expense recommendations. CPT code 37215 was the key reference service code for the physician work survey and has the same direct practice expense inputs.

**3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:**

N/A

**4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:**

Staple removal pack added for the surveyed code with is “open” compared with the reference code, which is percutaneous through groin.

**5. Please describe in detail the clinical activities of your staff:**

**Pre-Service Clinical Labor Activities:**

The standard inputs for 090-day codes have been recommended for this procedure.

**Intra-Service Clinical Labor Activities:**

The standard time for discharge day management has been recommended for this procedure.

**Post-Service Clinical Labor Activities:**

Standard times to ready patient/records and assist physician at each post-op office visit have been applied.

	A	B	C	D	E	F	G
1	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.			<b>REFERENCE CODE</b>		<b>Surveyed Code</b>	
2	**Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please			<b>37215</b>		<b>37217</b>	
3	Meeting Date: 04/2013 Tab: 7 Retrograde Treatment Open Carotid Stent Specialty: Vascular Surgery and NeuroSurgery	CMS Code	Staff Type	Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with		Transcatheter placement of an intravascular stent(s), intrathoracic common carotid artery or	
4	LOCATION			Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			090	090	090	090
6	TOTAL CLINICAL LABOR TIME			0.0	144.0	0.0	144.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	60.0	0.0	60.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	12.0	0.0	12.0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	72.0	0.0	72.0
10	<b>PRE-SERVICE</b>						
11	Start: Following visit when decision for surgery or procedure made						
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5		5
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20		20
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8		8
15	Provide pre-service education/obtain consent						0
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		20		20
17	*Other Clinical Activity - specify:	L037D	RN/LPN/MTA		7		7
18	End: When patient enters office/facility for surgery/procedure						
19	<b>SERVICE PERIOD</b>						
20	Start: When patient enters office/facility for surgery/procedure:						
21	Greet patient, provide gowning, ensure appropriate medical records are available						
22	Obtain vital signs						
23	Provide pre-service education/obtain consent						
24	Prepare room, equipment, supplies						
25	Setup scope (non facility setting only)						
26	Prepare and position patient/ monitor patient/ set up IV						
27	Sedate/apply anesthesia						
28	*Other Clinical Activity - specify:						
29	<b>Intra-service</b>						
30	Assist physician in performing procedure						
31	<b>Post-Service</b>						
32	Monitor pt. following service/check tubes, monitors, drains						
33	Clean room/equipment by physician staff						
34	Clean Scope						
35	Clean Surgical Instrument Package						
36	Complete diagnostic forms, lab & X-ray requisitions						
37	Review/read X-ray, lab, and pathology reports						
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
39	*Other Clinical Activity - specify:						
40	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			n/a		n/a	
41	Dischrg mgmt (1.0 x 99238) (enter 12 min)	L037D	RN/LPN/MTA	n/a	12	n/a	12
42	Dischrg mgmt (1.0 x 99239) (enter 15 min)			n/a		n/a	
43	End: Patient leaves office						
44	<b>POST-SERVICE Period</b>						
45	Start: Patient leaves office/facility						
46	Conduct phone calls/call in prescriptions						
47	Office visits: List Number and Level of Office Visits			# visits	# visits	# visits	# visits
48	99211 16 minutes		16				
49	99212 27 minutes		27				
50	99213 36 minutes		36		2		2
51	99214 53 minutes		53				
52	99215 63 minutes		63				
53	Total Office Visit Time			0.0	72.0	0.0	72.0
54	*Other Clinical Activity - specify:						
55	End: with last office visit before end of global period						

	A	B	C	D	E	F	G
1	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.			<b>REFERENCE CODE</b>		<b>Surveyed Code</b>	
2	**Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please			<b>37215</b>		<b>37217</b>	
3	Meeting Date: 04/2013 Tab: 7 Retrograde Treatment Open Carotid Stent Specialty: Vascular Surgery and NeuroSurgery	CMS Code	Staff Type	Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with		Transcatheter placement of an intravascular stent(s), intrathoracic common carotid artery or	
4	LOCATION			Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			090	090	090	090
56	<b>MEDICAL SUPPLIES**</b>						
		CODE	UNIT				
57	pack, minimum multi-specialty visit	SA048	pack		2		2
58	pack, post-op incision care (suture & staple)	SA053	pack				1
59							
60							
61							
62							
63	<b>EQUIPMENT</b>						
		CODE					
64	table, exam	EF023			72		72
65							
66							
67							
68							

AMA/Specialty Society RVS Update Committee Summary of Recommendations  
*High Volume Growth / Codes Reported Together 75% or More*

April 2013

**Transcatheter Placement of Intravascular Stent**

In February 2010, the CPT Editorial Panel revised CPT codes 37208-37028 as part of the larger Endovascular Revascularization issue. Initially, the RUC requested review of these codes in tandem with the new lower extremity revascularization codes, but subsequently deferred review because it would be difficult to describe the typical patient given the removal of the lower extremity revascularization services. In April 2010, CPT code 37205 *Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; initial vessel* was identified through the High Volume and Codes Reported Together 75% or More screens and the specialties were encouraged to create new bundled codes. In February 2013, the CPT Editorial Panel deleted four intravascular stent placement codes: 37205 *Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; initial vessel*, 37206 *Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; each additional vessel*, 37207 *Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; initial vessel* and 37208 *Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; each additional vessel (List separately in addition to code for primary procedure)* and one radiological supervision and interpretation code, 75960 *Transcatheter introduction of intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity artery), percutaneous and/or open, radiological supervision and interpretation, each vessel* and established four new bundled codes to describe transcatheter placement of intravascular stent.

***37236 Transcatheter placement of an intravascular stent(s) (except lower extremity, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery***

The RUC reviewed the survey results from 77 vascular surgeons, radiologists and cardiologists and determined that a work RVU of 9.00, the survey median, appropriately accounts for the physician work of this procedure. The RUC noted that 37236 will be reported with a catheter placement code, 36200 *Introduction of catheter, aorta* (work RVU=3.02), 36215 *Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family* (work RVU=4.67), 36216 *Selective catheter placement, arterial system; initial second order thoracic or brachiocephalic branch, within a vascular family* (work RVU=5.27), 36217 *Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family* (work RVU=6.29), 36245 *Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family* (work RVU=4.67), 36246 *Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family* (work RVU=5.27) or 36247 *Selective catheter placement, arterial system; initial third order or more selective abdominal,*

*pelvic, or lower extremity artery branch, within a vascular family* (work RVU=6.29), and the catheter code will be subject to the multiple procedure payment reduction. The retention of the catheter codes was necessary to account for variation in anatomical sites. To ensure the recommended value is relative to similar stenting procedures, the RUC reviewed several newly bundled services in the lower extremity revascularization family of services. Prior to comparing, the RUC noted that these codes have catheterization bundled in and appropriately applied the multiple procedure reduction in order to provide a useful comparison to 37236. The RUC reviewed the following CPT codes: 37221 *Iliac stent* (work RVU= 10.00) and removed the work of catheterization code 36245 (work RVU=  $4.67/2 = 2.33$ ) for a comparison value of 7.67; 37226 *Femoral stent* (work RVU= 10.49) and removed the work of catheterization code 36247 (work RVU=  $6.29/2 = 3.15$ ) for a comparison value of 7.34 and 37230 *Tibial stent* (work RVU= 13.80) and removed the work of catheterization code 36247 (work RVU=  $6.29/2 = 3.15$ ) for a comparison value of 10.65. The surveyed code describes intravascular stenting of any vessel other than lower extremity, coronary or carotid. The remaining vessels represent a wide variety of sizes, anatomies and locations; all of which are now described in 37236. Given this, the RUC agreed that the recommended value of 9.00 for 37236 is appropriately aligned between these three comparison codes.

For further comparison, the RUC compared 37236 to key reference code 37184 *Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel* (work RVU=8.66) and noted that although these two codes have exact intra service time (90 minutes), and similar total time, (161 versus 160 minutes), the survey respondents indicated that 37236 is more intense and complex compared to the key reference code, 37184. The RUC agreed that the survey 25<sup>th</sup> percentile work RVU of 8.00 would create a rank order anomaly. The RUC also reviewed CPT code 52355 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic tumor* (work RVU=9.00) and agreed that the physician work and complexity of these two procedures is similar. **The RUC recommends a work RVU of 9.00 for CPT code 37236.**

***37237 Transcatheter placement of an intravascular stent(s) (except lower extremity, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; each additional artery (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 61 vascular surgeons, radiologists and cardiologists and determined that a work RVU of 4.25, the survey 25<sup>th</sup> percentile is appropriate. The RUC also agreed with the specialty society that 1 minute of pre and 1 minute of post time is appropriate for this add-on code to account for the additional evaluation time above the base code to assess placement of an additional stent in a separate vessel. This additional time is consistent with other ZZZ global codes in the vascular family (e.g. 37222, 37223 and 37232). To ensure relativity, the RUC reviewed two add-on codes: 35685 *Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit* (work RVU= 4.04) and 60512 *Parathyroid autotransplantation (List separately in addition to code for primary procedure)* (work RVU= 4.44) and noted that both have identical intra times as 37237, 45 minutes, and provide appropriate brackets to validate the recommended work RVU. **The RUC recommends a work RVU of 4.25 for CPT code 37237.**



***37238 Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; initial vein***

The RUC reviewed survey results from 75 vascular surgeons, radiologists and cardiologists and determined that a direct crosswalk to CPT code 36247 *Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family* (work RVU= 6.29, and intra-service time of 60 minutes), is appropriate. A work value of 6.29 for 37238 is slightly higher than the survey 25<sup>th</sup> percentile. The RUC reviewed CPT code 35460 *Transluminal balloon angioplasty, open; venous* (work RVU= 6.03) and agreed that a work RVU lower than 6.29 would create a rank order anomaly since 37238 includes the physician work of an angioplasty and placement of a stent. To further support this value, the RUC reviewed CPT code 37197 *Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), includes radiological supervision and interpretation, and imaging guidance (ultrasound or fluoroscopy), when performed* (work RVU=6.29, intra-service time=60 minutes) and agreed that both codes have the same intra-service time and similar complexity and should be valued the same. **The RUC recommends a work RVU of 6.29 for CPT code 37238.**

***37239 Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; each additional vein (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results of 61 vascular surgeons, radiologists and cardiologists and determined that a direct crosswalk to CPT code 35686 *Creation of distal arteriovenous fistula during lower extremity bypass surgery (non-hemodialysis) (List separately in addition to code for primary procedure)* (work RVU= 3.34 and intra-service time of 35 minutes) accurately accounts for the work involved in this service. The RUC also agreed with the specialty societies that 1 minute of pre-service and 1 minute of post-service time is appropriate to account for the additional evaluation time above the base code to assess placement of an additional stent in a separate vessel. The RUC also compared the work RVU of 3.34 to 37237 and agreed that since 37239 has 15 minutes less intra time, it is appropriately valued lower than 37237. To support this value, the RUC reviewed key reference code 37185 *Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); second and all subsequent vessel(s) within the same vascular family (List separately in addition to code for primary mechanical thrombectomy procedure)* (work RVU=3.28, intra-service time=40 minutes) and determined that the physician work and intensity of 37239 is higher, justifying the higher work value. **The RUC recommends 3.34 work RVUs for CPT code 37239.**

**Practice Expense:**

The RUC accepted the direct PE inputs with minor modifications as recommended by the PE Subcommittee.

**Work Neutrality**

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

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<b>Category I</b> <b>Surgery</b> <b>Cardiovascular System</b> <b>Heart and Pericardium</b> <b>Single Ventricle and Other Complex</b> <b>Cardiac Anomalies</b>				
33621		Transthoracic insertion of catheter for stent placement with catheter removal and closure (eg, hybrid approach stage 1)  (For placement of stent, use <del>37207</del> <u>37236</u> )  (Report both 33620, 33621 if performed in same session)		
<b>Vascular Injection Procedures</b> <b>Intra-Arterial—Intra-Aortic</b> <b>Interventions for Arteriovenous (AV) Shunts Created for Dialysis (AV Grafts and AV Fistulae):</b> For the purposes of coding interventional procedures in arteriovenous (AV) shunts created for dialysis (both arteriovenous fistulae [AVF] and arteriovenous grafts [AVG]), the AV shunt is artificially divided into two vessel segments. The first segment is peripheral and extends from the peri-arterial anastomosis through the axillary vein (or entire cephalic vein in the case of cephalic venous outflow). The second segment includes the veins central to the axillary and cephalic veins, including the subclavian and innominate veins through the vena cava. Interventions performed in a single segment, regardless of the number of lesions treated, are coded as a single intervention.  The AV shunt is considered to be venous and most interventions are coded with the venous intervention codes (ie, angioplasty is reported with venous angioplasty codes <u>35476</u> , <u>75978</u> ). Codes <u>35476</u> and <u>75978</u> would be reported once to describe all angioplasty work performed in one segment of the AV dialysis shunt, regardless of the number of distinct lesions treated within that segment, the number of times the balloon is inflated, or the number of balloon catheters required to open all lesions.				

There is an exception to the use of venous interventional codes. When there is a stenosis at the arterial anastomosis, it typically extends across the anastomosis and involves the artery just proximal to and at the anastomosis as well as the outflow vessel or graft. This segment is called the peri-anastomotic (or juxta-anastomotic) region, and even though the stenosis can involve multiple vessels, it is typically a single lesion with a single etiology crossing the anastomosis, and treatment to open this lesion crosses from the artery into the vein or venous graft. An intervention treated in this peri-anastomotic segment is coded as an arterial intervention (35475, 75962). Since the entire segment of the AV shunt from the peri-arterial anastomosis through the axillary vein is considered a single vessel for coding of interventions, the arterial angioplasty codes include the work of opening the peri-anastomotic stenosis, as well as all other stenoses treated within this segment of the vessel. Codes 35475 and 75962 are reported once to describe all work done to angioplasty any lesion from the peri-arterial anastomosis through the axillary vein in procedures that involve angioplasty of the peri-arterial anastomosis of the AV shunt. In these special instances, venous angioplasty codes would not be reported additionally for this first or most peripheral shunt segment, even if balloon angioplasty is performed on segments of the AV dialysis shunt that are purely venous anatomy within this specific vessel segment.

It is never appropriate to report removal of the arterial plug during a declot/thrombectomy procedure as an arterial or venous angioplasty (35475, 35476). Removal of the arterial plug is included in the work of a fistula thrombectomy (36870), even if a balloon catheter is used to mechanically dislodge the resistant thrombus.

The central veins (eg, subclavian, innominate, and cava) are considered an additional, separate venous vessel segment for purposes of interventional coding for AV dialysis shunt interventions. If one or more central venous stenoses are treated with angioplasty, this is reported as a single venous angioplasty (35476, 75978), regardless of the number of discrete lesions treated within this segment, and also independent of the number of balloon inflations or number of balloon catheters or sizes required. This additional work should be clearly documented in the patient record and in the recorded images.

~~The codes for stents placed in AV dialysis accesses are generic for intravascular work and not specific for arterial or venous anatomy. However,~~ The same rules used for angioplasty apply to stent placements for AV dialysis shunts with respect to the number of interventions reported for each patient. ~~Stent codes (37205, 75960) are~~ Either code 37236 or 37238 is reported once to describe all work of stenting lesions within the defined AV dialysis shunt segment from the peri-arterial anastomosis through the axillary and cephalic veins, regardless of the number of stents placed or the number of discrete lesions treated within that vessel segment. Code 37238 is reported for placement of AV access stent unless the treated lesion includes the peri-anastomotic region. This peri-anastomotic region is considered an artery and therefore code 37236 is reported instead of code 37238. If additional stenting is required for central venous stenosis, this may be reported as an additional stent placement (~~37206, 75960-37239~~), describing all the work of stent placement within the central venous segment .

The work of catheterizing all the veins in the dialysis AV shunt is included in 36147 (and, if appropriate, 36148). Selective catheterization of the inferior/superior vena cava and central veins cannot be separately reported when performed from a direct puncture of the AVF/AVG.

However, if additional venous side branches off of the conduit, known as accessory veins, are separately catheterized for intervention such as embolization of a large competing accessory vein, this additional work may be separately reported using the appropriate selective venous catheterization codes (36011 and 36012). The embolization may be reported using 37204, 75894.

**Transcatheter Procedures**  
**Other Procedures**

D37205		<del>Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; initial vessel</del> <del>(For radiological supervision and interpretation, use 75960)</del> <del>(For transcatheter placement of intravascular cervical carotid artery stent(s), see 37215, 37216)</del> <del>(For transcatheter placement of intracranial stents, use 61635)</del> <del>(For transcatheter coronary stent placement, see 92980, 92981)</del> <del>(For transcatheter stent placement of extracranial vertebral or intrathoracic carotid artery stent(s), see Category III codes 0075T, 0076T)</del>	000	N/A
		<del>(For stent placement in iliac, femoral, popliteal, and tibial/peroneal arteries, see 37221, 37223, 37226, 37227, 37230, 37231, 37234, 37235)</del>		
D+37206		<del>each additional vessel (List separately in addition to code for primary procedure)</del> <del>(Use 37206 in conjunction with 37205)</del> <del>(For radiological supervision and interpretation, use 75960)</del>	ZZZ	N/A

D37207		<p>Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; initial vessel</p> <p>(For stent placement in iliac, femoral, popliteal, and tibial/peroneal arteries, see 37221, 37223, 37226, 37227, 37230, 37231, 37234, 37235)</p>	000	N/A
D+37208		<p>each additional vessel (List separately in addition to code for primary procedure)</p> <p>(Use 37208 in conjunction with 37207)</p> <p>(For radiological supervision and interpretation, use 75960)</p> <p>(For catheterizations, see 36215-36248)</p> <p>(For transcatheter placement of intracoronary stent(s), see 92980, 92981)</p> <p>(Codes 37205-37208 have been deleted. To report, see 37241-37244)</p>	ZZZ	N/A
<p>●37215</p> <p>Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection</p>				

◎37216

without distal embolic protection

(37215 and 37216 include all ipsilateral selective carotid catheterization, all diagnostic imaging for ipsilateral, cervical and cerebral carotid arteriography, and all related radiological supervision and interpretation. When ipsilateral carotid arteriogram (including imaging and selective catheterization) confirms the need for carotid stenting, 37215 and 37216 are inclusive of these services. If carotid stenting is not indicated, then the appropriate codes for carotid catheterization and imaging should be reported in lieu of 37215 and 37216)

(Do not report 37215, 37216 in conjunction with 36222- 36224 for the treated carotid artery)

(For transcatheter placement of extracranial vertebral or intrathoracic carotid artery stent(s), see Category III codes 0075T, 0076T)

(For percutaneous transcatheter placement of intravascular stents other than coronary, carotid, or vertebral, see 37205, 37206)

**Endovascular Revascularization (Open or Percutaneous, Transcatheter)**

◎✚37235 Revascularization, endovascular, open or percutaneous with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)

(Use 37235 in conjunction with 37231)

Codes 37236-37239 are used to report endovascular revascularization for vessels other than lower extremity (ie, 37221, 37223, 37226-37227, 37230-37231, 37234-37235), cervical carotid (ie, 37215-37216), intracranial (ie, 61635), intracoronary (ie, 92928-92929, 92933-92934, 92937-92938, 92941, 92943-92944), extracranial vertebral or intrathoracic carotid (ie, 0075T-0076T) performed percutaneously and/or through an open surgical exposure, or open retrograde intrathoracic common carotid or innominate (3741).

Codes 37236-37237 describe transluminal intravascular stent insertion in an artery while codes 37238-37239 describe transluminal intravascular stent insertion in a vein. Multiple stents placed in a single vessel may only be reported with a single code. If a lesion extends across the margins of one vessel into another, but can be treated with a single therapy, the intervention should be reported only once. When additional, different vessels are treated in the same session, report 37237 and/or 37239 as appropriate. Each code in this family (37236-37239) includes any and all balloon angioplasty(s) performed in the treated vessel, including any pre-dilation (whether performed as a primary or secondary angioplasty), post-dilation following stent placement, treatment of a lesion outside the stented segment but in the same vessel, or use of larger/smaller balloon to achieve therapeutic result. Angioplasty in a separate and distinct vessel may be reported separately. Non-selective and/or selective catheterization(s) (eg, 36005, 36010-36015, 36200, 36215-36218, 36245-36248) is reported separately.

Codes 37236-37239 include radiological supervision and interpretation directly related to the intervention(s) performed, closure of the arteriotomy by pressure, application of an arterial closure device or standard closure of the puncture by suture, and imaging performed to document completion of the intervention in addition to the intervention(s) performed. Extensive repair or replacement of an artery may be reported separately (eg, 35226 or 35286). Report 76937 for ultrasound guidance for vascular access, when performed in conjunction with 37236-37239. Intravascular ultrasound may be reported separately (ie, 37250-37251). For mechanical thrombectomy and/or thrombolytic therapy, when performed, see 37184-37188, 37211-37214.

Intravascular stents, both covered and uncovered, are a class of devices that may be used as part of an embolization procedure. As such, there is the potential for overlap among codes used for placement of vascular stents and those used for embolization. When a stent is placed for the purpose of providing a latticework for deployment of embolization coils, such as for embolization of an aneurysm, the embolization code is reported and not the stent code. If a covered stent is deployed as the sole management of an aneurysm, pseudoaneurysm, or vascular extravasation then the stent deployment code should be reported and not the embolization code.

●⊕37236	X1	Transcatheter placement of an intravascular stent(s) (except lower extremity, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery	000	9.00
●⊕⊕37237	X2	<p>each additional artery (List separately in addition to code for primary procedure)</p> <p><u>(Use 37237 in conjunction with 37236)</u></p> <p><u>(For stent placement(s) in iliac, femoral, popliteal, or tibial/peroneal artery(s), see 37221, 37223, 37226, 37227, 37230, 37231, 37234, 37235)</u></p> <p><u>(For transcatheter placement of intravascular cervical carotid artery stent(s), see 37215, 37216)</u></p> <p><u>(For transcatheter placement of intracranial stent(s), use 61635)</u></p> <p><u>(For transcatheter placement of intracoronary stent(s), see 92928-92929, 92933-92934, 92937-92938, 92941, 92943-92944)</u></p>	ZZZ	4.25



		<p><u>(For stenting of visceral arteries in conjunction with fenestrated endovascular repair of the visceral aorta, see 34841-34844, and with fenestrated endovascular repair of the visceral aorta and concomitant infrarenal abdominal aorta, see 34845-34848)</u></p> <p><u>(For percutaneous transcatheter placement of extracranial vertebral artery or intrathoracic carotid artery stent(s), see Category III codes 0075T, 0076T)</u></p> <p><u>(For open retrograde transcatheter placement of intrathoracic common carotid/innominate artery stent(s), use 37217)</u></p>		
●◎37238	X3	Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; initial vein	000	6.29
●◎+37239	X4	<p>each additional vein (List separately in addition to code for primary procedure)</p> <p><u>(Use 37239 in conjunction with 37238)</u></p> <p><u>(Do not report 37236-37239 in conjunction with 34841-34848 for bare metal or covered stents placed into the visceral arteries.)</u></p>	ZZZ	3.34
<b>Radiology</b> <b>Diagnostic Radiology (Diagnostic Imaging)</b> <b>Transcatheter Procedures</b>				
D75960		<del>Transcatheter introduction of intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity artery), percutaneous and/or open, radiological supervision and interpretation, each vessel</del>	XXX	N/A

		<p>peroneal arteries, see 37221, 37223, 37226, 37227, 37230, 37231, 37234, 37235)</p> <p>(For procedure, see 37205-37208)</p> <p>(For radiologic supervision and interpretation for transcatheter placement of extracranial vertebral or intrathoracic carotid artery stent(s), see Category III codes 0075T, 0076T)</p> <p><u>(75960 has been deleted. To report radiologic supervision for transcatheter placement of stent[s], see 37236-37239, 37221, 37223, 37226-37227, 37230-37231, 37234-37235, 37215-37216, 61635, 92928-92929, 92933-92934, 92937-92938, 92941, 92943-92944, 0075T-0076T, 3741)</u></p> <p>(75961 has been deleted. To report, use 37197)</p> <p>(For removal of a vena cava filter, use 37193)</p>		
<b>Category III Codes</b> <del>(0078T-0081T should be reported in accordance with the Endovascular Abdominal Aneurysm Repair guidelines established for 34800-34826)</del>				
D0078T		<p><del>Endovascular repair using prosthesis of abdominal aortic aneurysm, pseudoaneurysm or dissection, abdominal aorta involving visceral branches (superior mesenteric, celiac and/or renal artery[s])</del></p> <p><del>(Do not report in 0078T in conjunction with 34800-34805, 35081, 35012, 35454, 35472)</del></p> <p><del>(Report 0078T in conjunction with 37205-37208, 37220-37223, only when these procedures are performed outside the target zone of the endoprosthesis)</del></p>	XXX	N/A

D+0079T		Placement of visceral extension prosthesis for endovascular repair of abdominal aortic aneurysm involving visceral vessels, each visceral branch (List separately in addition to code for primary procedure) (Use 0079T in conjunction with 0078T)	ZZZ	N/A
D0080T		Endovascular repair using prosthesis of abdominal aortic aneurysm, pseudoaneurysm or dissection, abdominal aorta involving visceral vessels (superior mesenteric, celiac and/or renal artery[s]), radiological supervision and interpretation (Do not report 008T in conjunction with 34800-34805, 35801, 35102, 35452, 35472) (Report 008T in conjunction with 37205-37208, 37220-37223, only when these procedures are performed outside the target zone of the endoprosthesis)	XXX	N/A
D+0081T		Placement of visceral extension prosthesis for endovascular repair of abdominal aortic aneurysm involving visceral vessels, each visceral branch, radiological supervision and interpretation (List separately in addition to code for primary procedure) (Use 0081T in conjunction with 0080T) (0078T-0081T have been deleted. To report, see 34841-34848)	ZZZ	N/A
0262T                      Implantation of catheter-delivered prosthetic pulmonary valve, endovascular approach (0262T includes all congenital cardiac catheterization[s], intraprocedural contrast injection[s], fluoroscopic radiological supervision and interpretation, and imaging guidance performed to complete the pulmonary valve procedure. Do not report 0262T in conjunction with 76000, 76001, 93530, 93563, 93566- 93568 )				

(0262T includes percutaneous balloon angioplasty/valvuloplasty of the pulmonary valve/conduit. Do not report 0262T in conjunction with 92990)

(0262T includes stent deployment within the pulmonary conduit. Do not report ~~37205, 37206, 75960~~ 37236-37239 for stent placement within the pulmonary conduit. Report ~~37236-37239~~ 37205, 37206, 92928-92944, ~~75960~~ separately when cardiovascular stent placement is performed at a site separate from the prosthetic valve delivery site. Report 92997, 92998 separately when pulmonary artery angioplasty is performed at a site separate from the prosthetic valve delivery site unless stenting also performed at that site)

## AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 37236	Tracking Number X1	Original Specialty Recommended RVU: <b>9.00</b>
		Presented Recommended RVU: <b>9.00</b>
Global Period: 000		RUC Recommended RVU: <b>9.00</b>

CPT Descriptor: Transcatheter placement of an intravascular stent(s) (except lower extremity, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery

### CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old female smoker presents with a 6-month history of post-prandial abdominal pain, fear of food, and 30 pound weight loss. Diagnostic imaging demonstrates severe stenoses of the mesenteric vessels. A superior mesenteric artery stent(s) is placed.

Percentage of Survey Respondents who found Vignette to be Typical: 87%

#### Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

#### Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 86%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 81%

#### Description of Pre-Service Work:

- The patient's history and pertinent non-invasive diagnostic studies are reviewed, with special attention to associated symptoms as well as co-morbidities that would place the patient at higher risk for open surgical reconstruction.
- Physical exam is reviewed to ensure that the patient has suitable access vessels for percutaneous access including femoral, brachial, and radial pulses.
- Medications are reviewed including antiplatelet and anticoagulant agents that the patient is or needs to be taking.
- Preprocedural laboratory evaluation is reviewed with a focus on coagulation and renal function studies. If renal insufficiency is present, attention is given to whether the patient needs and/or has received appropriate renal protective agents and periprocedural hydration.
- Based on this review, the physician estimates the range of equipment including guiding catheters/sheaths, guidewires, selective catheters, balloons, stents, and embolic protection devices that may be required and ensures that all are available for use.
- The imaging suite/hybrid operating room is checked to ensure proper function and configuration of the imaging equipment including compliance with all radiation safety issues as well as proper function of all patient monitoring equipment including ECG and hemodynamic monitors
- The physician ensures that all technical personnel have been familiarized with the procedure and are familiar with the devices to be used.

- Procedure details, including alternatives and risks, are discussed with the patient and the family. Informed consent is reviewed with the patient and the family.
- Confirm patient positioning and supervise sterile prep of access site(s) and subsequent draping
- Perform preprocedural “time out”
- Intravenous access is started and moderate sedation is administered

#### Description of Intra-Service Work:

Arterial access is separately reported and the vessel in question has a catheter in place when the work of this service begins.

#### Angiographic procedure:

- \* All steps are performed under fluoroscopic guidance
- \* Conscious sedation is ongoing and adequate monitoring is verified
- \* IV heparin is administered to achieve therapeutic anticoagulation and levels adjusted as needed thereafter
- \* Inject contrast to localize stenosis and allow measurements for appropriate device
- \* Depending on required device, guiding sheath may need to be switched out for a larger caliber
- \* Cross lesion with hydrophilic guidewire and advance low profile catheter across lesion.
- \* Exchange hydrophilic guidewire for more rigid guidewire needed to support balloons and stents, as required
- \* Predilate stenosis with a low profile angioplasty balloon if required (not separately reportable)
- \* Inject contrast to confirm positioning within the SMA beyond the stenosis
- \* Advance sheath or guiding catheter across lesion as required by type of lesion and stent to be deployed
- \* Advance appropriately sized stent across intended treatment zone
- \* Withdraw sheath and deploy balloon-expandable or self- expanding stent
- \* Retract stent delivery system and balloon
- \* Insert appropriately sized balloon and inflate for post-dilation (not separately reportable)
- \* Reimage and repeat post-deployment balloon angioplasty as often as required to fully seat and expand stent
- \* Remove balloon catheter and reimage vessel to assess postprocedural success and to exclude distal embolism
- \* Capture final completion images
- \* Remove all delivery catheters and secure hemostasis with manual pressure or with closure device
- \* Ensure adequate circulation distal to arterial access site prior to transfer to recovery area

#### Radiologic Supervision and Interpretation is included in this procedure:

- Direct technical personnel throughout the procedure
- Interpretation of imaging of vessel being treated as well as vessels accessed en route (e.g. iliac, brachial, axillary, subclavian arteries, aorta) including all imaging to manipulate the wires, catheters, and devices into position, as well as to correctly position and deploy all balloons and stents
- Ensure accurate radiologic views, exposures, shielding, image size, injection sequences, radiation protection and management for patient and staff
- Real-time interpretation of imaging to assess post-procedural success and complications as well as removal of all catheters and devices

#### Description of Post-Service Work:

- Apply sterile dressings
- Assist team in moving patient to stretcher and transporting to recovery area
- Ensure blood pressure and heart rate are normal and stable upon arrival to recovery area and discuss post-procedure care with recovery area staff
- Write postop orders
- Communicate with family and referring physicians
- Review results of procedure with patient once sedation wears off
- Review and interpret all images
- Post-process radiologic images and archive for permanent record
- Review and record patient fluoroscopic exposure time and contrast volume
- Dictate procedure note including interpretation of diagnostic and therapeutic imaging
- Review, revise, and sign final report
- Send final report to PCP and any other referring providers

- Discharge day management includes communication with PCP and family, writing orders for follow-up labs, x-rays and patient care, as well as assurance that discharge criteria are met including evaluation of procedural success and assessment for access site complications

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Gary Seabrook, MD, Robert Zwolak, MD, Matthew Sideman, MD, Michael Sutherland, MD, Sean Tutton, MD, Michael Hall, MD, Jerry Niedzwiecki, MD, Zeke Silva, MD, Kurt Schoppee, MD, Richard Wright, MD and Clifford Kavinsky, MD, PhD				
<b>Specialty(s):</b>	Vascular Surgery, Interventional/Diagnostic Radiology and Cardiology				
<b>CPT Code:</b>	37236				
<b>Sample Size:</b>	3404	<b>Resp N:</b>	77	<b>Response:</b> 2.2 %	
<b>Description of Sample:</b>	SVS Random Sample, 1320 SIR Random Sample, 1075 ACR Random Sample, 950 ACC/SCAI Random Sample, 59 (volunteers from entire SCAI membership)				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	4.00	10.00	25.00	150.00
<b>Survey RVW:</b>	5.00	8.00	9.00	11.00	23.00
<b>Pre-Service Evaluation Time:</b>			65.00		
<b>Pre-Service Positioning Time:</b>			15.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			15.00		
<b>Intra-Service Time:</b>	20.00	60.00	90.00	120.00	180.00
<b>Immediate Post Service-Time:</b>	<b>30.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	37236	<b>Recommended Physician Work RVU: 9.00</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		33.00	33.00	0.00
<b>Pre-Service Positioning Time:</b>		3.00	1.00	2.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00
<b>Intra-Service Time:</b>		90.00		
<b>Immediate Post Service-Time:</b>	<b>30.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		



Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
37184	000	8.66	RUC Time

CPT Descriptor Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
15004	000	4.58	RUC Time	20,050
<u>CPT Descriptor 1</u>				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		
<u>CPT Descriptor 2</u>				

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
52355	000	9.00	RUC Time

CPT Descriptor Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic tumor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 24      % of respondents: 31.1 %

**TIME ESTIMATES (Median)**

	<u>CPT Code:</u> 37236	<u>Key Reference CPT Code:</u> 37184	<u>Source of Time</u> RUC Time
Median Pre-Service Time	41.00	40.00	
Median Intra-Service Time	90.00	90.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>161.00</b>	<b>160.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.54
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.08	3.79
--	------	------

Urgency of medical decision making	3.58	3.92
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.38	4.17
--------------------------	------	------

Physical effort required	4.00	3.96
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.29	3.79
---	------	------

Outcome depends on the skill and judgment of physician	4.42	3.96
--	------	------

Estimated risk of malpractice suit with poor outcome	4.00	3.63
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.83	3.67
----------------------------------	------	------

Intra-Service intensity/complexity	4.33	4.13
------------------------------------	------	------

Post-Service intensity/complexity	3.50	3.50
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

## **Why is this code being reviewed?**

Four interventional codes (37205-8) and one radiological supervision and interpretation code (75960) were identified in a screen for codes reported >75% together because they form a logical component coding pairs (37205+75960, 37206+75960, 37207+75960 and 37208+75960). Each code pair includes one vascular stent deployment and one radiological S&I code. All five of these codes will be deleted in 2014. In their place, four new CPT codes will be created that bundle the procedure with the S&I.

Codes to be deleted relevant to this SoR include percutaneous approach to an initial artery or vein (37205), open approach to an initial artery or vein (37207); and the S&I (75960). Because current interventionalists believe there is a difference in work depending on whether the procedure is done in an artery or a vein, the new codes are broken out with a code representing arterial stenting and another representing venous stenting. In each case, the radiological S&I is bundled into the procedure code.

For 37236, the three relevant to-be-deleted codes are 37205 (percutaneous transcatheter stent placement, initial vessel), 37207 (open transcatheter stent placement, initial vessel) and 75960 (radiologic supervision and interpretation code for vascular stent). Since the new code recommendations reflect different RVWs for arterial vs. venous work, a work neutrality analysis is presented at the end of this section.

In considering the work RVU of this service it is also important to note that this code will be co-reported with a catheter placement code (36200, 36215-7, or 36245-7), and the catheter code will be subject to multiple procedure payment reduction. Retaining the separate catheterization code is necessary because these new stent codes will be reported for all remaining arteries and veins in the body after anatomic site-specific codes have been created to specifically report coronary stents, lower extremity stents, extracranial cervical carotid stents, and intracranial stents. Thus, the significant variation in work to reach many different target zones has to be represented by the catheterization code.

## **Methodology**

An invitation to participate in a standard RUC survey for 37236 was sent to random sample of members of the Society for Vascular Surgery (SVS), the Society for Interventional Radiology (SIR), the American College of Radiology (ACR), the American College of Cardiology (ACC) and the Society for Cardiovascular Angiography and Interventions (SCAI) through an email list-service. There were 77 respondents out of 3404 survey requests for a response rate of 2.2%. There was a high degree of concordance among the survey respondents with a very tight distribution of recommendations. 87% of the respondents thought the vignette described the typical patient.

## **Work RVU Recommendation**

We recommend the median survey value of 9.00 RVU for 37236.

## **Pre-time**

Our expert panel recommends that pre-time package 2b (facility- difficult patient/straightforward procedure with sedation / anesthesia) is appropriate, with 2 additional minutes for positioning:

Evaluation: Survey respondents indicated a median evaluation time of 65 minutes to review multiple pre-operative tests, consultations and images for responsible pre-operative planning. The society expert panel recommends accepting the package 2b evaluation time of 33 minutes.

Positioning: Package 2b positioning time is 1 minute. An additional 2 minutes (total=3) of pre-service positioning time for 37236 is recommended to assist with adjusting the imaging table and anesthesia lines for appropriate positioning in order to be able to obtain all appropriately necessary views required for the intervention.

Scrub, dress & wait: The society expert panel recommends accepting the pre-time 2b package evaluation time of 5 minutes.

## **Comparison to Key Reference Code**

### **Clinical Comparison with Key Reference Code**

The reference code chosen by majority of the survey respondents was 37184 (*Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel*). The key reference 37184 has a 000 day global, and is similar to 37236 in they are both endovascular procedures performed on similar arteries for occlusive disease. 37184 was evaluated by the RUC in April 2005.

### **Work Comparison with Key References**

Both 37236 and 37184 have 90 minutes of intra time and nearly identical total times for physician work. Survey respondents rated 37236 as more intense and complex for both pre-service and intra-service work, with identical ratings for post-service work. The

reference service has an RVW of 8.66. The recommended value for 37236 is 0.34 RVUs greater, at 9.00. The 0.34 increment is justified by the higher intensity and complexity ratings during 90 minutes of intra-service time. This works out to a miniscule additional 0.0038 RVUs per minute during the intra-service portion of the procedure. This comparison justifies our recommendation for the median survey value of 9.00 for 37236.

	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	IM-post
<b>37236</b>	9.00	0.083	161	33	3	5	90	30
<b>37184</b>	8.66	0.080	160	20	10	10	90	30

### **Comparison to CPT Code from Another Specialty**

CPT Code 52355 (*Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic tumor*) is a minimally invasive interventional code from another specialty with a 000 day global evaluated by the RUC in September 2011, with identical RVW's and pre-service evaluations times, and nearly identical total times and IWPUT's. This comparison justifies our recommendation for the median survey value of 9.00 for 37236.

	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	IM-post
<b>37236</b>	9.00	0.083	161	33	3	5	90	30
<b>52355</b>	9.00	0.084	155	33	5	15	90	20

### **Comparison to MPC Code**

CPT Code 15004 (*Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children*) is the closest valued MPC code with a 000 day global. There is no clinical similarity between 37236 and 15004. There is no way to perform a valid pre-service comparison between 37236 and 15004 because 15004 was evaluated by the RUC in 2006, and that was before implementation of the RUC pre-service time packages. The only way to compare pre-time between these codes is to look at survey times, and in that analysis our new code has a total of 95 minutes of pre-service survey time which would compare to 75 minutes of survey time for 15004. This analysis favors 37236 in terms of pre-service work.

More importantly, intra-service time for 37236 is twice that of 15004, and the recommended RVW for 37236 is twice that of the MPC code 15004. Since there is no possible clinical comparison, this primarily intra-time comparison to an MPC service justifies our recommendation for the median survey value of 9.00 for 37236.

	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	IM-post
<b>37236</b>	9.00	0.083	161	33	3	5	90	30
<b>15004</b>	4.58	0.054	150	45*	15*	15*	45	30

Please note that pre-times for 15004 are asterisked\* because they were assigned prior to implementation of RUC pre-time packages.

### **Work Neutrality Considerations**

Since there are two daughter codes (37236 and 37238) it is important to perform an analysis of work neutrality. The parent codes (37205 or 37207 plus 75960) have a combined current work RVU of 8.27 + 0.82 for a total of 9.09. Our recommendations for the daughter codes are 9.00 work RVUs for the arterial stent (37236 – this SoR) and 6.29 work RVUs for the vein stent (37238). Thus, the artery stent code recommendation is 0.09 RVUs less than current value, while the vein stent code recommendation is 2.80 RVUs less than current value, and the net change will inevitably result in a reduction in work RVUs for this family.

Based on review of the diagnosis codes used to report the current code pair of 37205/37207 & 75960 as well as understanding of current day practice, our expert panel estimates that this service is performed 75% of the time in arteries and 25% of the time in veins. Thus, for every 100 procedures with the new codes, 37236 will be reported 75 times, while 37238 will be reported 25 times.

Current work value of 100 services 37205/37207 + 75960 = 100 x (8.27 + 0.82) = 909 RVUs

Proposed work value for 100 daughter services:

Artery stent code 37236 projected frequency 75 x 9.00 RVUs =	675 RVUs
Vein stent code 37238 projected frequency 25 x 6.29 RVUs =	157 RVUs
Total add-on work for combination of two daughter codes =	832 RVUs

Net Reduction in work RVUs for this frequency distribution	-77.00 RVUs for each 100 procedures reported
Percentage reduction in RVUs for this frequency distribution	-8.5%

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. This code bundles the existing surgical procedure and radiological supervision and interpretation codes into one code as requested by the RUC, based on the 75% screen. Stent insertion can occur in any vessel, both arterial and venous. The work required for endovascular stent insertion will depend on the specific vessel that needs to be catheterized. Therefore, it is expected that coding for the procedure will include one or more vascular catheterization codes in addition to the arterial or venous stent code. This reflects current coding practice and appropriately represents the highly variable work required for stenting of different vessels.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 37205 Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; initial vessel OR 37207 Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; initial vessel

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Vascular Surgery	How often? Commonly
----------------------------	---------------------

Specialty Radiology	How often? Commonly
---------------------	---------------------

Specialty Cardiology	How often? Commonly
----------------------	---------------------

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National data is not available.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?  
39,810 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.  
Please explain the rationale for this estimate. Combining 37205 (51,400) and 37207 (1,640) adds up to 53,080 which will crosswalk to the total number of claims adding 37236 and 37238. It is estimated that 75% of the 53,080 will be captured with 37236 and 25% with 37238.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

---

**Professional Liability Insurance Information (PLI)**

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 36247

## AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 37237      Tracking Number   X2      Original Specialty Recommended RVU: **4.25**  
 Presented Recommended RVU: **4.25**  
 Global Period: ZZZ      RUC Recommended RVU: **4.25**

CPT Descriptor: Transcatheter placement of an intravascular stent(s) (except lower extremity, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; each additional artery

### CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old female smoker presents with a 6-month history of post-prandial abdominal pain, fear of food, and 30 pound weight loss. Diagnostic imaging demonstrates severe stenoses of the mesenteric vessels. After deployment of a superior mesenteric artery stent (reported separately), a stent(s) is placed in the celiac artery.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

#### Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

#### Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 91%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 57%

#### Description of Pre-Service Work:

- Patients who require interventional treatment at more than one site will obligatorily require an increment of additional pre-service evaluation work by the physician for completion of a thorough preprocedural assessment
- The physician needs to consider the additional site of treatment, diameter and length of necessary stent(s) for the second site, availability of those devices, the order in which to proceed, and what approach to use

#### Description of Intra-Service Work:

Arterial access is separately reported and the target vessel has a catheter in place when the work of this service begins.

- \* All steps are performed under fluoroscopic guidance
- \* Conscious sedation is ongoing and adequate monitoring is verified
- \* Adequacy of heparinization is assessed with additional doses administered as required
- \* Inject contrast to localize stenosis and allow measurements for appropriate stent diameter and length
- \* Depending on required stent, guiding sheath may need to be exchanged for a larger caliber
- \* Cross lesion with hydrophilic guidewire and advance low profile catheter through the stenosis
- \* Exchange hydrophilic guidewire for more rigid guidewire needed to support balloons and stents, as required
- \* Pre-dilate stenosis with a low profile angioplasty balloon if required (not separately reportable)
- \* Remove balloon and advance balloon-expandable or self-expanding stent across the target stenosis

- \* Recheck position and deploy stent
- \* Remove stent catheter
- \* Inject contrast to image lesion and determine if post dilation is necessary
- \* Post-dilate as indicated with an appropriately sized angioplasty balloon (not separately reportable)
- \* Exchange balloon catheter for larger diameter balloon if required (not separately reportable)
- \* Re-image and re-dilate as many times as necessary to fully seat and expand stent (not separately reportable)
- \* Remove balloon catheter & perform final contrast injections to assess success and exclude extravasation or embolization
- \* Remove all delivery catheters and secure hemostasis with manual compression or a closure device
- \* Ensure adequate circulation distal to arterial access site prior to transfer to recovery area

Description of Post-Service Work:

- Additional postservice work over and above that already provided for the primary procedure includes time to review extra films as well as dictate extra procedural details into the interpretation
- Patients with more than one treatment site require longer discussion and explanation with the patient and family
- In patients with multiple treatment areas and multiple access sites, more attention needs to be paid to evaluation of procedural success and assessment for access site complications



**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Gary Seabrook, MD, Robert Zwolak, MD, Matthew Sideman, MD, Michael Sutherland, MD, Sean Tutton, MD, Michael Hall, MD, Jerry Niedzwiecki, MD, Zeke Silva, MD, Kurt Schoppee, MD, Richard Wright, MD and Clifford Kavinsky, MD, PhD				
<b>Specialty(s):</b>	Vascular Surgery, Interventional/Diagnostic Radiology and Cardiology				
<b>CPT Code:</b>	37237				
<b>Sample Size:</b>	3404	<b>Resp N:</b>	61	<b>Response:</b> 1.7 %	
<b>Description of Sample:</b>	SVS Random Sample, 1320 SIR Random Sample, 1075 ACR Random Sample, 950 ACC/SCAI Random Sample, 59 (volunteers from entire SCAI membership)				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	2.00	8.00	15.00	120.00
<b>Survey RVW:</b>	2.35	4.25	5.00	7.65	20.00
<b>Pre-Service Evaluation Time:</b>			15.00		
<b>Pre-Service Positioning Time:</b>			0.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.00		
<b>Intra-Service Time:</b>	15.00	30.00	45.00	60.00	180.00
<b>Immediate Post Service-Time:</b>	<b>10.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

ZZZ Global Code

<b>CPT Code:</b>	37237	<b>Recommended Physician Work RVU: 4.25</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		1.00	0.00	1.00
<b>Pre-Service Positioning Time:</b>		0.00	0.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	0.00	0.00
<b>Intra-Service Time:</b>		45.00		
<b>Immediate Post Service-Time:</b>	<b>1.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		

Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
37186	ZZZ	4.92	RUC Time

CPT Descriptor Secondary percutaneous transluminal thrombectomy (eg, nonprimary mechanical, snare basket, suction technique), noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injections, provided in conjunction with another percutaneous intervention other than primary mechanical thrombectomy (List separately in addition to code for primary procedure)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
57267	ZZZ	4.88	RUC Time	20,679

CPT Descriptor 1 Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (List separately in addition to code for primary procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 17 % of respondents: 27.8 %

**TIME ESTIMATES (Median)**

	<u>CPT Code:</u> 37237	<u>Key Reference CPT Code:</u> 37186	<u>Source of Time</u> RUC Time
Median Pre-Service Time	1.00	0.00	
Median Intra-Service Time	45.00	60.00	
Median Immediate Post-service Time	1.00	0.00	

Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>47.00</b>	<b>60.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.24	3.94
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.18	3.88
--	------	------

Urgency of medical decision making	4.06	4.18
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.47	4.12
--------------------------	------	------

Physical effort required	4.18	4.00
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.47	4.18
---	------	------

Outcome depends on the skill and judgment of physician	4.47	4.35
--	------	------

Estimated risk of malpractice suit with poor outcome	4.29	4.18
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.35	3.41
----------------------------------	------	------

Intra-Service intensity/complexity	4.35	4.06
------------------------------------	------	------

Post-Service intensity/complexity	3.65	3.35
-----------------------------------	------	------

---

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

### **Why is this code being reviewed?**

Four interventional codes (37205-8) and one radiological supervision and interpretation code (75960) were identified in a screen for codes reported >75% together because they form a logical component coding pairs (37205+75960, 37206+75960, 37207+75960 and 37208+75960). Each code pair includes one vascular stent deployment and one radiological S&I code. All five of these codes will be deleted in 2014. In their place, four new CPT codes will be created that bundle the procedure with the S&I.

Codes to be deleted relevant to this SoR include percutaneous approach to an additional artery or vein (37206), open approach to an additional artery or vein (37208); and the S&I (75960). Because current interventionalists believe there is a difference in work depending on whether the procedure is done in an artery or a vein, the new codes are broken out with a code representing arterial stenting and another representing venous stenting. In each case, the radiological S&I is bundled into the procedure code.

For 37237, the three relevant to-be-deleted codes are 37206 (percutaneous transcatheter stent placement, additional vessel), 37208 (open transcatheter stent placement, additional vessel) and 75960 (radiologic supervision and interpretation code for vascular stent). Since the new code recommendations reflect different RVWs for arterial vs. venous work, a work neutrality analysis is presented at the end of this section.

In considering the work RVU of this service it is also important to note that this code will be co-reported with a catheter placement code (36200, 36215-7, or 36245-7), and the catheter code will be subject to multiple procedure payment reduction. Retaining the separate catheterization code is necessary because these new stent codes will be reported for all remaining arteries and veins in the body after anatomic site-specific codes have been created to specifically report coronary stents, lower extremity stents, extracranial cervical carotid stents, and intracranial stents. Thus, the significant variation in work to reach many different target zones has to be represented by the catheterization code.

### **Methodology**

An invitation to participate in a standard RUC survey for 37237 was sent to random sample of members of the Society for Vascular Surgery (SVS), the Society for Interventional Radiology (SIR), the American College of Radiology (ACR), the American College of Cardiology (ACC) and the Society for Cardiovascular Angiography and Interventions (SCAI) through an email list-service. There were 61 respondents out of 3404 survey requests for a response rate of 1.7%. There was a high degree of concordance among the survey respondents with a very tight distribution of recommendations. 89% of the respondents thought the vignette described the typical patient.

### **Work RVU Recommendation**

We are recommending the 25<sup>th</sup> percentile survey value of 4.25 RVU for 37237 which is a ZZZ Global Code.

### **Pre-time**

Our expert panel recommends that 10 minutes of pre-time be added to the ZZZ global package because unlike other stent codes or other ZZZ codes, the patient in 37237 is undergoing additional stent placement in a totally different vessel. In the typical vignette, the initial stent is placed in the patient's superior mesenteric artery, and this requires certain pre-service work. However, additional pre-service work is required for consideration of stenting the celiac, and this is all evaluation time. The celiac must be studied intensively on all pre-operative imaging such as CT scans and MRAs. The length and diameter must be assessed to ensure appropriate balloons and stents are on site. Liver function blood tests must be considered as well as the anatomy of the common hepatic and splenic arteries. There is no denying the fact that this takes a minimum of 10 minutes.

### **Post-time**

Again, unlike an additional stent in a lower extremity artery, stenting a different vessel requires additional post-service consideration. Physical exam must be done to exclude liver or splenic tenderness. Post-procedure liver function blood tests should be assessed if there is any question about adequacy of liver perfusion. The median time estimate for this work was 10 minutes by our survey respondents, and the expert panel cut that in half to 5 minutes.

### **Comparison to Key Reference Code**

#### **Clinical Comparison with Key Reference Code**

The reference code chosen by majority of the survey respondents was 37186 (*Secondary percutaneous transluminal thrombectomy (eg, nonprimary mechanical, snare basket, suction technique), noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injections, provided in conjunction with another percutaneous intervention other than primary mechanical thrombectomy (List separately in addition to code for primary procedure)*). The key

reference 37186 is a ZZZ global and is similar to 37237 in they are both endovascular procedures performed on various arteries in the body. 37186 was evaluated by the RUC in April 2005.

### Work Comparison with Key References

37237 has a survey median time of 45 minutes compared to 60 minutes for the key reference 37186. Survey respondents rated the intra-service work of 37237 as more intense than the key reference service. The 15 minute difference in intra time x the IWPUT of 0.082 = -1.23 RVUs. 37237 has 15 minutes of combined pre and immediate post-work compared to zero for the key reference. Valued at 0.0224 rvu/min, this represents 0.34 RVUs in the new code above and beyond that in the reference. Thus, to relate the new code to the reference, start with the value of 4.92 for the reference, subtract 1.23 for difference in work and add 0.34 for difference in pre/post. The value comes out to 4.03. Then an additional adjustment must be made for the greater intra-service intensity of the new code over the reference. 45 minutes of intra-time is multiplied by the difference in IWPUT of 0.005, which equals 0.225. When this is added to the previous sum of 4.03, the final relative value is 4.26. This comparison serves to justify our recommendation for the 25<sup>th</sup> percentile survey value of 4.25 for 37236.

	RVW	IWPUT	Total Time	Eval	INTRA	IM-post
<b>37237</b>	4.25	0.087	60	10	45	5
<b>37186</b>	4.92	0.082	60	0	60	0

### Comparison to MPC Code

CPT Code 57267 (*Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (List separately in addition to code for primary procedure)*) is the closest valued MPC code with a ZZZ global. There is no clinical similarity between 37237 and 57267. 37237 has 10 minutes of pre-service evaluation time compared to zero for 57267. This is logical because insertion of mesh during an open surgery case does not require evaluation time, while consideration of stenting a completely different artery such as the celiac absolutely does require pre-service evaluation time. Thus, pre-service comparison favors 37237 in terms of work.

Importantly, intra-service time for 37237 is exactly that of 57267, yet the recommended RVW for 37237 is substantially less than that of the MPC code. Thus, a comparison of 37237 to the closest valued ZZZ MPC service clearly justifies our recommendation for the 25<sup>th</sup> percentile survey value of 4.25 for 37237.

	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	IM-post
<b>37237</b>	4.25	0.087	60	10	0	0	45	5
<b>57267</b>	4.88	0.108	45	0	0	0	45	0

### Comparison to Another Vascular CPT Code

CPT Code 37223 (*Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)*) is another minimally invasive interventional code with a ZZZ global evaluated by the RUC in April 2010, with identical RVWs and intra-service times and nearly identical total times and IWPUT's. This comparison justifies our recommendation for the 25<sup>th</sup> percentile survey value of 4.25 for 37237.

	RVW	IWPUT	Total Time	INTRA
<b>37237</b>	4.25	0.087	60	45
<b>37223</b>	4.25	0.093	47	45

### Work Neutrality Considerations

Since there are two daughter codes (37237 and 37239) it is important to perform an analysis of work neutrality. The parent codes (37206 or 37208 plus 75960) have a combined current work RVU of 4.12 + 0.82 for a total of 4.94. Our recommendations for the daughter codes are 4.25 work RVUs for the additional vessel arterial stent (37237, this SoR) and 3.50 work RVUs for the vein stent

(37239). Thus, the additional vessel artery stent code recommendation is 0.69 RVUs less than current value, while the additional vessel vein stent code recommendation is 1.44 RVUs less than current value, and the net change will inevitably result in a reduction in work RVUs for this family.

Based on review of the diagnosis codes used to report the current code pair of 37206/37208 & 75960 as well as understanding of current day practice, our expert panel estimates that this service is performed 75% of the time in arteries and 25% of the time in veins. Thus, for every 100 procedures with the new codes, 37237 will be reported 75 times, while 37239 will be reported 25 times.

Current work value of 100 services 37206/37208 + 75960 =  $100 \times (4.12 + 0.82) = 494$  RVUs

Proposed work value for 100 daughter services:

Additional Artery stent code 37237 projected frequency  $75 \times 4.25$  RVUs = 318.75 RVUs

Additional Vein stent code 37239 projected frequency  $25 \times 3.50$  RVUs = 87.50 RVUs

Total add-on work for combination of two daughter codes = 406.25 RVUs

Net Reduction in work RVUs for this frequency distribution: -87.75 RVUs for each 100 procedures reported

Percentage reduction in RVUs for this frequency distribution: -17.8%

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. This code bundles the existing surgical procedure and radiological supervision and interpretation codes into one code as requested by the RUC, based on the 75% screen. Stent insertion can occur in any vessel, both arterial and venous. The work required for endovascular stent insertion will depend on the specific vessel that needs to be catheterized. Therefore, it is expected that coding for the procedure will include one or more vascular catheterization codes in addition to the arterial or venous stent code. This reflects current coding practice and appropriately represents the highly variable work required for stenting of different vessels.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 37206 Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; each additional vessel (List separately in addition to code for primary procedure) OR 37208 Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; each additional vessel (List separately in addition to code for primary procedure)

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Vascular Surgery

How often? Commonly

Specialty Radiology                      How often? Commonly

Specialty Cardiology                      How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National data is not available.

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 4,217

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Combining 37206 (5,416) and 37208 (207) adds up to 5,623 which will crosswalk to the total number of claims adding 37237 and 37239. It is estimated that 75% of the 5,623 will be captured with 37236.

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 37223

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 37238      Tracking Number X3      Original Specialty Recommended RVU: **6.29**  
 Presented Recommended RVU: **6.29**  
 Global Period: 000      RUC Recommended RVU: **6.29**

CPT Descriptor: Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial vein

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 64-year-old female on dialysis through a left upper arm brachio-cephalic fistula develops high venous pressures and excessive bleeding after needle removal. Diagnostic imaging demonstrates a stenosis in the left subclavian vein central to the fistula. A subclavian vein stent(s) is placed.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 84%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 72%

**Description of Pre-Service Work:**

- The patient's history and pertinent non-invasive diagnostic studies are reviewed, with special attention to associated symptoms as well as co-morbidities that would place the patient at higher risk for open surgical reconstruction.
- Physical exam is reviewed to ensure that the patient has suitable access vessels including relevant arteries, veins or fistula, depending on the required route.
- Medications are reviewed including antiplatelet and anticoagulant agents that the patient is or needs to be taking.
- Pre-procedural laboratory evaluation is reviewed with a focus on coagulation and renal function studies. In a non-ESRD patient with renal insufficiency, attention is given to whether the patient needs and/or has received appropriate renal protective agents and periprocedural hydration.
- Based on this review, the physician estimates the range of equipment including guiding catheters/sheaths, guidewires, selective catheters, balloons, stents, and embolic protection devices that may be required and ensures that all are available for use.
- The imaging suite/hybrid operating room is checked to ensure proper function and configuration of the imaging equipment including compliance with all radiation safety issues as well as proper function of all patient monitoring equipment including ECG and hemodynamic monitors.
- Intravenous access is started and moderate sedation is administered.

**Description of Intra-Service Work:**

Venous access is separately reportable, and the vessel in question has a catheter in place when the work of this service begins.



- \* All steps are performed under fluoroscopic guidance
- \* Moderate sedation is ongoing and adequate monitoring is verified.
- \* Roadmapping images are obtained for vessel sizing, to document anatomy, and assess exact location of stenosis.
- \* Area of stenosis/occlusion is crossed with a guidewire, and a sheath is advanced to or through the lesion.
- \* IV heparin is administered
- \* IV antibiotics are administered as indicated
- \* Sheath exchange if needed for appropriately sized stent
- \* Pre-treat lesion with balloon angioplasty if needed to allow passage of stent delivery system (not separately reportable)
- \* Appropriately sized stent is selected and introduced to the through the sheath
- \* Fluoroscopic guidance and appropriate roadmapping to position stent exactly across the intended treatment zone
- \* Deploy self-expanding or balloon-expandable stent
- \* Seat or fully expand stent with additional ballooning (not separately reportable).
- \* Remove or retract stent delivery system and balloon
- \* Inject contrast to assess adequacy of treatment
- \* Repeat balloon inflations as required, or additional larger diameter balloons as needed for adequate stent expansion.
- \* Multiple segments of disease within the same vessel are treated with appropriate-sized stents (not separately reportable).
- \* Inject contrast for completion images, document absence of extravasation or embolization
- \* Remove sheath
- \* Achieve hemostasis with manual compression, closure device, or standard surgical closure of the venotomy

#### Description of Post-Service Work:

- Apply sterile dressings
- Assist team in moving patient to stretcher and transporting to recovery area
- Ensure BP and heart rate are normal & stable upon arrival to recovery area
- \* Discuss post-procedure care with recovery area staff
- Write postop orders
- Communicate with family and referring physicians
- Review results of procedure with patient once sedation wears off
- Review and interpret all images
- Post-process radiologic images and archive for permanent record
- Review and record patient fluoroscopic exposure time and contrast volume
- Dictate procedure note including interpretation of diagnostic and therapeutic imaging
- Review, revise, and sign final report
- Send final report to PCP and any other referring providers

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Gary Seabrook, MD, Robert Zwolak, MD, Matthew Sideman, MD, Michael Sutherland, MD, Sean Tutton, MD, Michael Hall, MD, Jerry Niedzwiecki, MD, Zeke Silva, MD, Kurt Schoppee, MD, Richard Wright, MD and Clifford Kavinsky, MD, PhD				
<b>Specialty(s):</b>	Vascular Surgery, Interventional/Diagnostic Radiology and Cardiology				
<b>CPT Code:</b>	37238				
<b>Sample Size:</b>	3404	<b>Resp N:</b>	75	<b>Response:</b> 2.2 %	
<b>Description of Sample:</b>	SVS Random Sample, 1320 SIR Random Sample, 1075 ACR Random Sample, 950 ACC/SCAI Random Sample, 59 (volunteers from entire SCAI membership)				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	4.50	10.00	30.00	150.00
<b>Survey RVW:</b>	3.50	6.00	8.00	9.18	18.50
<b>Pre-Service Evaluation Time:</b>			60.00		
<b>Pre-Service Positioning Time:</b>			15.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			15.00		
<b>Intra-Service Time:</b>	30.00	45.00	60.00	77.50	180.00
<b>Immediate Post Service-Time:</b>	<b>30.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	37238	<b>Recommended Physician Work RVU: 6.29</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		33.00	33.00	0.00
<b>Pre-Service Positioning Time:</b>		3.00	1.00	2.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00
<b>Intra-Service Time:</b>		60.00		
<b>Immediate Post Service-Time:</b>	<b>30.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		

Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
37187	000	8.03	RUC Time

CPT Descriptor Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
15002	000	4.58	RUC Time	20,050

CPT Descriptor 1 Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
36247	000	6.29	RUC Time

CPT Descriptor Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 27 % of respondents: 36.0 %

**TIME ESTIMATES (Median)**

	<u>CPT Code:</u> 37238	<u>Key Reference CPT Code:</u> 37187	<u>Source of Time</u> RUC Time
Median Pre-Service Time	41.00	40.00	
Median Intra-Service Time	60.00	85.00	
Median Immediate Post-service Time	30.00	20.00	

Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>131.00</b>	<b>145.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.30	3.41
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.67	3.59
--	------	------

Urgency of medical decision making	3.19	3.56
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.70	3.78
--------------------------	------	------

Physical effort required	3.56	3.59
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.59	3.74
---	------	------

Outcome depends on the skill and judgment of physician	3.93	3.85
--	------	------

Estimated risk of malpractice suit with poor outcome	3.59	3.59
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.11	3.30
----------------------------------	------	------

Intra-Service intensity/complexity	3.56	3.74
------------------------------------	------	------

Post-Service intensity/complexity	2.96	3.19
-----------------------------------	------	------

---

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

### **Why is this code being reviewed?**

Four interventional codes (37205-8) and one radiological supervision and interpretation code (75960) were identified in a screen for codes reported >75% together because they form a logical component coding pairs (37205+75960, 37206+75960, 37207+75960 and 37208+75960). Each code pair includes one vascular stent deployment and one radiological S&I code. All five of these codes will be deleted in 2014. In their place, four new CPT codes will be created that bundle the procedure with the S&I.

Codes to be deleted relevant to this SoR include percutaneous approach to an initial artery or vein (37205), open approach to an initial artery or vein (37207); and the S&I (75960). Because current interventionalists believe there is a difference in work depending on whether the procedure is done in an artery or a vein, the new codes are broken out with one code representing arterial stenting and another representing vein stenting. In each case, the radiological S&I is bundled into the procedure code.

For 37238, the three relevant to-be-deleted codes are 37205 (percutaneous transcatheter stent placement, initial vessel), 37207 (open transcatheter stent placement, initial vessel) and 75960 (radiologic supervision and interpretation code for vascular stent). Since the new code recommendations reflect different RVWs for arterial vs. venous work, a work neutrality analysis is presented at the end of this section.

In considering the work RVU of this service it is also important to note that this code will be co-reported with a catheter placement code (36010-36012). These code pairs will be subject to multiple procedure payment reduction. Retaining the separate catheterization code is necessary because these new stent codes will be reported for all remaining arteries and veins in the body after anatomic site-specific codes have been created to specifically report coronary stents, lower extremity stents, extracranial cervical carotid stents, and intracranial stents. Thus, the significant variation in work to reach many different target zones has to be represented by the catheterization code.

### **Methodology**

An invitation to participate in a standard RUC survey for 37238 was sent to random sample of members of the Society for Vascular Surgery (SVS), the Society for Interventional Radiology (SIR), the American College of Radiology (ACR), the American College of Cardiology (ACC) and the Society for Cardiovascular Angiography and Interventions (SCAI) through an email list-service. There were 75 respondents out of 3404 survey requests for a response rate of 2.2%. There was a high degree of concordance among the survey respondents with a very tight distribution of recommendations. 88% of the respondents thought the vignette described the typical patient.

### **Work RVU Recommendation**

We are recommending the value of 6.29 RVU for 37238 based on a direct crosswalk to CPT Code 36247. We make this recommendation because compared to other recommended RVWs in this family of codes, we believe the median value of 8.00 would create rank order anomaly on the high side, while the 25<sup>th</sup> percentile value of 6.00 would create a rank order anomaly on the low side. The RUC-assessed code 36247 has the exact time inputs and accurate intensity inputs to serve as a crosswalk for 37238.

	RVW	IWP/UT	Total Time	Eval	Posit	SDW	INTRA	IM-post
<b>37238</b>	6.29	0.080	131	33	3	5	60	30
<b>36247</b>	6.29	0.080	131	33	3	5	60	30

### **Pre-time**

Our expert panel recommends that pre-time package 2b (facility- difficult patient/straightforward procedure with sedation / anesthesia) is appropriate, with 2 additional minutes for positioning:

Evaluation: Survey respondents indicated a median evaluation time of 60 minutes to review multiple pre-operative tests, consultations and images for responsible pre-operative planning. The society expert panel recommends accepting the package 2b evaluation time of 33 minutes.

Positioning: Package 2b positioning time is 1 minute. An additional 2 minutes (total=3) of pre-service positioning time for 37238 is recommended to assist with adjusting the imaging table and anesthesia lines for appropriate positioning in order to be able to obtain all appropriately necessary views required for the intervention.

Scrub, dress & wait: The society expert panel recommends accepting the pre-time 2b package evaluation time of 5 minutes.

## **Comparison to Key Reference Code**

### **Clinical Comparison with Key Reference Code**

The reference code chosen by majority of the survey respondents was 37187 (*Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance*). The key reference 37187 has a 000 day global, and is similar to 37238 in they are both endovascular procedures performed on similar veins. 37187 was evaluated by the RUC in April 2005.

### **Work Comparison with Key References**

37238 has 7 more minutes of pre-service evaluation time, 2 less minutes of positioning time, 4 less minutes of scrub, dress, and wait time, and 10 more minutes of immediate post-service time. This difference can be accounted for by adding a net 15 minutes at 0.0224 RVUs (Eval, posit, post) and subtracting 4 minutes at 0.0081 RVUs (SDW) or 0.34 – 0.03 for a total increment of 0.31 RVUs more than the reference service. The new code has an intra-service survey time of 60 minutes while 37187 has 85 minutes of intra time. Both codes have the identical IWPUT. The 25 minute difference in intra time x the IWPUT of 0.080 = 2.00 RVUs less than the Key Reference. Thus, starting with the Key Reference RVW of 8.03 and adding 0.31 for the pre and post difference, while subtracting 2.00 for the intra-service difference results in an estimated work value of 6.34. This comparison strongly justifies our recommendation for the value of 6.29 for 37238.

	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	IM-post
<b>37238</b>	6.29	0.080	131	33	3	5	60	30
<b>37187</b>	8.03	0.080	145	26	5	9	85	20

## **Comparison to MPC Code**

CPT Code 15004 (*Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children*) is the closest valued MPC code with a 000 day global. There is no clinical similarity between 37238 and 15004. There is no way to perform a valid pre-service comparison between 37238 and 15004 because 15004 was evaluated by the RUC in 2006, and that was before implementation of the RUC pre-service time packages. The only way to compare pre-time between these codes is to look at survey times, and in that analysis our new code has a total of 90 minutes of pre-service survey time which would compare to 75 minutes surveyed for 15004. This analysis favors 37238 in terms of pre-service work.

More importantly, intra-service time for 37238 is 33% greater than 15004, and the recommended RVW for 37238 is 37% greater than the MPC code. Given more pre and post work for 37238, this primarily time-based comparison to the closest valued MPC service justifies our recommendation of 6.29 work RVUs for 37238.

	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	IM-post
<b>37238</b>	6.29	0.080	131	33	3	5	60	30
<b>15004</b>	4.58	0.054	150	45*	15*	15*	45	30

Please note that pre-times for 15004 are asterisked\* because they were assigned prior to implementation of RUC pre-time packages.

## **Comparison to two vascular CPT Codes Representing Similar Work**

CPT Code 36247 (*Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family*) is an endovascular code with a 000 day global evaluated by the RUC in February 2011, and is presented as a cross walk to recommend the value of 6.29 for 37238.

	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	IM-post
<b>37238</b>	6.29	0.080	131	33	3	5	60	30
<b>36247</b>	6.29	0.080	131	33	3	5	60	30

CPT Code 37197 (*Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), includes radiological supervision and interpretation, and imaging guidance (ultrasound or fluoroscopy), when performed*) is another endovascular code with a 000 day global, evaluated by the RUC in September 2011, with intra time identical to 36247. These comparisons also justify our recommendation of 6.29 work RVUs for 37238.

	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	IM-post
<b>37238</b>	6.29	0.080	131	33	3	5	60	30
<b>37197</b>	6.29	0.083	140	40	10	10	60	20

### Work Neutrality Considerations

Since there are two daughter codes (37236 and 37238) it is important to perform an analysis of work neutrality. The parent codes (37205 or 37207 plus 75960) have a combined current work RVU of  $8.27 + 0.82$  for a total of 9.09. Our recommendations for the daughter codes are 9.00 work RVUs for the arterial stent (37236) and 6.29 work RVUs for the vein stent (37238-this SoR). Thus, the artery stent code recommendation is 0.09 RVUs less than current value, while the vein stent code recommendation is 2.80 RVUs less than current value, and the net change will inevitably result in a work RVU reduction for this family.

Based on review of the diagnosis codes used to report the current code pair of 37205/37207 & 75960 as well as understanding of current day practice, our expert panel estimates that this service is performed 75% of the time in arteries and 25% of the time in veins. Thus, for every 100 procedures with the new codes, 37236 will be reported 75 times, while 37238 will be reported 25 times.

Current work value of 100 services  $37205/37207 + 75960 = 100 \times (8.27 + 0.82) = 909$  RVUs

Proposed work value for 100 daughter services:

Artery stent code 37236 projected frequency  $75 \times 9.00$  RVUs = 675 RVUs  
 Vein stent code 37238 projected frequency  $25 \times 6.29$  RVUs = 157 RVUs  
 Total add-on work for combination of two daughter codes = 832 RVUs

Net Reduction in work RVUs for this frequency distribution -77.00 RVUs for each 100 procedures reported  
 Percentage reduction in RVUs for this frequency distribution -8.5%

### SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. This code bundles the existing surgical procedure and radiological supervision and interpretation codes into one code as requested by the RUC, based on the 75% screen. Stent insertion can occur in any vessel, both arterial and venous. The work required for endovascular stent insertion will depend on the specific vessel that needs to be catheterized. Therefore, it is expected that coding for the procedure will include one or more

vascular catheterization codes in addition to the arterial or venous stent code. This reflects current coding practice and appropriately represents the highly variable work required for stenting of different vessels.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 37205 Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; initial vessel OR 37207 Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; initial vessel

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Vascular Surgery                      How often? Commonly

Specialty Radiology                              How often? Commonly

Specialty Cardiology                            How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National data not available

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

13,270 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Combining 37205 (51,400) and 37207 (1,640) adds up to 53,080 which will crosswalk to the total number of claims adding 37236 and 37238. It is estimated that 75% of the 53,080 will be captured with 37236 and 25% with 37238.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States?

## Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 36247



## AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 37239      Tracking Number   X4      Original Specialty Recommended RVU: **3.50**  
 Presented Recommended RVU: **3.34**  
 Global Period: ZZZ      RUC Recommended RVU: **3.34**

CPT Descriptor: Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological and supervision and interpretation and including all angioplasty within the same vessel, when performed; each additional vein

### CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 64-year-old female on dialysis through a left upper arm brachio-cephalic fistula develops high venous pressures and excessive bleeding after needle removal. Diagnostic imaging demonstrates a stenosis in the both the outflow brachial vein and the innominate vein central to the fistula. After deployment of a brachial vein stent (reported separately), an additional stent(s) is placed in the innominate vein.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

### Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

### Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 94%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 50%

Description of Pre-Service Work: This is a zzz add-on code, so much of the pre-service work lies with the primary service code. Nevertheless, the typical patient for this service has two vessels that are stenotic compared to only one stenotic vessel in the patient who does not require this add-on service. The pre-service work includes pre-operative estimate of stent diameter and length of the second site to ensure appropriately sized stents and balloons are on site. Additional technical considerations also focus on whether a larger diameter or longer introducer sheath will be required to deploy a stent in the second site. This is certainly the case with the vignette patient in whom a larger diameter central vein deep in the chest will be treated. Finally, technical considerations of patient positioning and imaging angles must be considered during the pre-service period as there are clearly additional challenges to setting up the table and imaging equipment to adequately visualize a secondary vein that may lie deep in the chest when the initially treated vein lies in the arm, leg or different part of the body.

### Description of Intra-Service Work:

Venous access is separately reported and the target vessel has a catheter in place when the work of this service begins.

- \* All steps are performed under fluoroscopic guidance
- \* Conscious sedation is ongoing and adequate monitoring is verified
- \* Adequacy of heparinization is assessed with additional doses administered as required
- \* Inject contrast to localize stenosis and allow measurements for appropriate stent diameter and length
- \* Depending on required stent, guiding sheath may need to be exchanged for a larger caliber
- \* Cross lesion with hydrophilic guidewire and advance low profile catheter through the stenosis

- \* Exchange hydrophilic guidewire for more rigid guidewire needed to support balloons and stents, as required
- \* Pre-dilate stenosis with a low profile angioplasty balloon if required (not separately reportable)
- \* Remove balloon and advance balloon-expandable or self-expanding stent across the target stenosis
- \* Recheck position and deploy stent
- \* Remove stent catheter
- \* Inject contrast to image lesion and determine if post dilation is necessary
- \* Post-dilate as indicated with an appropriately sized angioplasty balloon (not separately reportable)
- \* Exchange balloon catheter for larger diameter balloon if required (not separately reportable)
- \* Re-image and re-dilate as many times as necessary to fully seat and expand stent (not separately reportable)
- \* Remove balloon catheter & perform final contrast injections to assess success and exclude extravasation
- \* Remove all delivery catheters and secure hemostasis with manual compression

Description of Post-Service Work:

- Additional postservice work over and above that already provided for the primary procedure includes time to review extra films as well as dictate extra procedural details into the interpretation
- Patients with more than one treatment site require longer discussion and explanation with the patient and family
- In patients with multiple treatment areas and multiple access sites, more attention needs to be paid to evaluation of procedural success and assessment for access site complications.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Gary Seabrook, MD, Robert Zwolak, MD, Matthew Sideman, MD, Michael Sutherland, MD, Sean Tutton, MD, Michael Hall, MD, Jerry Niedzwiecki, MD, Zeke Silva, MD, Kurt Schoppee, MD, Richard Wright, MD and Clifford Kavinsky, MD, PhD				
<b>Specialty(s):</b>	Vascular Surgery, Interventional/Diagnostic Radiology and Cardiology				
<b>CPT Code:</b>	37239				
<b>Sample Size:</b>	3404	<b>Resp N:</b>	61	<b>Response:</b> 1.7 %	
<b>Description of Sample:</b>	SVS Random Sample, 1320 SIR Random Sample, 1075 ACR Random Sample, 950 ACC/SCAI Random Sample, 59 (volunteers from entire SCAI membership)				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	2.00	5.00	20.00	110.00
<b>Survey RVW:</b>	2.00	3.50	5.00	6.35	15.00
<b>Pre-Service Evaluation Time:</b>			10.00		
<b>Pre-Service Positioning Time:</b>			0.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.00		
<b>Intra-Service Time:</b>	10.00	25.00	30.00	60.00	160.00
<b>Immediate Post Service-Time:</b>	<b>10.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

ZZZ Global Code

<b>CPT Code:</b>	37239	<b>Recommended Physician Work RVU: 3.34</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		1.00	0.00	1.00
<b>Pre-Service Positioning Time:</b>		0.00	0.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	0.00	0.00
<b>Intra-Service Time:</b>		30.00		
<b>Immediate Post Service-Time:</b>	<b>1.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		

Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
37185	ZZZ	3.28	RUC Time

CPT Descriptor Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); second and all subsequent vessel(s) within the same vascular family

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
57267	ZZZ	4.88	RUC Time	20,679

CPT Descriptor 1 Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (List separately in addition to code for primary procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
37223	ZZZ	4.25	RUC Time

CPT Descriptor Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 13      % of respondents: 21.3 %

**TIME ESTIMATES (Median)**

	<u>CPT Code:</u> 37239	<u>Key Reference CPT Code:</u> 37185	<u>Source of Time</u> RUC Time
Median Pre-Service Time	1.00	0.00	
Median Intra-Service Time	30.00	40.00	

Median Immediate Post-service Time	1.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>32.00</b>	<b>40.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)**(of those that selected Key  
Reference code)**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.46	3.38
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.46	3.31
--	------	------

Urgency of medical decision making	3.23	3.15
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.77	3.62
--------------------------	------	------

Physical effort required	3.46	3.31
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.46	3.46
---	------	------

Outcome depends on the skill and judgment of physician	3.77	3.77
--	------	------

Estimated risk of malpractice suit with poor outcome	3.46	3.54
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.08	3.08
----------------------------------	------	------

Intra-Service intensity/complexity	3.62	3.38
------------------------------------	------	------

Post-Service intensity/complexity	3.00	3.00
-----------------------------------	------	------

## **Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

### **Why is this code being reviewed?**

Four interventional codes (37205-8) and one radiological supervision and interpretation code (75960) were identified in a screen for codes reported >75% together because they form a logical component coding pairs (37205+75960, 37206+75960, 37207+75960 and 37208+75960). Each code pair includes one vascular stent deployment and one radiological S&I code. All five of these codes will be deleted in 2014. In their place, four new CPT codes will be created that bundle the procedure with the S&I.

Codes to be deleted relevant to this SoR include percutaneous approach to an additional artery or vein (37206), open approach to an additional artery or vein (37208); and the S&I (75960). Because current interventionalists believe there is a difference in work depending on whether the procedure is done in an artery or a vein, the new codes are broken out with a code representing arterial stenting and another representing vein stenting. In each case, the radiological S&I is bundled into the procedure code.

For 37239, the three relevant to-be-deleted codes are 37206 (percutaneous transcatheter stent placement, additional vessel), 37208 (open transcatheter stent placement, additional vessel) and 75960 (radiologic supervision and interpretation code for vascular stent). Since the new code recommendations reflect different RVWs for arterial vs. venous work, a work neutrality analysis is presented at the end of this section.

In considering the work RVU of this service it is also important to note that this code will be co-reported with a catheter placement code (36010-36012), and the catheter code will be subject to multiple procedure payment reduction. Retaining the separate catheterization code is necessary because these new stent codes will be reported for all remaining arteries and veins in the body after anatomic site-specific codes have been created to specifically report coronary stents, lower extremity stents, extracranial cervical carotid stents, and intracranial stents. Thus, the significant variation in work to reach many different target zones has to be represented by the catheterization code.

### **Methodology**

An invitation to participate in a standard RUC survey for 37239 was sent to random sample of members of the Society for Vascular Surgery (SVS), the Society for Interventional Radiology (SIR), the American College of Radiology (ACR), the American College of Cardiology (ACC) and the Society for Cardiovascular Angiography and Interventions (SCAI) through an email list-service. There were 61 respondents out of 3404 survey requests for a response rate of 1.7%. There was a high degree of concordance among the survey respondents with a very tight distribution of recommendations. 92% of the respondents thought the vignette described the typical patient.

### **Work RVU Recommendation**

We are recommending the 25<sup>th</sup> percentile survey value of 3.50 RVU for 37239 which is a ZZZ Global Code.

### **Pre-time**

Our expert panel recommends that 10 minutes of pre-time be added to the ZZZ global package because unlike other stent codes or other ZZZ codes, the patient in 37239 is undergoing additional stent placement in a totally different vessel. In the typical vignette, the initial stent is placed in the patient's brachial vein, and this requires certain pre-service work. However, additional pre-service work is required for consideration of stenting the innominate vein, which is the additional vessel, and this is all evaluation time. The innominate must be studied intensively on all pre-operative imaging such as CT scans and MRVs. The length and diameter of the stenosis must be assessed pre-operatively to ensure appropriate balloons and stents are on site. Planning must be undertaken to ensure the imaging equipment will be adjustable to the correct cranial-caudal and laterally oblique angles required for the innominate. There is no denying the fact that this takes a minimum of 10 minutes.

### **Post-time**

Again, unlike an additional stent in a lower extremity artery or elsewhere, stenting a different venous vessel requires additional post-service consideration. Physical exam must be done to exclude post-operative problems. The median time estimate for this work was 10 minutes by our survey respondents, and the expert panel cut that in half to 5 minutes.

## **Comparison to Key Reference Code**

### **Comparison with Key Reference Code**

37239 has a survey median total time of 45 minutes and 37185 has 40 minutes of total time. Survey respondents rated the intra-service work of 37239 as slightly less intense than the key reference service. This comparison justifies our recommendation for the 25<sup>th</sup> percentile survey value of 3.50 for 37239.

	RVW	IWPUT	Total Time	INTRA
<b>37239</b>	3.50	0.105	45	30
<b>37185</b>	3.28	0.082	40	40

### **Comparison to Another Vascular CPT Code**

CPT Code 37223 (*Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)*) is another minimally invasive interventional code with a zzz day global evaluated by the RUC in April 2010, with a slightly higher RVW but similar total-service time. This comparison justifies our recommendation for the 25<sup>th</sup> percentile survey value of 3.50 for 37239.

	RVW	IWPUT	Total Time	INTRA
<b>37239</b>	3.50	0.105	45	30
<b>37223</b>	4.25	0.093	47	45

### **Comparison to MPC Code**

CPT Code 57267 (*Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (List separately in addition to code for primary procedure)*) is the closest valued MPC code with a ZZZ global. There is no clinical similarity between 37239 and 57267. 37239 has 10 minutes of pre-service evaluation time compared to zero for 57267. This is logical because insertion of mesh during an open surgery case does not require evaluation time, while consideration of stenting a completely different artery such as the celiac absolutely does require pre-service evaluation time. Thus, pre-service comparison favors 37239 in terms of work.

Importantly, IWPUT for 37239 is almost exactly that of 57267, yet the recommended RVW for 37239 is substantially less than that of the MPC code. A potential RVW for 37239 can be estimated from 57267 by subtracting 15 minutes of intra-time at an IWPUT of 0.108 ( $15 \times 0.108 = 1.62$ ) and adding 15 minutes of pre and post time ( $15 \times 0.0224 = 0.34$ ) resulting in a RVW of 3.6 ( $4.88 - 1.62 + 0.34$ ). Thus, a comparison of 37239 to the closest valued ZZZ MPC service clearly justifies our recommendation for the 25<sup>th</sup> percentile survey value of 3.5 for 37239.

	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	IM-post
<b>37239</b>	3.50	0.105	45	10	0	0	30	5
<b>57267</b>	4.88	0.108	45	0	0	0	45	0

### **Work Neutrality Considerations**

Since there are two daughter codes (37237 and 37239) it is important to perform an analysis of work neutrality. The parent codes (37206 or 37208 plus 75960) have a combined current work RVU of  $4.12 + 0.82$  for a total of 4.94. Our recommendations for the daughter codes are 4.25 work RVUs for the additional vessel arterial stent (37237) and 3.50 work RVUs for the vein stent (37239, this SoR). Thus, the additional vessel artery stent code recommendation is 0.69 RVUs less than current value, while the additional vessel vein stent code recommendation is 1.44 RVUs less than current value, and the net change will inevitably result in a reduction in work RVUs for this family.

Based on review of the diagnosis codes used to report the current code pair of 37206/37208 & 75960 as well as understanding of current day practice, our expert panel estimates that this service is performed 75% of the time in arteries and 25% of the time in veins. Thus, for every 100 procedures with the new codes, 372X6 will be reported 75 times, while 37239 will be reported 25 times.

Current work value of 100 services  $37206/37208 + 75960 = 100 \times (4.12 + 0.82) = 494$  RVUs

Proposed work value for 100 daughter services:

Additional Artery stent code 37237 projected frequency  $75 \times 4.25$  RVUs = 318.75 RVUs

Additional Vein stent code 37239 projected frequency  $25 \times 3.50$  RVUs = 87.50 RVUs

Total add-on work for combination of two daughter codes =

406.25 RVUs

Net Reduction in work RVUs for this frequency distribution:

-87.75 RVUs for each 100 procedures reported

Percentage reduction in RVUs for this frequency distribution:

-17.8%

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. This code bundles the existing surgical procedure and radiological supervision and interpretation codes into one code as requested by the RUC, based on the 75% screen. Stent insertion can occur in any vessel, both arterial and venous. The work required for endovascular stent insertion will depend on the specific vessel that needs to be catheterized. Therefore, it is expected that coding for the procedure will include one or more vascular catheterization codes in addition to the arterial or venous stent code. This reflects current coding practice and appropriately represents the highly variable work required for stenting of different vessels.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 37206 Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; each additional vessel (List separately in addition to code for primary procedure) OR 37208 Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; each additional vessel (List separately in addition to code for primary procedure)

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Vascular Surgery

How often? Commonly

Specialty Radiology

How often? Commonly

Specialty Cardiology

How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National data not available

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---



Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,406  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Combining 37206 (5,416) and 37208 (207) adds up to 5,623 which will crosswalk to the total number of claims adding 37237 and 37239. It is estimated that 75% of the 5,623 will be captured with 37236.

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States?

---

**Professional Liability Insurance Information (PLI)**

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 37223

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	AO	AP	AQ	AR	AS
12	ISSUE: Transcatheter Placement of Intravascular Stent																								
13	TAB: 9																								
14	Source	CPT	DESC	Resp	IWPUT	RVW					Total Time	PRE-TIME			INTRA-TIME					IMMD POST	SURVEY EXPERIENCE				
15						MIN	25th	MED	75th	MAX		EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX		MIN	25th	MED	75th	MAX
16	REF	37184	Primary percu	24	0.080			8.66			160	20	10	10			90			30					
17	CURRENT	37205	Transcatheter plac		0.064			8.27			198	30	15	20			98			35					
18	CURRENT	75960	Transcatheter introd		0.048			0.82			17						17								
19	CURRENT				#DIV/0!						0														
20	SVY	37236	Transcatheter	77	0.071	5.00	8.00	9.00	11.00	23.00	215	65	15	15	20	60	90	120	180	30	0	4	10	25	150
21	REC				0.083	9.00					161	33	3	5			90			30					
22																									
23	Source	CPT	DESC	Resp	IWPUT	RVW					Total Time	PRE-TIME			INTRA-TIME					IMMD POST	SURVEY EXPERIENCE				
24						MIN	25th	MED	75th	MAX		EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX		MIN	25th	MED	75th	MAX
25	REF	37186	Secondary pe	18	0.069			4.12			60						60								
26	CURRENT	37206	Transcatheter plac		0.046			4.12			90						90								
27	CURRENT	75960	Transcatheter introd		0.048			0.82			17						17								
28	CURRENT				#DIV/0!						0														
29	SVY	37237	each addition	61	0.099	2.35	4.25	5.00	7.65	20.00	70	15			15	30	45	60	180	10	0	2	9	15	120
30	REC				0.087	4.25					60	10					45			5					
31																									
32	Source	CPT	DESC	Resp	IWPUT	RVW					Total Time	PRE-TIME			INTRA-TIME					IMMD POST	SURVEY EXPERIENCE				
33						MIN	25th	MED	75th	MAX		EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX		MIN	25th	MED	75th	MAX
34	REF	37187	Percutaneous	27	0.080			8.03			145	26	5	9			85			20					
35	CURRENT	37205	Transcatheter plac		0.064			8.27			198	30	15	20			98			35					
36	CURRENT	75960	Transcatheter introd		0.048			0.82			17						17								
37	CURRENT				#DIV/0!						0														
38	SVY	37238	Transcatheter	75	0.092	3.50	6.00	8.00	9.18	18.50	180	60	15	15	30	45	60	78	180	30	0	5	10	30	150
39	REC				0.080	6.29					131	33	3	5			60			30					
40																									
41	Source	CPT	DESC	Resp	IWPUT	RVW					Total Time	PRE-TIME			INTRA-TIME					IMMD POST	SURVEY EXPERIENCE				
42						MIN	25th	MED	75th	MAX		EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX		MIN	25th	MED	75th	MAX
43	REF	37186	Secondary pe	11	0.069			4.12			60						60								
44	CURRENT	37206	Transcatheter plac		0.046			4.12			90						90								
45	CURRENT	75960	Transcatheter introd		0.048			0.82			17						17								
46	CURRENT				#DIV/0!			4.94			0														
47	SVY	37239	each addition	61	0.152	2.00	3.50	5.00	6.35	15.00	50	10			10	25	30	60	180	10	0	2	5	20	110
48	REC				0.110	3.34					32	1					30			1					

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

**Meeting Date:** April 2013

**CPT Long Descriptor:**

*Transcatheter placement of an intravascular stent(s) (except lower extremity, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed;*

37236 initial artery (000)

+37237 each additional artery (ZZZ)

(List separately in addition to code for primary procedure)

*Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed;*

37238 initial vein (000)

+37239 each additional vein (ZZZ)

(List separately in addition to code for primary procedure)

**1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:**

The multispecialty organizations (SIR, ACR, SVS, ACC and SCAI) convened a panel that included a number of experts familiar with these services to evaluate the direct practice expense inputs for this procedure. The panel made recommendations based on existing inputs and the new coding conventions.

**2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison. You must provide an explanation for the selection of reference codes. Reference Code Rationale:**

The new surveyed codes are the result of a bundling screen. As such, we have included columns with the existing inputs for reference. In addition to including the exiting inputs for 37205-8 and 75960, we included the inputs for CPT code 37224. This procedure has a similar process of care and was recently reviewed by the PE Subcommittee. It is typical that a needle/catheter code would be performed along with these new CPT codes. There is no particular needle/catheter code that appears in the billed together data as 'typical'. Therefore, we have included the direct practice expense inputs for CPT Code 36147, which has the highest billed together frequency.

**3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:**

Pre Service Period

We are requesting pre service clinical time for these 000 services. The physician typically uses his/her own clinical staff to complete pre-service diagnostic/referral forms and to work with the insurance companies/radiation oncology benefits manager. They ensure all pre authorization forms are completed and forward approved forms to the appropriate personnel. Their clinical staff works with the facility to ensure that the facility is available as well as all the necessary supplies.

**4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:**

We are requesting pre service clinical time for these 000 service. (See Question #3)

**5. Please describe in detail the clinical activities of your staff:**

Pre-Service Clinical Labor Activities:

A clinically trained individual (RN,/LPN/MA) will review and complete all referral forms for the various insurance entities and ensure that the indication has met medical necessity for the planned procedure and forward the approved forms to the appropriate personnel including by fax if necessary. The clinical staff contacts the facility to make sure appropriate time for the room is available as well as all the supplies, which will be required for the scheduled procedure.

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

N/A.

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

**Meeting Date:** April 2013

**CPT Long Descriptor:**

*Transcatheter placement of an intravascular stent(s) (except lower extremity, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed;*

37236 initial artery (000)

+37237 each additional artery (ZZZ)

(List separately in addition to code for primary procedure)

*Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed;*

37238 initial vein (000)

+37239 each additional vein (ZZZ)

(List separately in addition to code for primary procedure)

**1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:**

The multispecialty organizations (SIR, ACR, SVS, ACC and SCAI) convened a panel that included a number of experts familiar with these services to evaluate the direct practice expense inputs for this procedure. The panel made recommendations based on existing inputs and the new coding conventions.

**2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison. You must provide an explanation for the selection of reference codes. Reference Code Rationale:**

The new surveyed codes are the result of a bundling screen. As such, we have included columns with the existing inputs for reference. In addition to including the exiting inputs for 37205-8 and 75960, we included the inputs for CPT code 37224. This procedure has a similar process of care and was recently reviewed by the PE Subcommittee. It is typical that a needle/catheter code would be performed along with these new CPT codes. There is no particular needle/catheter code that appears in the billed together data as 'typical'. Therefore, we have included the direct practice expense inputs for CPT Code 36147, which has the highest billed together frequency.

**3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:**

Pre Service Period

*Complete pre-service diagnostic and referral forms:*

A clinically trained individual (RN,/LPN/MA) will review and complete all referral forms for the various insurance entities and ensure that the indication has met medical necessity for the planned procedure.

*Coordinate pre-surgery services:*

Clinical staff member ensures that all appropriate labs (CBC, CHEM7, etc.) are drawn and results are acceptable.

*Follow-up phone calls and prescriptions:*

Clinical staff will contact the patient prior to the procedure to ensure that they will be NPO, answer any questions the patient may have regarding the scheduled procedure, confirm their arrival time, review allergies and call the pharmacy with any prescription if needed, such as medication for contrast allergy or poor renal function.

Service Period

*Prepare Room, Equipment, Supplies*

Interventional technologist checks imaging equipment to make sure that it is turned on, warmed up, functioning properly, enters the patient demographics, opens the sterile tray and sets it up, goes to the storage room to pull all the supplies that will be used for the procedure, and brings them to the procedure room. The standard for prepare room is 2 minutes and the standard for prepare scope is 5 minutes. We are essentially accepting two standards on one line. We are 'preparing imaging equipment' as the second part of the prepare room, equipment and supplies line.

*Prepare and Position Patient*

Once the patient is brought into the procedure room, time is taken to ensure appropriate position of the patient on the procedure table. Care is taken to ensure the patient's comfort as they will be required to remain still for a long period of time. As well as time is taken to ensure an unobstructed the field of view over the targeted areas of interest; this involves making sure that nursing monitoring and other equipment that could obstruct the images is clear. The area around the angiographic imaging equipment is clear to allow for manipulation of the equipment throughout the procedure. These activities take more than the standard of 2 minutes.

**4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:**

The procedures described by the new coding convention were previously reported with CPT codes 37205-8. CPT codes 37205 & 6 are currently priced in the office setting. CPT codes 37207 & 8 are not currently priced in the office setting. We are requesting that all four of these new codes be priced in the office.

Upon review of the existing direct practice expense inputs we determined that many of the standard clinical activities did not have time included. As this code will be the 'base' code when performed, it is essential that this procedure include all typical clinical activities. The needle/catheter code will be subject to the multiple surgical reductions.

In addition, we are recommending adding conscious sedation inputs to these procedures.

#### Increase In Current Clinical Staff Time

##### *Vitals*

Blood pressure, heart rate, respiratory rate, temperature, rhythm strip and pulse oximetry, are all obtained.

##### *Pre service Education*

The clinical staff educates the patient regarding the procedure, what to expect in the procedure room, reviews the risk of contrast and radiation, and obtains consent for the above.

##### *Sedate*

*The RN administers moderate sedation.*

##### *Addition of Clinical Staff*

The existing inputs currently have a scrubbed in angio tech to assist the physician at 100% of the physician work time. We are recommending conscious sedation for these procedures as such we are recommending the addition of an RN for 100% of the physician work time. Finally we are requesting an additional individual who is not scrubbed will assist with the imaging equipment and opening supplies. This is the current standard for endovascular procedures performed in an angio suite. This is the blended person, which per prior discussions has been 75% angio tech, 25% of other clinical staff (therefore there are 3 FTEs present during the entire procedure.)

##### *Monitor*

We are recommending four hours of post procedure monitoring for 37236 (artery) and three hours of post procedure monitoring for 37238 (vein).

##### *Check Dressing/Wound Care Instructions/Coordinate Office Visits/Prescriptions*

In addition to checking the dressings and reviewing at home instructions the clinical staff will also obtain pain prescriptions for the patients and review the medications with them.

##### *Post Procedure Image Processing*

The angiography tech post procedure annotates the images, processes them, and then either hangs the films for interpretation or sends digital images to PACS and ensures they are received.

Increase In Current Supplies

We are making recommendations to modify the clinical supplies for these new codes. Many of the supplies included in the existing inputs remain unchanged (Lines 88-99). We have deleted some of the existing inputs (Lines 102-103).

We are recommending **adding** the following items (Line 68-85):

- Expandable Stent (***Invoice Included***)  
Balloon expandable rigid stent is required to restore patency to the firm plaque filled vessel.
- Micro Catheter  
Small diameter catheter is used to cross the lesion with a soft wire. The soft wire is then exchanged through the micro catheter for a stiffer support wire. (37236)
- PTA Balloon & Inflation Device
  - An additional non-complaint balloon is required to fully dilate the stent at the site of the narrowing.
  - An inflation device is required to inflate the balloons at high pressure to fully deploy or post
- Guidewires
  - The hydrophilic wire is necessary to select the origin of the target vessel (37236 and 37238)
  - A stiffer small vessel wire is required to support the rigid stent as it crosses the tight stenosis.
- Introducer Sheath  
A longer, supporting sheath is required maintain stability of the working system while carefully passing the stent into the artery.
- Sterile Radio-opaque ruler  
A sterile ruler is required to accurately determine size of the target vessel so that correct size stents, PTA balloons, (or embolic) are chosen.
- Moderate Sedation  
We are recommending the standard conscious sedation supply inputs.

Upon review of the existing supplies we determined that many of the necessary supplies were not included in CPT code 37205. As this code will be the 'base' code when performed, it is essential that this procedure include all typical/necessary supplies. The access code will be subject to the multiple surgical reductions and account for any possible overlap:

- Minimum multi-specialty visit pack
- Tray, shave prep
- Drapes
- Closed flush system
- Syringe w-needle



- Blade
- Sponge tipped applicator
- Gauze
- Steri-strip
- Tape
- Lidocaine & Betadine
- XRay ID card and envelope
- AccuStick system
- Gowns, masks, caps and shoe covers
- Disinfectant and sodium chloride
- Underpad

#### Increase In Equipment

We are recommending adding the standard conscious sedation equipment items.

We are also including time for patient recovery on a stretcher. We recognize that a ‘stretcher’ is not an approved conscious sedation standard. However, the patient needs a stretcher/table in the recovery period. We are looking for feedback from the PE subcommittee and/or CMS regarding patient recovery stretchers/tables.

#### **5. Please describe in detail the clinical activities of your staff:**

##### Pre-Service Clinical Labor Activities:

Complete pre-service diagnostic and referral forms: a clinically trained individual (RN/LPN/MA) will review and complete all referral forms for the various insurance entities and ensure that the indication has met medical necessity for the planned procedure and forward the approved forms to the appropriate personnel including by fax if necessary. Coordinate pre-surgery services: Clinical staff member ensures that all appropriate labs (CBC, CHEM7, etc.) are drawn and results are acceptable. Follow-up phone calls and prescriptions: Clinical staff will contact the patient prior to the procedure to ensure that they will be NPO, answer any questions the patient may have regarding the scheduled procedure, confirm their arrival time, review allergies and call the pharmacy with any prescription if needed, such as medication for contrast allergy or poor renal function. Other clinical activities: The angiography technologist prior to the patient’s arrival will retrieve any prior imaging exams, hang or display these exams for the physician to review, verify orders, review the chart to incorporate any relative clinical information and confirm contrast protocol.

##### Intra-Service Clinical Labor Activities:

Greet patient, provide gowning, and ensure appropriate medical records are available: Patient is greeted by the clinical staff, escorted to the intake area, provided with gowning and given assistance with changing into the gown if needed. Obtain vital signs: blood pressure, heart rate, respiratory rate, temperature, rhythm strip and pulse oximetry, are all obtained. Provide pre-service education/obtain consent: the clinical staff educates the patient regarding the procedure, what to expect in the procedure room, reviews the risk of contrast and radiation, and obtains consent for the above. Prepare room, equipment, supplies: Interventional technologist checks imaging equipment to make sure that it is turned on, warmed up, functioning properly, enters the patient demographics, opens the sterile tray and sets it up, goes to the storage room to pull all the supplies that will be used for the procedure,

and brings them to the procedure room. Prepare and position patient/Monitor patient/Setup IV. Intra-service Time of varying clinical personnel: there is a RN that is present with the patient the entire time to monitoring for sedation, an angio tech is scrubbed next to the physician the entire case, an additional 3<sup>rd</sup> individual who is not scrubbed will assist with the imaging equipment and opening supplies. Monitor patient following service/Check tubes, monitors, drains. The standard recommendation of CMS is that patients are recovered at a ratio of 1 nurse for 4 patients. Check dressings and wound/home care instructions/coordinated office visits/prescriptions. In addition to checking the dressings and reviewing at home instructions the clinical staff will also discuss pain prescriptions for the patients and review the medications with them. Other clinical activities: The angiography tech post procedure annotates the images, processes them, and then either hangs the films for interpretation or sends digital images to PACS and ensures they are received.

Post-Service Clinical Labor Activities:

Conducts phone calls/call in prescription: the clinical staff calls the patient the day after the procedure to make sure that there are no complications, answers any questions, ensures that pain control is adequate, and calls in additional prescriptions if needed.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
1	REVISED			EXISTING CODES										NEW CODES			
2	Meeting Date: April 2013 Tab: 9 Specialty: Interventional Radiology, Diagnostic Radiology, Vascular Surgery and Cardiology  *Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as			37205		37206		37207		37208		75960		37236		37237	
3				Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; initial vessel		Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; each additional vessel		Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; initial vessel		Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; each additional vessel		Transcatheter introduction of intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous and/or open, radiological		Transcatheter placement of an intravascular stent(s) extracranial vertebral or intrathoracic carotid, including radiological supervision and interpretation		Transcatheter placement of an intravascular stent(s) extracranial vertebral or intrathoracic carotid, including radiological supervision and interpretation	
4		CMS Code	Staff Type											initial artery		each additional artery	
5				Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6				000		ZZZ		000		ZZZ		XXX		000		ZZZ	
7	TOTAL CLINICAL LABOR TIME			124	3	45	0		30			31	0	386	9	141	0
8	TOTAL PRE-SERV CLINICAL LABOR TIME			0	0	0	0		30			0	0	15	6	0	0
9		L037D	RN/LPN/MTA	0	0	0	0						0	9	6	0	0
10		L041A	Angio Tech	0		0								6		0	
11	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			121	0	45	0					31	0	368	0	141	0
12		L037D	RN/LPN/MTA	8		0								50		12	
13		L041A	Angio Tech	98		45						31		163		84	
14		L051A	RN	15		0								155		45	
15		L041B	Rad Tech														
16	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	3	3	0	0					0	0	3	3	0	0
17	PRE-SERVICE																
18	Start: Following visit when decision for surgery or procedure made																
19	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA						5					3	3		
20	Coordinate pre-surgery services	L037D	RN/LPN/MTA						10					3			
21	Schedule space and equipment in facility	L037D	RN/LPN/MTA						5						3		
22	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA						7								
23	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA						3					3			
24	*Other Clinical Activity - specify: retrieve prior imaging exams, verify orders, review the chart	L041A	Angio Tech											6			
25	End: When patient enters office/facility for surgery/procedure																
26	SERVICE PERIOD																
27	Start: When patient enters office/facility for surgery/procedure:																
28	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA											3			
29	Obtain vital signs	L037D	RN/LPN/MTA											5			
30	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	3										5			
31	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2										7		1	
32	Setup scope (non facility setting only)																
33	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA											5			
34	Sedate/apply anesthesia	L051A	RN											2			
35	*Other Clinical Activity - specify: Pre procedure doppler check in addition to vitals	L041A	Angio Tech														
36	Intra-service																
37	Assist physician in performing procedure	L041A	Angio Tech	98		45								90		45	
38	Assist physician with conscious sedation monitoring	L051A	RN											90		45	
39	Assisting with flouroscopy/image acquisition (75%)	L041A	Angio Tech									17		68		34	
40	Circulating throughout procedure (25%)	L037D	RN/LPN/MTA											22		11	
41	Post-Service																
42	Monitor pt. following service/check tubes, monitors, drains	L051A	RN	15										60			
43	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	3								3		3			
44	Clean Scope																
45	Clean Surgical Instrument Package																
46	Complete diagnostic forms, lab & X-ray requisitions																
47	Review/read X-ray, lab, and pathology reports																
48	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA											3			
49	*Other Clinical Activity - specify: post procedure image processing	L041A	Angio Tech									11		5		5	
53	End: Patient leaves office																
54	POST-SERVICE Period																
55	Start: Patient leaves office/facility																
56	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	3	3									3	3		
64	*Other Clinical Activity - specify:																
65	End: with last office visit before end of global period																

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
1	REVISED			EXISTING CODES										NEW CODES			
2	Meeting Date: April 2013 Tab: 9 Specialty: Interventional Radiology, Diagnostic Radiology, Vascular Surgery and Cardiology			37205		37206		37207		37208		75960		37236		37237	
3				Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; initial vessel		Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; each additional vessel		Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; initial vessel		Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; each additional vessel		Transcatheter introduction of intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity artery), percutaneous and/or open, radiological supervision and interpretation	Transcatheter placement of an intravascular stent(s) extracranial vertebral or intrathoracic carotid, including radiological supervision and interpretation		Transcatheter placement of an intravascular stent(s) extracranial vertebral or intrathoracic carotid, including radiological supervision and interpretation		
4	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as	CMS Code	Staff Type											initial artery		each additional artery	
5	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6	GLOBAL PERIOD			000		ZZZ		000		ZZZ		XXX		000		ZZZ	
66	MEDICAL SUPPLIES**	CODE	UNIT														
67	ADDED ITEMS																
68	pack, minimum multi-specialty visit	SA048	pack											1			
69	pack, moderate sedation	SA044	pack											1			
70	balloon expandable	NEW	item											0		0	
71	catheter, microcatheter	SD154	item											1			
72	catheter, balloon, PTA	SD152	item											1		1	
73	catheter, balloon, low profile PTA	SC151	item													1	
74	catheter, balloon inflation device	SD149	item											1			
75	guidewire, hydrophilic	SD089	item											1			
76	guidewire, low profile (SpartaCore)	SD173	item											1			
77	introducer sheath, Ansel [45 cm 6 Fr Ansel]	SD250	item											1			
78	Sterile Radio-opaque ruler	SD249	item											1			
79	applicator, sponge-tipped	SG009	item											4			
80	blade, surgical (Bard-Parker)	SF007	item											1			
81	cap, surgical	SB001	item											4			
82	closed flush system, angiography	SC010	item											1			
83	disinfectant, surface (Envirocide, Sanizide)	SM013	oz											6			
84	drape-towel, sterile 18inx26in	SB019	item											4			
85	drape, sterile, femoral	SB009	item											1			
86	gauze, sterile 4in x 4in	SG055	item											2			
87	gown, surgical, sterile	SB028	item											2			
88	kit, AccuStick II Introducer System with RO Marker	SA071	item											1			
89	lidocaine 1%-2% inj (Xylocaine)	SH047	ml											10			
90	mask, surgical, with face shield	SB034	item											4			
91	povidone soln (Betadine)	SJ041	ml											60			
92	shoe covers, surgical	SB039	pair											4			
93	sodium chloride 0.9% flush syringe	SH065	item											2			
94	steri-strip (6 strip uou)	SG074	item											1			
95	syringe w-needle, OSHA compliant (SafetyGlide)	SC058	item											2			
96	tape, surgical paper 1in (Micropore)	SG079	item											6			
97	tray, shave prep	SA067	tray											1			
98	underpad 2ftx3ft (Chux)	SB044	item											1			
99	x-ray envelope	SK091	item											1			
100	x-ray ID card (flashcard)	SK093	item											1			
101																	
102	Existing Items - No Change																
103	stent, vascular, deployment system, Cordis SMART	SA103	item	1.5		1											
104	suture device for vessel closure (Perclose A-T)	SD207	item	1										1			
105	heparine	SH039	ml	5		3								5			
106	stop cock, 3 way	SC049	item	1		1								1			
107	syringe, 10 cc	SC051	item	1		1								1			
108	syringe, 30 cc	SC054	item	1		1								1			
109	sterile gloves	SB024	item	3		3								3			
110	sheath, peel away	SD206	item	1		1											
111	guidewire, steerable (Transcend)	SD175	item	1		1								1			
112	film, x-ray 14in x 17in	SK034	item									10		10		1	
113	x-ray developer solution	SK089										10		10		6	
114	x-ray fixer solution	SK092										10		10		6	
115																	
116	Existing Items - Deleted																
117	pig tail catheter 5 fr angiographic	SC008	item	1		1											
118	guidewire, steerable (Hi-Torque)	SD174	item	1		1											
119																	
120	Fem/Pop PTA (not included in surveyed codes)																
121	brush, protected airway specimen	SD141	item														
122	guidewire, cerebral (Bentson)	SD172	item														
123																	
124	Introduction of needle/catheter (not included in surveyed codes)																
125	drape, sterile, c-arm, fluoro	SB008	item														
126	guidewire	SD088	item														
127	Conray Inj (iothalamate 43%)	SH026	ml														
128	computer media, dvd	SK013	item														
129																	
130	EQUIPMENT	CODE															
131	Angiographic room	EL011		89		36						9		107		46	

AMA/Specialty Society RVS Update Committee Summary of Recommendations  
*Codes Reported Together 75% or More Screen*

April 2013

**Embolization and Occlusion Procedures**

CPT code 37204 *Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck* was identified through the Codes Reported Together 75% or More screen. In April 2010, the RUC accepted the specialties' recommendation to submit a code change proposal that would address any duplication when these services are reported together on the same date by the same physician. In February 2013, the CPT Editorial Panel deleted 37204 *Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non head or neck* and 37210 *Uterine fibroid embolization (UFE, embolization of the uterine arteries to treat uterine fibroids, leiomyomata), percutaneous approach inclusive of vascular access, vessel selection, embolization, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the procedure* and established four bundled codes to report embolization and occlusion procedures.

**37241 *Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles)*** The RUC reviewed the survey results from 75 vascular surgeons and radiologists and agreed that a work RVU of 9.00, the survey 25<sup>th</sup> percentile is appropriate, setting a proper base for this family of services. There was consensus among the RUC that the following physician time components are appropriate: pre-time of 27 minutes, intra service time of 90 minutes and post service time of 30 minutes. Furthermore, the RUC agreed that an additional 2 minutes of pre-time is appropriate to account for positioning of the patient on the angiographic table, as well as optimizing EKG monitoring lead placement to avoid obscuring imaging during embolization. The RUC compared 37241 to key reference code 37182 *Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation/dilatation, stent placement and all associated imaging guidance and documentation)*(work RVU=16.97) and agreed that the time and intensity of 37182 is greater. The RUC also reviewed CPT code 37211 *Transcatheter therapy, arterial infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, initial treatment day* (work RVU=8.00) and determined that since 37241 requires more physician work and intensity it should be valued higher. **The RUC recommends a work RVU of 9.00 for CPT code 37241.**

***37242 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)***

The RUC reviewed the survey results from 59 vascular surgeons and radiologists for CPT code 37242 and agreed that a direct crosswalk to CPT code 34833 *Open iliac artery exposure with creation of conduit for delivery of aortic or iliac endovascular prosthesis, by abdominal or retroperitoneal incision, unilateral* (work RVU= 11.98 and 100 minutes intra-service time) is appropriate. Both services have identical intra times and should have identical values. There was consensus among the RUC that the following physician time components are appropriate: pre-time of 41 minutes, intra service time of 100 minutes and post service time of 30 minutes. Furthermore, the RUC agreed that an additional 2 minutes of pre-time is appropriate to account for positioning of the patient on the angiographic table, as well as optimizing EKG monitoring lead placement to avoid obscuring imaging during embolization. To validate this value, the Committee reviewed CPT codes 61640 *Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel* (work RVU= 12.32, and 90 minutes intra-service time/) and 37228 *Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty* (work RVU= 11.00, and 90 minutes intra-service time) and noted that while catheterization is included in both these reference codes, the resulting values provide an adequate level of relativity across similar services. **The RUC recommends a work RVU of 11.98 for CPT code 37242.**

***37243 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction***

The RUC reviewed survey results from 62 vascular surgeons and radiologists and compared the intra-service times from 37243, 120 minutes, to 37244, 90 minutes. The RUC noted that 37244 is a more intense procedure. CPT code 37244 typically describes a hemorrhaging patient after trauma, in which the patient must be treated expeditiously to prevent exsanguination. Therefore, the intra-service time is less, but the service is much more intense. Therefore, a work RVU of 14.00 is appropriate for CPT code 37243, given the intensity difference. There was consensus among the RUC that the following physician time components are appropriate: pre-time of 41 minutes, intra service time of 120 minutes and post service time of 45 minutes. Furthermore, the RUC agreed that an additional 2 minutes of pre-time is appropriate to account for positioning of the patient on the angiographic table, as well as optimizing EKG monitoring lead placement to avoid obscuring imaging during embolization. To validate a work RVU of 14.00, the RUC reviewed CPT code 11005 *Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure* (work RVU= 14.24 and intra-service time of 120 minutes) and agreed that the recommendation is relative to other services. **The RUC recommends a work RVU of 14.00 for CPT code 37243.**

***37244 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation***

The Committee reviewed the survey data for CPT code 37244 and agreed that the survey 25<sup>th</sup> percentile work RVU of 14.00 accurately values this service. While the intra-service time of 90 minutes, is lower than some of the other codes in this family, this is the most intense procedure in the family. CPT code 37244 typically describes a hemorrhaging patient after trauma, in which the patient must be treated expeditiously to prevent exsanguination. Therefore, the intra-service time is less, but the service is much more intense. There was consensus among the RUC that the following physician time components are appropriate: pre-time of 41 minutes, intra service time of 90 minutes and post service time of 45 minutes. Furthermore, the RUC agreed that an additional 2 minutes of pre-time is appropriate to account for positioning of the patient on the angiographic table, as well as optimizing EKG monitoring lead placement to avoid obscuring imaging during embolization. To validate this value, the Committee reviewed CPT code 37229 *Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed* (work RVU= 14.05 and 120 minutes intra-service time) and agreed that while the reference code has more intra time, the service includes catheterization and is therefore a less intense service compared to the surveyed code. **The RUC recommends a work RVU of 14.00 for CPT code 37244.**

**Practice Expense:**

The RUC accepted the direct PE inputs with minor modifications as recommended by the PE Subcommittee.

**Work Neutrality**

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

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<b>Category I</b> <b>Surgery</b> <b>Cardiovascular System</b> <b>Arteries and Veins</b> <b>Vascular Injection Procedures</b> <b>Intra-Arterial – Intra-Aortic</b>				
<p><i><b>Diagnostic Studies of Arteriovenous (AV) Shunts for Dialysis:</b></i> For diagnostic studies, the arteriovenous (AV) dialysis shunt (AV shunt) is defined as beginning with the arterial anastomosis and extending to the right atrium. This definition includes all upper and lower extremity AV shunts (arteriovenous fistulae [AVF] and arteriovenous grafts [AVG]). Code 36147 includes the work of directly accessing and imaging the entire AV shunt. Antegrade and/or retrograde punctures of the AV shunt are typically used for imaging, and contrast may be injected directly through a needle or through a catheter placed into the AV shunt.</p>				



Occasionally the catheter needs to be advanced further into the shunt to adequately visualize the arterial anastomosis or the central veins, and all manipulation of the catheter for diagnostic imaging of the AV shunt is included in 36147. Advancement of the catheter to the vena cava to adequately image that segment of the AV shunt is included in 36147 and is not separately reported. Advancement of the catheter tip through the arterial anastomosis to adequately visualize the anastomosis is also considered integral to the work of 36147 and is not separately reported.

Ultrasound guidance for puncture of the AV shunt is not included in 36147. Particularly in the case of new or failing AVF, ultrasound may be necessary to safely and effectively puncture the AV access for evaluation, and this may be reported separately with 76937 if all the appropriate elements for reporting 76937 are performed.

Evaluation of the peri-anastomotic portion of the inflow is considered an integral part of the dialysis fistulagram and is included in the work of 36147. The peri-anastomotic portion of the vessel at the arterial anastomosis includes the short segment of the artery immediately adjacent to the anastomosis, the anastomosis itself, and the portion of the vessel or graft immediately distal to the anastomosis.

The arterial inflow to the AV access is considered a separate vessel. If a more proximal inflow problem separate from the peri-anastomotic segment is suspected and additional catheter work and imaging must be done for adequate evaluation, this work is not included in 36147. If a catheter is selectively advanced from the AV shunt puncture into the inflow artery, an additional catheterization code may be reported. In the typical case of an upper extremity AV shunt, 36215 is used to report this work, and includes placement of the catheter retrograde into the inflow artery and into the aorta if necessary (ie, 36200 may not be also reported since that work is included in the work defined by 36215).

***Interventions for Arteriovenous (AV) Shunts Created for Dialysis (AV Grafts and AV Fistulae):*** For the purposes of coding interventional procedures in arteriovenous (AV) shunts created for dialysis (both arteriovenous fistulae [AVF] and arteriovenous grafts [AVG]), the AV shunt is artificially divided into two vessel segments. The first segment is peripheral and extends from the peri-arterial anastomosis through the axillary vein (or entire cephalic vein in the case of cephalic venous outflow). The second segment includes the veins central to the axillary and cephalic veins, including the subclavian and innominate veins through the vena cava. Interventions performed in a single segment, regardless of the number of lesions treated, are coded as a single intervention.

The AV shunt is considered to be venous and most interventions are coded with the venous intervention codes (ie, angioplasty is reported with venous angioplasty codes 35476, 75978). Codes 35476 and 75978 would be reported once to describe all angioplasty work performed in one segment of the AV dialysis shunt, regardless of the number of distinct lesions treated within that segment, the number of times the balloon is inflated, or the number of balloon catheters required to open all lesions.

There is an exception to the use of venous interventional codes. When there is a stenosis at the arterial anastomosis, it typically extends across the anastomosis and involves the artery just proximal to and at the anastomosis as well as the outflow vessel or graft. This segment is called the peri-anastomotic (or juxta-anastomotic) region, and even though the stenosis can involve multiple vessels, it is typically a single lesion with a single etiology crossing the anastomosis, and treatment to open this lesion crosses from the artery into the vein or venous graft. An intervention treated in this peri-anastomotic segment is coded as an arterial intervention (35475, 75962). Since the entire segment of the AV shunt from the peri-arterial anastomosis through the axillary vein is considered a single vessel for coding of interventions, the arterial angioplasty codes include the work of opening the peri-anastomotic stenosis, as well as all other stenoses treated within this segment of the vessel. Codes 35475 and 75962 are reported once to describe all work done to angioplasty any lesion from the peri-arterial anastomosis through the axillary vein in procedures that involve angioplasty of the peri-arterial anastomosis of the AV shunt. In these special instances, venous angioplasty codes would not be reported additionally for this first or most peripheral shunt segment, even if balloon angioplasty is performed on segments of the AV dialysis shunt that are purely venous anatomy within this specific vessel segment.

It is never appropriate to report removal of the arterial plug during a declot/thrombectomy procedure as an arterial or venous angioplasty (35475, 35476). Removal of the arterial plug is included in the work of a fistula thrombectomy (36870), even if a balloon catheter is used to mechanically dislodge the resistant thrombus.

The central veins (eg, subclavian, innominate, and cava) are considered an additional, separate venous vessel segment for purposes of interventional coding for AV dialysis shunt interventions. If one or more central venous stenoses are treated with angioplasty, this is reported as a single venous angioplasty ( 35476, 75978), regardless of the number of discrete lesions treated within this segment, and also independent of the number of balloon inflations or number of balloon catheters or sizes required. This additional work should be clearly documented in the patient record and in the recorded images.

The codes for stents placed in AV dialysis accesses are generic for intravascular work and not specific for arterial or venous anatomy. However, the same rules used for angioplasty apply to stent placements for AV dialysis shunts with respect to the number of interventions reported for each patient. Stent codes (37205, 75960) are reported once to describe all work of stenting lesions within the defined AV dialysis shunt segment from the peri-arterial anastomosis through the axillary and cephalic veins, regardless of the number of stents placed or the number of discrete lesions treated within that vessel segment. If additional stenting is required for central venous stenosis, this may be reported as an additional stent placement (37206, 75960), describing all the work of stent placement within the central venous segment.

The work of catheterizing all the veins in the dialysis AV shunt is included in 36147 (and, if appropriate, 36148). Selective catheterization of the inferior/superior vena cava and central veins cannot be separately reported when performed from a direct puncture of the AVF/AVG.

However, if additional venous side branches off of the conduit, known as accessory veins, are separately catheterized for diagnosis or intervention such as embolization of a large competing accessory vein, this additional work may be separately reported using the appropriate selective venous catheterization codes (36011 and 36012). The embolization may be reported using 37241 once, irrespective of the number of branches embolized. ~~37204, 75894.~~

36215            Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family  
(For catheter placement for coronary angiography, see 93454- 93461)

36217            initial third order or more selective thoracic or brachiocephalic branch, within a vascular family

+36218            additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)

(Use 36218 in conjunction with 32616, 36217)

(For angiography, see 36147, 36222-36228, 75600-75774, 75791)

(For angioplasty, see 35471, 35472, 35475)

(For transcatheter therapies, see 37200-~~37208~~ 37204, 37241-37244, 61624, 61626)

(When coronary artery, arterial conduit [eg, internal mammary, inferior epigastric or free radical artery] or venous bypass graft angiography is performed in conjunction with cardiac catheterization, see the appropriate cardiac catheterization, injection procedure, and imaging supervision code[s] [93455, 93457, 93459, 93461, 93530-93533, 93564] in the **Medicine** section. When internal mammary artery angiography only is performed without a concomitant cardiac catheterization, use 36216 or 36217 as appropriate)

36470            Injection of sclerosing solution; single vein

36471            multiple veins, same leg

(For vascular embolization and occlusion procedures, see 37241-37244)

36475            Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated

+36476	<p>second and subsequent veins treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)</p> <p>(Use 36476 in conjunction with 36475)</p> <p>(Do not report 36475, 36476 in conjunction with 29581, 29582, 36000-36005, 36410, 36425, 36478, 36479, <del>37204</del> <u>37241</u>, 75894, 76000, 76001, 76937, 76942, 76998, 77022, 93970, 93971)</p>
36478	<p>Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated</p>
+36479	<p>second and subsequent veins treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)</p> <p>(Use 36479 in conjunction with 36478)</p> <p>(Do not report 36478, 36479 in conjunction with 29581, 29582, 36000-36005, 36410, 36425, 36475, 36476, <del>37204</del> <u>37241</u>, 75894, 76000, 76001, 76937, 76942, 76998, 77022, 93970, 93971)</p> <p><u>(Do not report codes 36468, 36470, 36471, 36475-36479 in conjunction with 37241-37244)</u></p>
<p><b>Category I</b>  <b>Surgery</b>  <b>Cardiovascular System</b>  <b>Arteries and Veins</b>  <b>Transcatheter Procedures</b>  <b>Other Procedures</b></p>	

D37204		<p><del>Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck</del></p> <p><del>(See also 61624, 61626)</del></p> <p><del>(For radiological supervision and interpretation, use 75894)</del></p> <p><del>(For uterine fibroid embolization {uterine artery embolization performed to treat uterine fibroids}, use 37210)</del></p> <p><del>(For obstetrical and gynecological embolization procedures other than uterine fibroid embolization {eg, embolization to treat obstetrical or postpartum hemorrhage} use 37204)</del></p> <p><del>(37204 has been deleted. To report, see 37241-37244, 61624, 61626)</del></p>	000	N/A
D37210		<p><del>Uterine fibroid embolization (UFE, embolization of the uterine arteries to treat uterine fibroids, leiomyomata), percutaneous approach inclusive of vascular access, vessel selection, embolization, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the procedure</del></p>	000	N/A

		<p><del>(37210 includes all catheterizations and intraprocedural imaging required for a UFE procedure to confirm the presence of previously known fibroids and to roadmap vascular anatomy to enable appropriate therapy)</del></p> <p><del>(Do not report 37210 in conjunction with 36200,36245-36248,37204, 75894, 75898)</del></p> <p><del>(For all other non-central nervous system (CNS) embolization procedures, use 37204)</del></p> <p><u>(37210 has been deleted. To report, use 37243)</u></p>		
<b>Category I</b> <b>Surgery</b> <b>Cardiovascular System</b> <b>Arteries and Veins</b> <b><u>Embolization</u></b> <b><u>Vascular Embolization and Occlusion Procedures</u></b>				
<p><u>Codes 37241-37244 are used to describe the work of vascular embolization and occlusion procedures, excluding the central nervous system and the head and neck, which are reported using codes 61624, 61626, 61710 and 75894, and excluding the ablation/sclerotherapy/sclerosis procedures for venous insufficiency/telangiectasia of the extremities/skin, which are reported using codes 36468, 36470, 36471.</u></p> <p><u>Embolization and occlusion procedures are performed for a wide variety of clinical indications and in a range of vascular territories. Arteries, veins, and lymphatics may all be the target of embolization.</u></p> <p><u>The embolization codes include all associated radiological supervision and interpretation, intra-procedural guidance and roadmapping, imaging necessary to document completion of the procedure, and moderate sedation. Code(s) for catheter placement(s) and diagnostic studies may be separately reportable using the appropriate diagnostic angiography codes with an appropriate modifier (eg, modifier 59). Please see</u></p>				

the guidelines on reporting of diagnostic angiography preceding CPT code 75600 in the *Radiology Guidelines, Vascular Procedures, Aorta and Arteries* section.

37241 is used to report vascular embolization or occlusion procedures performed for venous conditions other than hemorrhage. Examples include embolization of venous malformations, capillary hemangiomas, varicoceles, and visceral varices. Embolization of side branch(es) of an outflow vein from a hemodialysis access would be reported using 37241.

37242 is used to report vascular embolization or occlusion performed for arterial conditions other than hemorrhage or tumor such as arteriovenous malformations and arteriovenous fistulas whether congenital or acquired. Embolization of aneurysm and pseudoaneurysms are also reported with 37242. Tumor embolization is reported with 37243. Note that injection to treat an extremity pseudoaneurysm is correctly reported with code 36002. Sometimes, embolization and occlusion of an artery are performed prior to another planned interventional procedure; an example is embolization of the left gastric artery prior to planned implantation of an hepatic artery chemotherapy port. The artery embolization is reported with 37242.

37243 is used to report embolization for the purpose of tissue ablation and organ infarction or ischemia. This can be performed in many clinical circumstances, including embolization of benign or malignant tumors of the liver, kidney, uterus or other organs. When chemotherapy is given as part of an embolization procedure, additional codes (eg, 96420) may be separately reported. When a radioisotope (eg, Yttrium-90) is injected as part of an embolization, then additional codes (eg, 79445) may be separately reported. Uterine fibroid embolization is reported with 37243.

37244 is used to report embolization for treatment of hemorrhage or vascular or lymphatic extravasation. Examples include embolization for management of gastrointestinal bleed, trauma-induced hemorrhage of the viscera or pelvis, embolization of the thoracic duct for chylous effusion and bronchial artery embolization for hemoptysis. Embolization of the uterine arteries for management of hemorrhage (eg, post-partum hemorrhage) is also reported with 37244.

Intravascular stents, both covered and uncovered, are a class of devices that may be used as part of an embolization procedure. As such, there is the potential for overlap among codes used for placement of vascular stents and those used for embolization. When a stent is placed for the purpose of providing a latticework for deployment of embolization coils, such as for embolization of an aneurysm, the embolization code is reported and not the stent code. If a stent is deployed as the sole management of an aneurysm, pseudoaneurysm, or vascular extravasation then the stent deployment code should be reported and not the embolization code.

Only one embolization code should be reported for each surgical field (ie, the area immediately surrounding and directly involved in a treatment/procedure). For example, embolization of one or more venous side branches in a single arm for a patient with a dialysis arteriovenous fistula is reported with 37241 only once per session. Embolization procedures performed at a single setting and including multiple surgical fields (eg a patient with multiple trauma and bleeding from the pelvis and the spleen) may be reported with multiple embolization codes with the appropriate modifier (eg, modifier 59).

There may be overlapping indications for an embolization procedure. The code for the immediate indication for the embolization should be used. For instance, if the immediate cause for embolization is bleeding in a patient with an aneurysm, report code 37244.

☉●37241	W1	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles)  <u>(For sclerosis of veins or endovenous ablation of incompetent extremity veins, see 36468-36479)</u>	000	9.00
☉●37242	W2	arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)	000	11.98
☉●37243	W3	for tumors, organ ischemia, or infarction	000	14.00
☉●37244	W4	for arterial or venous hemorrhage or lymphatic extravasation <u>(For percutaneous treatment of extremity pseudoaneurysm, use 36002)</u> <u>(Do not report 37241-37244 in conjunction with 36468, 36470, 36471, 36475-36479, 75894, 75898)</u> <u>(For embolization procedures of the central nervous system or head and neck, see 61624, 61626, 61710)</u>	000	14.00
<b>Category I</b> <b>Surgery</b> <b>Nervous System</b> <b>Endovascular Therapy</b>				



61624	<p>Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal-cord)</p> <p><del>(See also 37204)</del></p> <p><u>(For noncentral nervous system and nonhead or neck embolization, see 37241-37244)</u></p> <p>(For radiological supervision and interpretation, use 75894)</p>
61626	<p>non-central nervous system, head or neck (extracranial, brachiocephalic branch)</p> <p><del>(See also 37204)</del></p> <p><u>(For noncentral nervous system and nonhead or neck embolization, see 37241-37244)</u></p> <p>(For radiological supervision and interpretation, use 75894)</p>
<b>Radiology</b> <b>Diagnostic Radiology (Diagnostic Imaging)</b> <b>Vascular Procedures</b> <b>Transcatheter Procedures</b>	
<p>Therapeutic transcatheter radiological supervision and interpretation code(s) include the following services associated with that intervention:</p> <ol style="list-style-type: none"> <li>1. Contrast injections, angiography/venography, roadmapping, and fluoroscopic guidance for the intervention,</li> <li>2. Vessel measurement, and</li> <li>3. Completion angiography/venography (except for those uses permitted by 75898).</li> </ol> <p>Unless specifically included in the code descriptor, diagnostic angiography/venography performed at the time of transcatheter therapeutic radiological and interpretation service(s) is separately reportable (eg, no prior catheter-based diagnostic angiography/venography study of the target vessel is available, prior diagnostic study is inadequate, patient's condition with respect to the clinical indication has changed since the prior study or during the intervention). See 75600- 75893.</p> <p><u>Do not report 75894, 75898 in conjunction with 37241-37244.</u></p>	

Codes 75956 and 75957 include all angiography of the thoracic aorta and its branches for diagnostic imaging prior to deployment of the primary endovascular devices (including all routine components of modular devices), fluoroscopic guidance in the delivery of the endovascular components, and intraprocedural arterial angiography (eg, confirm position, detect endoleak, evaluate runoff).

Code 75958 includes the analogous services for placement of each proximal thoracic endovascular extension. Code 75959 includes the analogous services for placement of a distal thoracic endovascular extension(s) placed during a procedure after the primary repair.

75894 Transcatheter therapy, embolization, any method, radiological supervision and interpretation

(Do not report 75894 in conjunction with 37241-37244)

~~(For uterine fibroid embolization, [uterine artery embolization performed to treat uterine fibroids], use 37210)~~

~~(For obstetrical and gynecological embolization procedures other than uterine fibroid embolization [eg, embolization to treat obstetrical or postpartum hemorrhage, use 37204])~~

75898 Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis.

(For thrombolysis infusion management other than coronary, see 37211-37214)

(Do not report 75898 in conjunction with 37211-37214, 37241-37244)

(75900 has been deleted. For exchange of a previously placed intravascular catheter during thrombolytic therapy with contrast monitoring, radiological supervision and interpretation, see 37211-37214)

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 37241	Tracking Number W1	Original Specialty Recommended RVU: <b>11.50</b>
		Presented Recommended RVU: <b>11.50</b>
Global Period: 000		RUC Recommended RVU: <b>9.00</b>

CPT Descriptor: Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 17-year-old male presents with left scrotal pain. Ultrasound demonstrates a left varicocele. The patient is referred for embolization.

Percentage of Survey Respondents who found Vignette to be Typical: 87%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 93%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 80%

**Description of Pre-Service Work:**

**DESCRIPTION OF WORK – Separately Reportable**

The right common femoral vein is accessed and a sheath placed. A guiding catheter is advanced into the origin of the left gonadal vein (Separately coded)

Gonadal venography is performed from the guiding catheter in order to assess the degree of reflux and identify venous anatomy and number of branches to be embolized. (Separately coded)

**Description of Pre-Service Work**

- A targeted H&P is performed obtaining relevant clinical information including indications, physical exam findings, and important laboratory findings. Careful review of axial imaging studies and multiplanar reformatted images is performed to assess access vessel, variants of anatomy, post-surgical changes, vessel diameter, and target tissue to be embolized.
  - The proposed procedure is discussed with the patient and family. Formal consent is obtained.
- The exam, procedural plans and consent are documented in the medical record.

**Description of Intra-Service Work:**

- Supporting base catheter, embolization catheter, and wire combinations are selected and assembled on the sterile table. In comparison to and in addition to diagnostic venography, Tri-axial systems are typically required to support embolization in the target vessel. Embolic material (coils, Sotradecol) is selected.
- The embolization system is advanced to the level of the distal gonadal vein.
- A microcatheter is guided through the base catheter deep into the target branches of the gonadal vein at or near the inguinal ligament using a steerable guidewire, fluoroscopy, and roadmapping including contrast material injection as needed.
- Embolic material is prepared and then serially loaded into the catheter system. Coils are carefully delivered to the end of the microcatheter and deployed. The microcatheter and coils may need to be repositioned to achieve a tight coil pack and avoid non-target embolization.
- Intermittent control follow-up venography is performed to document evidence of stasis, presence of collaterals, and need for additional treatment. The catheter is pulled back under fluoroscopic control and coils and Sotradecol are deployed at multiple levels typically along the entire course of the gonadal vein, corresponding to the position of side and parallel branches.
- Final coil deployment is performed through the base catheter at the upper end of the gonadal vein near the junction with the left renal vein.
- Completion venography of the left renal vein is performed to confirm elimination of reflux and occlusion of the left gonadal vein. When embolization is complete, the catheter system is removed.

#### Description of Post-Service Work:

- Appropriate care orders for post-embolization syndrome (pain, pyrexia, nausea, inflammatory response) specific to embolization are entered in the electronic medical record.
- The procedure is documented in the chart using a short post procedure note.
- The patient is transferred from the procedure table to the recovery area and monitored for 4 hours.
- The procedure outcome is discussed with the patient and family. Post procedure care instructions and plans for follow-up are also discussed.
- Recovery care and targeted exam findings are documented in a progress/discharge note. Discharge orders are written, including new medication prescriptions, and the patient is discharged to home.
- The procedure is formally documented in the medical record by dictating an operative report. The report is subsequently reviewed and authenticated after transcription is completed.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Sean Tutton, MD, Robert Vogelzang, MD, Jerry Niedzwiecki, MD, Michael Hall, Gary Seabrook, MD, Robert Zwolak, MD, Matthew Sideman, MD, Michael Sutherland, MD, Zeke Silva, MD and Kurt Schoppe, MD				
<b>Specialty(s):</b>	Vascular Surgery, Interventional Radiology and Diagnostic Radiology				
<b>CPT Code:</b>	37241				
<b>Sample Size:</b>	3265	<b>Resp N:</b>	75	<b>Response:</b> 2.2 %	
<b>Description of Sample:</b>	SVS Random Sample, 1240 SIR Random Sample, 1075 ACR Random Sample, 950				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	3.00	<b>9.00</b>	10.00	100.00
<b>Survey RVW:</b>	5.31	9.00	<b>11.50</b>	16.45	25.00
<b>Pre-Service Evaluation Time:</b>			<b>60.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>15.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>15.00</b>		
<b>Intra-Service Time:</b>	30.00	60.00	<b>90.00</b>	120.00	240.00
<b>Immediate Post Service-Time:</b>	<b>30.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1b-FAC Straightforw Pat Procedure(w sedate/anes)

<b>CPT Code:</b>	37241	<b>Recommended Physician Work RVU: 9.00</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>19.00</b>	<b>19.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>3.00</b>	<b>1.00</b>	<b>2.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>5.00</b>	<b>5.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>90.00</b>		
<b>Immediate Post Service-Time:</b>	<b>30.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		

<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
37182	000	16.97	RUC Time

CPT Descriptor Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation/dilation, stent placement and all associated imaging guidance and documentation.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 12      % of respondents: 16.0 %

**TIME ESTIMATES (Median)**

	<b>CPT Code:</b> 37241	<b>Key Reference CPT Code:</b> 37182	<b>Source of Time</b> RUC Time
Median Pre-Service Time	27.00	30.00	
Median Intra-Service Time	90.00	150.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>147.00</b>	<b>210.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.00	4.09
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.36	4.50
Urgency of medical decision making	3.33	4.55

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.45	4.42
Physical effort required	3.83	4.45

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.18	4.25
Outcome depends on the skill and judgment of physician	4.58	4.45
Estimated risk of malpractice suit with poor outcome	4.45	3.92

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.08	4.27
Intra-Service intensity/complexity	4.09	4.00
Post-Service intensity/complexity	3.58	3.82

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Why are we here?**

Embolization therapy, CPT codes 37204 and 75894 *Transcatheter therapy, embolization, any method, radiological supervision and interpretation*, were identified as reported together greater than 75% of the time and, as a result, were sent to CPT. A code change proposal was created after extensive multi-disciplinary discussion. Among the options considered were complete procedures where work of embolization and all catheterization were included and partially bundled codes.

Major concerns that ultimately led to a less comprehensive bundling of only the embolization surgical and S&I codes included:

1. Embolization therapy is performed for tumors, bleeding, arterial, venous, lymphatic malformations and aneurysms.
2. There is no standard patient. The procedural approach, complexity, and intensity are disparate.
3. Embolization therapy is performed in the viscera, solid organs, and vasculature both above and below the diaphragm.
4. There was concern that the number of vascular beds, varied catheterization combinations, and variants of anatomy would result in a prohibitively large number of codes.

These issues were vetted and the CPT panel approved four new bundled embolization therapy codes (37237241-4). Additionally, in conjunction with the new family of four codes, CPT code 37210 (Uterine fibroid embolization) was deleted as part of the multi-specialty Code Change Proposal presented at the CPT Panel. The procedure described by 37210 falls within the clinical parameters of the new 37243 code, and the specialties maintained that having an “outlier” embolization code separate from the new family would not only create coding confusion, but also represented a detraction from the logical integrity of the new family.

A multi-disciplinary workgroup including ACR, SIR, and SVS was convened. A survey was distributed randomly to the members of the workgroup and a robust number of completed surveys were received. The surveys were reviewed by the multi-specialty group and determined to be valid and reflective of the work and intensity involved. Appropriate rank order appears to be reflected between the four codes. The survey results and recommendations are as follows

**Pre-Service Time**

For all four codes, the group is recommending pre service package 2B with 2 additional minutes of positioning time to account for positioning patient on the angiographic table, as well as optimizing EKG and monitoring lead placement to avoid obscuring imaging during embolization.

This additional positioning time is consistent with multiple recently valued procedures brought before the RUC in the last several cycles including thrombolysis (37211), foreign body retrieval (37197), selective catheterization (36245, 36246, 36200), and IVC filters (37191-3).

**Post-Service Time**

Survey respondents recommended a median post service time of 30 minutes for 37241, and 37242 which the expert panel felt appropriate given these patients are complex, but typically do not have significant post-embolization syndrome (pain, pyrexia, anorexia, nausea, vomiting). For 37243, respondents felt that 45 minutes of post-service time was required for management of patients after tumor embolization given the potential for post-embolization syndrome (PES), and tumor lysis syndrome. Survey respondents recommended 45 minutes for 37244 given severity of patients injuries and the need to follow-up frequently during the course of the day to assess, and reassess for signs of ongoing bleeding, ischemia, and the typical arterial sheaths left in place.

**Work Recommendations**

It is the multi-disciplinary panel’s expert opinion that in the family of recently valued endovascular procedures, embolization therapy ranks at the top for intensity, risk, and difficulty.

These procedures are more difficult and risky than thrombolysis catheter placement, foreign body retrieval, and the less complex recently valued lower extremity (LE) revascularization codes e.g iliac angioplasty, stent placement 37221-2. Embolizations are similar in difficulty and intensity to carotid stent placement (37215), TIPS placement (37182), and the more complex LE revascularizations e.g. tibial interventions (37226-8).



**How Does This Compare?**

CPT Code	Descriptor	RVU	Pre	Intra	Post	90	Total	IWPUT
37230	LE tibial	13.80	48	120	30		198	0.101
37227	LE fem pop	14.50	48	125	30		203	0.1026
37229	LE tibial	14.05	48	120	30		198	0.1031
37228	LE tibial	11.00	48	90	30		168	0.1036
37182	TIPS	16.97	30	150	30		210	0.1042
37211	Thrombolysis	8.00	48	60	30		138	0.1054
<b>37241</b>	<b>Embo venous</b>	<b>11.50</b>	<b>41</b>	<b>90</b>	<b>30</b>		<b>161</b>	<b>0.111</b>
37215	Carotid Stents	19.68	90	103	30	124	347	0.1223
<b>37243</b>	<b>Embo tumors</b>	<b>17.00</b>	<b>41</b>	<b>120</b>	<b>45</b>		206	<b>0.126</b>
<b>37242</b>	<b>Embo arterial</b>	<b>16.00</b>	<b>41</b>	<b>100</b>	<b>30</b>		171	<b>0.145</b>
<b>37244</b>	<b>Embo hemorrhage</b>	<b>17.00</b>	<b>41</b>	<b>90</b>	<b>45</b>		176	<b>0.168</b>

**37241**

CPT Code 37241 describes the permanent occlusion/embolization of a venous varicocity, venous aneurysm, venous malformation, or venous tributary. The vignette was considered typical by greater than 87% of respondents. Our key reference service code (KRS) was CPT code 37182 *insertion of TIPS*.

The median intra service time of **90 minutes** was felt to be accurate by the expert panel and we are recommending the median **RVW of 11.50** yielding an IWPUT of 0.111, which is consistent with other highly intense endovascular procedures (see table). Of the four codes, 37237241 is the least intense in the family given it is performed in the venous circulation, however the risk of coil migration to the heart or pulmonary arterial circulation is real and explains the procedure's intensity.

**37242**

37237242 describes the permanent occlusion/embolization of an arterial aneurysm, malformation, or potential feeding artery in aneurysm therapy. Embolization therapy in the arterial circulation is inherently more risky than in the venous system. Arterial rupture, unintended ischemia, or non-target embolization are risks the operator must avoid. The vignette was considered typical by greater than 98% of respondents. Our KRS was CPT code 37184 *mechanical thrombectomy*.

The median intra service time was **100 minutes** which was felt to be accurate, and in rank order compared to 37241 and 37243. The expert panel is recommending the median RVW of 16.00 yielding an IWPUT of 0.145 which is higher than most endovascular procedures, but supported by the intensity, risk, and difficulty of the therapy.

**37243**

37237243 describes the pre-operative or definitive embolization therapy for benign and malignant tumors. The vignette describes treatment of a patient with carcinoid mets to the liver and 92% of survey respondents considered this typical. The KRS was CPT Code 37182.

The median intra service time was **120 minutes**, which was felt to be accurate. The expert panel is recommending the median RVW of 17.00 in line with other highly intense endovascular procedures like carotid stent (37215) and TIPS creation (37182). The IWPUT of 0.126 is lower reflecting a longer, more detailed, slightly less intense procedure when compared to 37242 and 37244. Tumor embolization requires precise catheter location beyond that required for diagnostic angiography. Catheter position must be chosen to avoid vasospasm and ensure precise tumor treatment while limiting non-target normal organ damage. Embolic solution must be of correct density and specific gravity to support suspension of beads/particles for uniform delivery to the tumor bed. Cautious intermittent delivery of small aliquots of embolic material is required to achieve effective tumor infarction. The process is slow and deliberate in the setting of tumor therapy.

**37244**

37237244 describes a nearly opposite embolization scenario. This vignette describes the hemorrhaging patient after extensive pelvic trauma which 98 % respondents considered typical. This patient must be treated as expeditiously as possible to prevent exsanguination. The operator is working as quickly as humanly possible under extreme conditions and intensity. This explains the decrease in intra service time to **90 minutes**. The KRS 37182 was again chosen.

The expert panel recommends the median **RVW of 17.00** despite the lower intra service time. It is the expert panel's assertion that 37237244 likely represents one of the most challenging, stressful therapies in the endovascular family warranting a high RVW and IWPOT (0.168).

**Reference Service Codes**

Further, the most common and key reference service chosen for all four codes was CPT Code 61624 *transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, any method; central nervous system (intracranial, spinal cord)*. We included this code on our RSL. The RUC database has the source as "RUC", there are updated times and RUC meeting dates. However, there is a note that says "Do Not Use to Validate for Physician Work". As such, we included the 2<sup>nd</sup> most selected reference code as our key reference code.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. These four new CPT codes bundle 37204/37210 and the corresponding radiological supervision and interpretation codes into new bundled procedures. Access will be gained by using one of the existing catheterization codes, which are separately reportable.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) CPT codes 37204, 75894 and 75898

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Interventional Radiology

How often? Commonly

Specialty Diagnostic Radiology

How often? Commonly

Specialty Vascular Surgery

How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National Frequency Data is Not Available

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3,148

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The new codes will represent 100% of the instances where 37204 is now used (30,764) and 100% of the instances where 37210 is now used (357). We estimate that uses of 75894 (36,341) will decline sharply, but that code will still be used with CPT codes 61624 & 61626.

Specialty Vascular Surgery	Frequency 473	Percentage 15.02 %
----------------------------	---------------	--------------------

Specialty Radiology	Frequency 2675	Percentage 84.97 %
---------------------	----------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 37204

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 37242	Tracking Number W2	Original Specialty Recommended RVU: <b>16.00</b>
		Presented Recommended RVU: <b>11.98</b>
Global Period: 000		RUC Recommended RVU: <b>11.98</b>

CPT Descriptor: Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 35-year-old woman presents with intermittent abdominal and back pain. A CT scan shows a 3 cm splenic artery aneurysm. The patient is referred for embolization.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 91%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 89%

**Description of Pre-Service Work:**

**DESCRIPTION OF WORK – Separately Reportable**

Via right common femoral access, a base guiding catheter is advanced into the celiac artery (Separately coded).

Diagnostic planning angiography of the celiac artery is performed to delineate vascular anatomy and identify the principal target of embolization and routes of approach. (Separately coded)

**Description of Pre-service work**

- A targeted H&P is performed obtaining relevant clinical information including indications, physical exam findings, and important laboratory findings. Careful review of previously acquired imaging studies including multiplanar reformatted images is performed to assess access vessel, variants of anatomy, post-surgical changes, vessel diameter, and target vessel to be embolized.

- The proposed procedure is discussed with the patient and family. Consent is obtained.

- The exam, procedural plans and consent are documented in the medical record.

Diagnostic images are reviewed to determine appropriate catheter selection, placement, and embolization.

**Description of Intra-Service Work:**

- Supporting base catheter, embolization catheter, and wire combinations are selected and assembled on the sterile table. In comparison to and in addition diagnostic arteriography Tri-axial systems are typically required to support embolization in the target vessel. Appropriate sized coils are selected.
  - Using fluoroscopic guidance and roadmapping technique, the embolization system is advanced over a steerable guidewire to the midportion of the tortuous splenic artery.
  - The embolization microcatheter is advanced to and beyond the aneurysm.
  - Coils are prepared and then serially loaded into the catheter system. Coils are carefully delivered to the end of the catheter and deployed. The microcatheter and coils may need to be retracted and redeployed to achieve a tight coil pack and to avoid non-target embolization.
  - Embolization of the aneurysm is performed using coils placed downstream to, within, and proximal to the aneurysm.
  - Intermittent control arteriograms are performed to assess progress toward vessel stasis, presence of collaterals, interval vascular complication such as spasm/dissection, and need for additional treatment.
  - Completion angiography is performed demonstrating exclusion of the aneurysm from the arterial circulation.
- When embolization is complete, the catheter system is removed.

#### Description of Post-Service Work:

- Appropriate care orders for post-embolization syndrome (pain, pyrexia, nausea, inflammatory response) specific to embolization are entered in the electronic medical record. The patient is evaluated for non-target embolization.
- The procedure is documented in the chart using a short post procedure note.
- The patient is transferred from the procedure table to the recovery area and monitored for 4 hours.
- The procedure outcome is discussed with the patient and family. Post procedure care instructions and plans for follow-up are also discussed.
- Recovery care and targeted exam findings are documented in a progress/discharge note. Discharge orders are written, including new medication prescriptions, and the patient is transferred to the inpatient/observational status or discharged to home as appropriate.
- The procedure is formally documented in the medical record by dictating an operative report. The report is subsequently reviewed and authenticated after transcription is completed.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Sean Tutton, MD, Robert Vogelzang, MD, Jerry Niedzwiecki, MD, Michael Hall, Gary Seabrook, MD, Robert Zwolak, MD, Matthew Sideman, MD, Michael Sutherland, MD, Zeke Silva, MD and Kurt Schoppe, MD				
<b>Specialty(s):</b>	Vascular Surgery, Interventional Radiology and Diagnostic Radiology				
<b>CPT Code:</b>	37242				
<b>Sample Size:</b>	3265	<b>Resp N:</b>	59	<b>Response:</b> 1.8 %	
<b>Description of Sample:</b>	SVS Random Sample, 1240 SIR Random Sample, 1075 ACR Random Sample, 950				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	3.00	8.00	20.00	75.00
<b>Survey RVW:</b>	6.76	10.05	16.00	19.63	25.58
<b>Pre-Service Evaluation Time:</b>			70.00		
<b>Pre-Service Positioning Time:</b>			15.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10.00		
<b>Intra-Service Time:</b>	30.00	63.00	100.00	120.00	240.00
<b>Immediate Post Service-Time:</b>	<u>30.00</u>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	37242	<b>Recommended Physician Work RVU: 11.98</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		33.00	33.00	0.00
<b>Pre-Service Positioning Time:</b>		3.00	1.00	2.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00
<b>Intra-Service Time:</b>		100.00		
<b>Immediate Post Service-Time:</b>	<u>30.00</u>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		

<b>Prolonged Services:</b>	<u><b>0.00</b></u>	99354x <b>0.00</b>	55x <b>0.00</b>	56x <b>0.00</b>	57x <b>0.00</b>
<b>Sub Obs Care:</b>	<u><b>0.00</b></u>	99224x <b>0.00</b>	99225x <b>0.00</b>	99226x <b>0.00</b>	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
37184	000	8.66	RUC Time

CPT Descriptor Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including flouroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); iniital vessel

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 11      % of respondents: 18.6 %**

**TIME ESTIMATES (Median)**

	<b>CPT Code: 37242</b>	<b>Key Reference CPT Code: 37184</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	41.00	40.00	
Median Intra-Service Time	100.00	90.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>171.00</b>	<b>160.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.73	3.45
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.36	3.82
--	------	------

Urgency of medical decision making	3.36	3.82
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.91	3.82
--------------------------	------	------

Physical effort required	3.64	3.64
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.64	3.91
---	------	------

Outcome depends on the skill and judgment of physician	4.36	4.00
--	------	------

Estimated risk of malpractice suit with poor outcome	3.91	3.82
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.82	3.73
----------------------------------	------	------

Intra-Service intensity/complexity	4.18	3.82
------------------------------------	------	------

Post-Service intensity/complexity	3.82	3.45
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*



**Why are we here?**

Embolization therapy, CPT codes 37204 and 75894 *Transcatheter therapy, embolization, any method, radiological supervision and interpretation*, were identified as reported together greater than 75% of the time and, as a result, were sent to CPT. A code change proposal was created after extensive multi-disciplinary discussion. Among the options considered were complete procedures where work of embolization and all catheterization were included and partially bundled codes.

Major concerns that ultimately led to a less comprehensive bundling of only the embolization surgical and S&I codes included:

1. Embolization therapy is performed for tumors, bleeding, arterial, venous, lymphatic malformations and aneurysms.
2. There is no standard patient. The procedural approach, complexity, and intensity are disparate.
3. Embolization therapy is performed in the viscera, solid organs, and vasculature both above and below the diaphragm.
4. There was concern that the number of vascular beds, varied catheterization combinations, and variants of anatomy would result in a prohibitively large number of codes.

These issues were vetted and the CPT panel approved four new bundled embolization therapy codes (37237241-4). Additionally, in conjunction with the new family of four codes, CPT code 37210 (Uterine fibroid embolization) was deleted as part of the multi-specialty Code Change Proposal presented at the CPT Panel. The procedure described by 37210 falls within the clinical parameters of the new 37243 code, and the specialties maintained that having an “outlier” embolization code separate from the new family would not only create coding confusion, but also represented a detraction from the logical integrity of the new family.

A multi-disciplinary workgroup including ACR, SIR, and SVS was convened. A survey was distributed randomly to the members of the workgroup and a robust number of completed surveys were received. The surveys were reviewed by the multi-specialty group and determined to be valid and reflective of the work and intensity involved. Appropriate rank order appears to be reflected between the four codes. The survey results and recommendations are as follows

**Pre-Service Time**

For all four codes, the group is recommending pre service package 2B with 2 additional minutes of positioning time to account for positioning patient on the angiographic table, as well as optimizing EKG and monitoring lead placement to avoid obscuring imaging during embolization.

This additional positioning time is consistent with multiple recently valued procedures brought before the RUC in the last several cycles including thrombolysis (37211), foreign body retrieval (37197), selective catheterization (36245, 36246, 36200), and IVC filters (37191-3).

**Post-Service Time**

Survey respondents recommended a median post service time of 30 minutes for 37241, and 37242 which the expert panel felt appropriate given these patients are complex, but typically do not have significant post-embolization syndrome (pain, pyrexia, anorexia, nausea, vomiting). For 37243, respondents felt that 45 minutes of post-service time was required for management of patients after tumor embolization given the potential for post-embolization syndrome (PES), and tumor lysis syndrome. Survey respondents recommended 45 minutes for 37244 given severity of patients injuries and the need to follow-up frequently during the course of the day to assess, and reassess for signs of ongoing bleeding, ischemia, and the typical arterial sheaths left in place.

**Work Recommendations**

It is the multi-disciplinary panel’s expert opinion that in the family of recently valued endovascular procedures, embolization therapy ranks at the top for intensity, risk, and difficulty.

These procedures are more difficult and risky than thrombolysis catheter placement, foreign body retrieval, and the less complex recently valued lower extremity (LE) revascularization codes e.g iliac angioplasty, stent placement 37221-2. Embolizations are similar in difficulty and intensity to carotid stent placement (37215), TIPS placement (37182), and the more complex LE revascularizations e.g. tibial interventions (37226-8).

**How Does This Compare?**

<b>CPT Code</b>	<b>Descriptor</b>	<b>RVU</b>	<b>Pre</b>	<b>Intra</b>	<b>Post</b>	<b>90</b>	<b>Total</b>	<b>IWPUT</b>
37230	LE tibial	13.80	48	120	30		198	0.101
37227	LE fem pop	14.50	48	125	30		203	0.1026
37229	LE tibial	14.05	48	120	30		198	0.1031
37228	LE tibial	11.00	48	90	30		168	0.1036
37182	TIPS	16.97	30	150	30		210	0.1042
37211	Thrombolysis	8.00	48	60	30		138	0.1054
<b>37241</b>	<b>Embo venous</b>	<b>11.50</b>	<b>41</b>	<b>90</b>	<b>30</b>		<b>161</b>	<b>0.111</b>
37215	Carotid Stents	19.68	90	103	30	124	347	0.1223
<b>37243</b>	<b>Embo tumors</b>	<b>17.00</b>	<b>41</b>	<b>120</b>	<b>45</b>		206	<b>0.126</b>
<b>37242</b>	<b>Embo arterial</b>	<b>16.00</b>	<b>41</b>	<b>100</b>	<b>30</b>		171	<b>0.145</b>
<b>37244</b>	<b>Embo hemorrhage</b>	<b>17.00</b>	<b>41</b>	<b>90</b>	<b>45</b>		176	<b>0.168</b>

**37241**

CPT Code 37241 describes the permanent occlusion/embolization of a venous varicocyt, venous aneurysm, venous malformation, or venous tributary. The vignette was considered typical by greater than 87% of respondents. Our key reference service code (KRS) was CPT code 37182 *insertion of TIPS*.

The median intra service time of **90 minutes** was felt to be accurate by the expert panel and we are recommending the median **RVW of 11.50** yielding an IWPUT of 0.111, which is consistent with other highly intense endovascular procedures (see table). Of the four codes, 37237241 is the least intense in the family given it is performed in the venous circulation, however the risk of coil migration to the heart or pulmonary arterial circulation is real and explains the procedure's intensity.

**37242**

37237242 describes the permanent occlusion/embolization of an arterial aneurysm, malformation, or potential feeding artery in aneurysm therapy. Embolization therapy in the arterial circulation is inherently more risky than in the venous system. Arterial rupture, unintended ischemia, or non-target embolization are risks the operator must avoid. The vignette was considered typical by greater than 98% of respondents. Our KRS was CPT code 37184 *mechanical thrombectomy*.

The median intra service time was **100 minutes** which was felt to be accurate, and in rank order compared to 37241 and 37243. The expert panel is recommending the median RVW of 16.00 yielding an IWPUT of 0.145 which is higher than most endovascular procedures, but supported by the intensity, risk, and difficulty of the therapy.

**37243**

37237243 describes the pre-operative or definitive embolization therapy for benign and malignant tumors. The vignette describes treatment of a patient with carcinoid mets to the liver and 92% of survey respondents considered this typical. The KRS was CPT Code 37182.

The median intra service time was **120 minutes**, which was felt to be accurate. The expert panel is recommending the median RVW of 17.00 in line with other highly intense endovascular procedures like carotid stent (37215) and TIPS creation (37182). The IWPUT of 0.126 is lower reflecting a longer, more detailed, slightly less intense procedure when compared to 37242 and 37244. Tumor embolization requires precise catheter location beyond that required for diagnostic angiography. Catheter position must be chosen to avoid vasospasm and ensure precise tumor treatment while limiting non-target normal organ damage. Embolic solution must be of correct density and specific gravity to support suspension of beads/particles for uniform delivery to the tumor bed. Cautious intermittent delivery of small aliquots of embolic material is required to achieve effective tumor infarction. The process is slow and deliberate in the setting of tumor therapy.

**37244**

37237244 describes a nearly opposite embolization scenario. This vignette describes the hemorrhaging patient after extensive pelvic trauma which 98 % respondents considered typical. This patient must be treated as expeditiously as possible to prevent exsanguination. The operator is working as quickly as humanly possible under extreme conditions and intensity. This explains the decrease in intra service time to **90 minutes**. The KRS 37182 was again chosen.

The expert panel recommends the median **RVW of 17.00** despite the lower intra service time. It is the expert panel's assertion that 37237244 likely represents one of the most challenging, stressful therapies in the endovascular family warranting a high RVW and IWPUT (0.168).

**Reference Service Codes**

Further, the most common and key reference service chosen for all four codes was CPT Code 61624 *transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, any method; central nervous system (intracranial, spinal cord)*. We included this code on our RSL. The RUC database has the source as "RUC", there are updated times and RUC meeting dates. However, there is a note that says "Do Not Use to Validate for Physician Work". As such, we included the 2<sup>nd</sup> most selected reference code as our key reference code.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. These four new CPT codes bundle 37204/37210 and the corresponding radiological supervision and interpretation codes into new bundled procedures. Access will be gained by using one of the existing catheterization codes, which are separately reportable.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) CPT codes 37204, 75894 and 75898

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Interventional Radiology

How often? Commonly

Specialty Diagnostic Radiology

How often? Commonly

Specialty Vascular Surgery

How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National Frequency Data is Not Available

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 7,870

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The new codes will represent 100% of the instances where 37204 is now used (30,764) and 100% of the instances where 37210 is now used (357). We estimate that uses of 75894 (36,341) will decline sharply, but that code will still be used with CPT codes 61624 & 61626.

Specialty Vascular Surgery	Frequency 1181	Percentage 15.00 %
----------------------------	----------------	--------------------

Specialty Radiology	Frequency 6690	Percentage 85.00 %
---------------------	----------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 37204

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 37243	Tracking Number W3	Original Specialty Recommended RVU: <b>17.00</b>
		Presented Recommended RVU: <b>14.00</b>
Global Period: 000		RUC Recommended RVU: <b>14.00</b>

CPT Descriptor: Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 72-year-old woman with metastatic carcinoid tumor has enlarging metastatic disease in the liver despite chemotherapy. The patient is referred for embolization.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 91%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 88%

**Description of Pre-Service Work:**

**DESCRIPTION OF WORK – Separately Reportable**

Via right common femoral access, a base guiding catheter is advanced into the celiac artery (Separately coded)

Diagnostic planning angiography of the celiac artery is performed to delineate vascular anatomy and identify the principal targets of embolization and routes of approach and mapping arteriography of the liver is performed in multiple projections to identify the number and location of tumor feeding vessels to be embolized (Separately coded)

**Description of Pre-service work**

- A targeted H&P is performed obtaining relevant clinical information including indications, physical exam findings, and important laboratory findings. Careful review of previously acquired imaging studies including multiplanar reformatted images is performed to assess access vessel, variants of anatomy, post-surgical changes, vessel diameter, and target vessel to be embolized.
- The proposed procedure is discussed with the patient and family. Consent is obtained.
- The exam, procedural plans and consent are documented in the medical record
- Diagnostic images are reviewed to determine appropriate catheter selection, placement, and embolization.

**Description of Intra-Service Work:**

- Supporting base catheter, embolization catheter, and wire combinations are selected and assembled on the sterile table. In comparison to and in addition to diagnostic arteriography, Tri-axial systems are typically required to support embolization in the target vessel. Appropriate sized coils are selected.
- Using fluoroscopic guidance and roadmapping, the embolization microcatheter and micro-steerable guidewire are advanced into the more selective target vessels supplying the tumor.
- Embolic material is delivered onto the sterile field and prepared in a suspension of contrast and saline. Concentration and suspension are titrated to the vascularity of the tumor accounting for arterio-venous shunting and vasospasm.
- Embolization is performed using small aliquots of embolic material mixed with contrast. Aliquots are slowly delivered to the target tumor tissue under fluoroscopic guidance until adequate flow arrest in the targeted vessel is achieved
- Intermittent control arteriograms are performed to assess continued flow in the parent artery.
- Subsequent tumors are targeted and embolized with control angiograms performed to assess progress and need for further treatment. Coil embolization of non-target vessels may be required.
- Completion arteriography is performed demonstrating cessation of flow to the metastases and absence of iatrogenic vessel injury.
- When embolization is complete, the catheter system is removed.

#### Description of Post-Service Work:

- Appropriate care orders for post-embolization syndrome (pain, pyrexia, nausea, inflammatory response) specific to embolization are entered in the electronic medical record. The patient is evaluated for non-target embolization.
- The procedure is documented in the chart using a short post procedure note.
- The patient is transferred from the procedure table to the recovery area and monitored for 4 hours.
- The procedure outcome is discussed with the patient and family. Post procedure care instructions and plans for follow-up are also discussed.
- Recovery care and targeted exam findings are documented in a progress/discharge note. Admission orders are written.
- The procedure is formally documented in the medical record by dictating an operative report. The report is subsequently reviewed and authenticated after transcription is completed.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Sean Tutton, MD, Robert Vogelzang, MD, Jerry Niedzwiecki, MD, Michael Hall, Gary Seabrook, MD, Robert Zwolak, MD, Matthew Sideman, MD, Michael Sutherland, MD, Zeke Silva, MD and Kurt Schoppe, MD				
<b>Specialty(s):</b>	Vascular Surgery, Interventional Radiology and Diagnostic Radiology				
<b>CPT Code:</b>	37243				
<b>Sample Size:</b>	3265	<b>Resp N:</b>	62	<b>Response:</b> 1.8 %	
<b>Description of Sample:</b>	SVS Random Sample, 1240 SIR Random Sample, 1075 ACR Random Sample, 950				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	4.00	<b>20.00</b>	50.00	700.00
<b>Survey RVW:</b>	8.00	11.99	<b>17.00</b>	20.00	35.00
<b>Pre-Service Evaluation Time:</b>			<b>75.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>15.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>15.00</b>		
<b>Intra-Service Time:</b>	40.00	76.25	<b>120.00</b>	120.00	300.00
<b>Immediate Post Service-Time:</b>	<b>30.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

**Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:**  
2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	37243	<b>Recommended Physician Work RVU: 14.00</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>33.00</b>	<b>33.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>3.00</b>	<b>1.00</b>	<b>2.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>5.00</b>	<b>5.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>120.00</b>		
<b>Immediate Post Service-Time:</b>	<b>45.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		

<b>Prolonged Services:</b>	<u><b>0.00</b></u>	99354x <b>0.00</b>	55x <b>0.00</b>	56x <b>0.00</b>	57x <b>0.00</b>
<b>Sub Obs Care:</b>	<u><b>0.00</b></u>	99224x <b>0.00</b>	99225x <b>0.00</b>	99226x <b>0.00</b>	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
37182	000	16.97	RUC Time

CPT Descriptor Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation/dilation, stent placement and all associated imaging guidance and documentation.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 9      % of respondents: 14.5 %**

**TIME ESTIMATES (Median)**

	<b>CPT Code: 37243</b>	<b>Key Reference CPT Code: 37182</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	41.00	30.00	
Median Intra-Service Time	120.00	150.00	
Median Immediate Post-service Time	45.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	



Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>206.00</b>	<b>210.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.44	4.00
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.75	4.33
--	------	------

Urgency of medical decision making	4.00	4.63
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.88	4.67
--------------------------	------	------

Physical effort required	4.22	4.63
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.38	4.33
---	------	------

Outcome depends on the skill and judgment of physician	4.67	4.50
--	------	------

Estimated risk of malpractice suit with poor outcome	3.63	3.33
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.22	4.00
----------------------------------	------	------

Intra-Service intensity/complexity	4.63	4.44
------------------------------------	------	------

Post-Service intensity/complexity	4.22	4.13
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Why are we here?**

Embolization therapy, CPT codes 37204 and 75894 *Transcatheter therapy, embolization, any method, radiological supervision and interpretation*, were identified as reported together greater than 75% of the time and, as a result, were sent to CPT. A code change proposal was created after extensive multi-disciplinary discussion. Among the options considered were complete procedures where work of embolization and all catheterization were included and partially bundled codes.

Major concerns that ultimately led to a less comprehensive bundling of only the embolization surgical and S&I codes included:

1. Embolization therapy is performed for tumors, bleeding, arterial, venous, lymphatic malformations and aneurysms.
2. There is no standard patient. The procedural approach, complexity, and intensity are disparate.
3. Embolization therapy is performed in the viscera, solid organs, and vasculature both above and below the diaphragm.
4. There was concern that the number of vascular beds, varied catheterization combinations, and variants of anatomy would result in a prohibitively large number of codes.

These issues were vetted and the CPT panel approved four new bundled embolization therapy codes (37237241-4). Additionally, in conjunction with the new family of four codes, CPT code 37210 (Uterine fibroid embolization) was deleted as part of the multi-specialty Code Change Proposal presented at the CPT Panel. The procedure described by 37210 falls within the clinical parameters of the new 37243 code, and the specialties maintained that having an “outlier” embolization code separate from the new family would not only create coding confusion, but also represented a detraction from the logical integrity of the new family.

A multi-disciplinary workgroup including ACR, SIR, and SVS was convened. A survey was distributed randomly to the members of the workgroup and a robust number of completed surveys were received. The surveys were reviewed by the multi-specialty group and determined to be valid and reflective of the work and intensity involved. Appropriate rank order appears to be reflected between the four codes. The survey results and recommendations are as follows

**Pre-Service Time**

For all four codes, the group is recommending pre service package 2B with 2 additional minutes of positioning time to account for positioning patient on the angiographic table, as well as optimizing EKG and monitoring lead placement to avoid obscuring imaging during embolization.

This additional positioning time is consistent with multiple recently valued procedures brought before the RUC in the last several cycles including thrombolysis (37211), foreign body retrieval (37197), selective catheterization (36245, 36246, 36200), and IVC filters (37191-3).

**Post-Service Time**

Survey respondents recommended a median post service time of 30 minutes for 37241, and 37242 which the expert panel felt appropriate given these patients are complex, but typically do not have significant post-embolization syndrome (pain, pyrexia, anorexia, nausea, vomiting). For 37243, respondents felt that 45 minutes of post-service time was required for management of patients after tumor embolization given the potential for post-embolization syndrome (PES), and tumor lysis syndrome. Survey respondents recommended 45 minutes for 37244 given severity of patients injuries and the need to follow-up frequently during the course of the day to assess, and reassess for signs of ongoing bleeding, ischemia, and the typical arterial sheaths left in place.

**Work Recommendations**

It is the multi-disciplinary panel’s expert opinion that in the family of recently valued endovascular procedures, embolization therapy ranks at the top for intensity, risk, and difficulty.

These procedures are more difficult and risky than thrombolysis catheter placement, foreign body retrieval, and the less complex recently valued lower extremity (LE) revascularization codes e.g iliac angioplasty, stent placement 37221-2. Embolizations are similar in difficulty and intensity to carotid stent placement (37215), TIPS placement (37182), and the more complex LE revascularizations e.g. tibial interventions (37226-8).

**How Does This Compare?**

<b>CPT Code</b>	<b>Descriptor</b>	<b>RVU</b>	<b>Pre</b>	<b>Intra</b>	<b>Post</b>	<b>90</b>	<b>Total</b>	<b>IWPUT</b>
37230	LE tibial	13.80	48	120	30		198	0.101
37227	LE fem pop	14.50	48	125	30		203	0.1026
37229	LE tibial	14.05	48	120	30		198	0.1031
37228	LE tibial	11.00	48	90	30		168	0.1036
37182	TIPS	16.97	30	150	30		210	0.1042
37211	Thrombolysis	8.00	48	60	30		138	0.1054
<b>37241</b>	<b>Embo venous</b>	<b>11.50</b>	<b>41</b>	<b>90</b>	<b>30</b>		<b>161</b>	<b>0.111</b>
37215	Carotid Stents	19.68	90	103	30	124	347	0.1223
<b>37243</b>	<b>Embo tumors</b>	<b>17.00</b>	<b>41</b>	<b>120</b>	<b>45</b>		206	<b>0.126</b>
<b>37242</b>	<b>Embo arterial</b>	<b>16.00</b>	<b>41</b>	<b>100</b>	<b>30</b>		171	<b>0.145</b>
<b>37244</b>	<b>Embo hemorrhage</b>	<b>17.00</b>	<b>41</b>	<b>90</b>	<b>45</b>		176	<b>0.168</b>

**37241**

CPT Code 37241 describes the permanent occlusion/embolization of a venous varicocity, venous aneurysm, venous malformation, or venous tributary. The vignette was considered typical by greater than 87% of respondents. Our key reference service code (KRS) was CPT code 37182 *insertion of TIPS*.

The median intra service time of **90 minutes** was felt to be accurate by the expert panel and we are recommending the median **RVW of 11.50** yielding an IWPUT of 0.111, which is consistent with other highly intense endovascular procedures (see table). Of the four codes, 37237241 is the least intense in the family given it is performed in the venous circulation, however the risk of coil migration to the heart or pulmonary arterial circulation is real and explains the procedure's intensity.

**37242**

37237242 describes the permanent occlusion/embolization of an arterial aneurysm, malformation, or potential feeding artery in aneurysm therapy. Embolization therapy in the arterial circulation is inherently more risky than in the venous system. Arterial rupture, unintended ischemia, or non-target embolization are risks the operator must avoid. The vignette was considered typical by greater than 98% of respondents. Our KRS was CPT code 37184 *mechanical thrombectomy*.

The median intra service time was **100 minutes** which was felt to be accurate, and in rank order compared to 37241 and 37243. The expert panel is recommending the median RVW of 16.00 yielding an IWPUT of 0.145 which is higher than most endovascular procedures, but supported by the intensity, risk, and difficulty of the therapy.

**37243**

37237243 describes the pre-operative or definitive embolization therapy for benign and malignant tumors. The vignette describes treatment of a patient with carcinoid mets to the liver and 92% of survey respondents considered this typical. The KRS was CPT Code 37182.

The median intra service time was **120 minutes**, which was felt to be accurate. The expert panel is recommending the median RVW of 17.00 in line with other highly intense endovascular procedures like carotid stent (37215) and TIPS creation (37182). The IWPUT of 0.126 is lower reflecting a longer, more detailed, slightly less intense procedure when compared to 37242 and 37244. Tumor embolization requires precise catheter location beyond that required for diagnostic angiography. Catheter position must be chosen to avoid vasospasm and ensure precise tumor treatment while limiting non-target normal organ damage. Embolic solution must be of correct density and specific gravity to support suspension of beads/particles for uniform delivery to the tumor bed. Cautious intermittent delivery of small aliquots of embolic material is required to achieve effective tumor infarction. The process is slow and deliberate in the setting of tumor therapy.

**37244**

37237244 describes a nearly opposite embolization scenario. This vignette describes the hemorrhaging patient after extensive pelvic trauma which 98 % respondents considered typical. This patient must be treated as expeditiously as possible to prevent exsanguination. The operator is working as quickly as humanly possible under extreme conditions and intensity. This explains the decrease in intra service time to **90 minutes**. The KRS 37182 was again chosen.

The expert panel recommends the median **RVW of 17.00** despite the lower intra service time. It is the expert panel's assertion that 37237244 likely represents one of the most challenging, stressful therapies in the endovascular family warranting a high RVW and IWPUT (0.168).

**Reference Service Codes**

Further, the most common and key reference service chosen for all four codes was CPT Code 61624 *transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, any method; central nervous system (intracranial, spinal cord)*. We included this code on our RSL. The RUC database has the source as "RUC", there are updated times and RUC meeting dates. However, there is a note that says "Do Not Use to Validate for Physician Work". As such, we included the 2<sup>nd</sup> most selected reference code as our key reference code.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. These four new CPT codes bundle 37204/37210 and the corresponding radiological supervision and interpretation codes into new bundled procedures. Access will be gained by using one of the existing catheterization codes, which are separately reportable.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) CPT codes 37204, 75894 and 75898 OR CPT codes 37210

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Interventional Radiology

How often? Commonly

Specialty Diagnostic Radiology

How often? Commonly

Specialty Vascular Surgery

How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National Frequency Data is Not Available

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

14,523 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The new codes will represent 100% of the instances where 37204 is now used (30,764) and 100% of the instances where 37210 is now used (357). We estimate that uses of 75894 (36,341) will decline sharply, but that code will still be used with CPT codes 61624 & 61626.

Specialty Vascular Surgery	Frequency 2179	Percentage 15.00 %
----------------------------	----------------	--------------------

Specialty Radiology	Frequency 12345	Percentage 85.00 %
---------------------	-----------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 37204

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 37244	Tracking Number W4	Original Specialty Recommended RVU: <b>17.00</b>
		Presented Recommended RVU: <b>14.00</b>
Global Period: 000		RUC Recommended RVU: <b>14.00</b>

CPT Descriptor: Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 40-year-old male presents to the emergency room in shock following a motorcycle accident. CT exam shows a complex left pelvic fracture and large left pelvic hematoma with active extravasation of contrast material. The patient is referred for emergency embolization.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 89%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 71%

**Description of Pre-Service Work:**

**DESCRIPTION OF WORK – Separately Reportable**

Catheterization of the right common femoral artery is performed and a pigtail catheter is advanced to the aortic bifurcation.

A Selective catheter is subsequently advanced into the iliac arterial system (Separately coded)

Diagnostic arteriography of the pelvis is performed to identify, characterize and target sites of active hemorrhage. (Separately coded)

**Description of Pre-service work**

- A targeted H&P is performed obtaining relevant clinical information including indications, physical exam findings, and important laboratory findings. Careful review of previously acquired imaging studies including multiplanar reformatted images is performed to assess access vessel, variants of anatomy, post-surgical changes, vessel diameter, and target vessel to be embolized.

- The proposed procedure is discussed with the patient and/or family. Consent is obtained.

- The exam, procedural plans and consent are documented in the medical record.

Diagnostic images are reviewed to determine appropriate catheter selection, placement, and embolization.

**Description of Intra-Service Work:**

- Supporting base catheter, embolization catheter, and wire combinations are selected and assembled on the sterile table. In comparison to and in addition to diagnostic arteriography Tri-axial systems are typically required to support embolization in the target vessel. Appropriate sized coils are selected.
- A microcatheter and microwire is advanced into the bleeding vessel(s) under roadmapping and fluoroscopic control.
- Embolization is performed using a combination of Gelfoam and coils.
- The embolic agents are slowly delivered to the target tumor tissue under fluoroscopic guidance until adequate flow arrest in the targeted vessel is achieved.
- Intermittent control angiograms are performed to assess progress in promoting arterial occlusion and to judge whether there is ongoing hemorrhage and collateral supply.
- Additional bleeding branches are targeted and embolized using Gelfoam and coils with intermittent control arteriography to assess progress.
- Completion angiography is performed demonstrating cessation of extravasation from the left pelvis and absence of iatrogenic vessel injury or non-target embolization.
- When embolization is complete, the catheter system is removed.

#### Description of Post-Service Work:

- Appropriate care orders for post-embolization syndrome (pain, pyrexia, nausea, inflammatory response) specific to embolization are entered in the electronic medical record. Signs of non-target embolization are evaluated.
- The procedure is documented in the chart using a short post procedure note.
- The patient is transferred from the procedure table to the recovery area and monitored for 4 hours.
- The procedure outcome is discussed with the patient and family. Post procedure care instructions and plans for follow-up are also discussed.
- Recovery care and targeted exam findings are documented in a progress/discharge note. Admission orders are written.
- The procedure is formally documented in the medical record by dictating an operative report. The report is subsequently reviewed and authenticated after transcription is completed.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Sean Tutton, MD, Robert Vogelzang, MD, Jerry Niedzwiecki, MD, Michael Hall, Gary Seabrook, MD, Robert Zwolak, MD, Matthew Sideman, MD, Michael Sutherland, MD, Zeke Silva, MD and Kurt Schoppe, MD				
<b>Specialty(s):</b>	Vascular Surgery, Interventional Radiology and Diagnostic Radiology				
<b>CPT Code:</b>	37244				
<b>Sample Size:</b>	3265	<b>Resp N:</b>	59	<b>Response:</b> 1.8 %	
<b>Description of Sample:</b>	SVS Random Sample, 1240 SIR Random Sample, 1075 ACR Random Sample, 950				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	5.00	10.00	20.00	75.00
<b>Survey RVW:</b>	8.75	14.00	17.00	20.00	27.00
<b>Pre-Service Evaluation Time:</b>			50.00		
<b>Pre-Service Positioning Time:</b>			15.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10.00		
<b>Intra-Service Time:</b>	45.00	75.00	90.00	120.00	360.00
<b>Immediate Post Service-Time:</b>	<u>45.00</u>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	37244	<b>Recommended Physician Work RVU: 14.00</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		33.00	33.00	0.00
<b>Pre-Service Positioning Time:</b>		3.00	1.00	2.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00
<b>Intra-Service Time:</b>		90.00		
<b>Immediate Post Service-Time:</b>	<u>45.00</u>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		



<b>Prolonged Services:</b>	<u>0.00</u>	99354x <b>0.00</b>	55x <b>0.00</b>	56x <b>0.00</b>	57x <b>0.00</b>
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x <b>0.00</b>	99225x <b>0.00</b>	99226x <b>0.00</b>	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
37182	000	16.97	RUC Time

CPT Descriptor Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation/dilation, stent placement and all associated imaging guidance and documentation

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	Most Recent <u>Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	Most Recent <u>Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 16      % of respondents: 27.1 %

**TIME ESTIMATES (Median)**

	CPT Code: 37244	Key Reference CPT Code: 37182	Source of Time RUC Time
Median Pre-Service Time	41.00	30.00	
Median Intra-Service Time	90.00	150.00	
Median Immediate Post-service Time	45.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>176.00</b>	<b>210.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.06	4.20
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.07	4.44
--	------	------

Urgency of medical decision making	4.81	4.40
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.60	4.75
--------------------------	------	------

Physical effort required	4.69	4.73
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.47	4.25
---	------	------

Outcome depends on the skill and judgment of physician	4.63	4.60
--	------	------

Estimated risk of malpractice suit with poor outcome	4.00	3.69
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.69	4.20
----------------------------------	------	------

Intra-Service intensity/complexity	4.73	4.56
------------------------------------	------	------

Post-Service intensity/complexity	3.50	4.00
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Why are we here?**

Embolization therapy, CPT codes 37204 and 75894 *Transcatheter therapy, embolization, any method, radiological supervision and interpretation*, were identified as reported together greater than 75% of the time and, as a result, were sent to CPT. A code change proposal was created after extensive multi-disciplinary discussion. Among the options considered were complete procedures where work of embolization and all catheterization were included and partially bundled codes.

Major concerns that ultimately led to a less comprehensive bundling of only the embolization surgical and S&I codes included:

1. Embolization therapy is performed for tumors, bleeding, arterial, venous, lymphatic malformations and aneurysms.
2. There is no standard patient. The procedural approach, complexity, and intensity are disparate.
3. Embolization therapy is performed in the viscera, solid organs, and vasculature both above and below the diaphragm.
4. There was concern that the number of vascular beds, varied catheterization combinations, and variants of anatomy would result in a prohibitively large number of codes.

These issues were vetted and the CPT panel approved four new bundled embolization therapy codes (37237241-4). Additionally, in conjunction with the new family of four codes, CPT code 37210 (Uterine fibroid embolization) was deleted as part of the multi-specialty Code Change Proposal presented at the CPT Panel. The procedure described by 37210 falls within the clinical parameters of the new 37243 code, and the specialties maintained that having an “outlier” embolization code separate from the new family would not only create coding confusion, but also represented a detraction from the logical integrity of the new family.

A multi-disciplinary workgroup including ACR, SIR, and SVS was convened. A survey was distributed randomly to the members of the workgroup and a robust number of completed surveys were received. The surveys were reviewed by the multi-specialty group and determined to be valid and reflective of the work and intensity involved. Appropriate rank order appears to be reflected between the four codes. The survey results and recommendations are as follows

**Pre-Service Time**

For all four codes, the group is recommending pre service package 2B with 2 additional minutes of positioning time to account for positioning patient on the angiographic table, as well as optimizing EKG and monitoring lead placement to avoid obscuring imaging during embolization.

This additional positioning time is consistent with multiple recently valued procedures brought before the RUC in the last several cycles including thrombolysis (37211), foreign body retrieval (37197), selective catheterization (36245, 36246, 36200), and IVC filters (37191-3).

**Post-Service Time**

Survey respondents recommended a median post service time of 30 minutes for 37241, and 37242 which the expert panel felt appropriate given these patients are complex, but typically do not have significant post-embolization syndrome (pain, pyrexia, anorexia, nausea, vomiting). For 37243, respondents felt that 45 minutes of post-service time was required for management of patients after tumor embolization given the potential for post-embolization syndrome (PES), and tumor lysis syndrome. Survey respondents recommended 45 minutes for 37244 given severity of patients injuries and the need to follow-up frequently during the course of the day to assess, and reassess for signs of ongoing bleeding, ischemia, and the typical arterial sheaths left in place.

**Work Recommendations**

It is the multi-disciplinary panel’s expert opinion that in the family of recently valued endovascular procedures, embolization therapy ranks at the top for intensity, risk, and difficulty.

These procedures are more difficult and risky than thrombolysis catheter placement, foreign body retrieval, and the less complex recently valued lower extremity (LE) revascularization codes e.g iliac angioplasty, stent placement 37221-2. Embolizations are similar in difficulty and intensity to carotid stent placement (37215), TIPS placement (37182), and the more complex LE revascularizations e.g. tibial interventions (37226-8).

**How Does This Compare?**

CPT Code	Descriptor	RVU	Pre	Intra	Post	90	Total	IWPUT
37230	LE tibial	13.80	48	120	30		198	0.101
37227	LE fem pop	14.50	48	125	30		203	0.1026
37229	LE tibial	14.05	48	120	30		198	0.1031
37228	LE tibial	11.00	48	90	30		168	0.1036
37182	TIPS	16.97	30	150	30		210	0.1042
37211	Thrombolysis	8.00	48	60	30		138	0.1054
<b>37241</b>	<b>Embo venous</b>	<b>11.50</b>	<b>41</b>	<b>90</b>	<b>30</b>		<b>161</b>	<b>0.111</b>
37215	Carotid Stents	19.68	90	103	30	124	347	0.1223
<b>37243</b>	<b>Embo tumors</b>	<b>17.00</b>	<b>41</b>	<b>120</b>	<b>45</b>		206	<b>0.126</b>
<b>37242</b>	<b>Embo arterial</b>	<b>16.00</b>	<b>41</b>	<b>100</b>	<b>30</b>		171	<b>0.145</b>
<b>37244</b>	<b>Embo hemorrhage</b>	<b>17.00</b>	<b>41</b>	<b>90</b>	<b>45</b>		176	<b>0.168</b>

**37241**

CPT Code 37241 describes the permanent occlusion/embolization of a venous varicocyt, venous aneurysm, venous malformation, or venous tributary. The vignette was considered typical by greater than 87% of respondents. Our key reference service code (KRS) was CPT code 37182 *insertion of TIPS*.

The median intra service time of **90 minutes** was felt to be accurate by the expert panel and we are recommending the median **RVW of 11.50** yielding an IWPUT of 0.111, which is consistent with other highly intense endovascular procedures (see table). Of the four codes, 37237241 is the least intense in the family given it is performed in the venous circulation, however the risk of coil migration to the heart or pulmonary arterial circulation is real and explains the procedure's intensity.

**37242**

37237242 describes the permanent occlusion/embolization of an arterial aneurysm, malformation, or potential feeding artery in aneurysm therapy. Embolization therapy in the arterial circulation is inherently more risky than in the venous system. Arterial rupture, unintended ischemia, or non-target embolization are risks the operator must avoid. The vignette was considered typical by greater than 98% of respondents. Our KRS was CPT code 37184 *mechanical thrombectomy*.

The median intra service time was **100 minutes** which was felt to be accurate, and in rank order compared to 37241 and 37243. The expert panel is recommending the median RVW of 16.00 yielding an IWPUT of 0.145 which is higher than most endovascular procedures, but supported by the intensity, risk, and difficulty of the therapy.

**37243**

37237243 describes the pre-operative or definitive embolization therapy for benign and malignant tumors. The vignette describes treatment of a patient with carcinoid mets to the liver and 92% of survey respondents considered this typical. The KRS was CPT Code 37182.

The median intra service time was **120 minutes**, which was felt to be accurate. The expert panel is recommending the median RVW of 17.00 in line with other highly intense endovascular procedures like carotid stent (37215) and TIPS creation (37182). The IWPUT of 0.126 is lower reflecting a longer, more detailed, slightly less intense procedure when compared to 37242 and 37244. Tumor embolization requires precise catheter location beyond that required for diagnostic angiography. Catheter position must be chosen to avoid vasospasm and ensure precise tumor treatment while limiting non-target normal organ damage. Embolic solution must be of correct density and specific gravity to support suspension of beads/particles for uniform delivery to the tumor bed. Cautious intermittent delivery of small aliquots of embolic material is required to achieve effective tumor infarction. The process is slow and deliberate in the setting of tumor therapy.

**37244**

37237244 describes a nearly opposite embolization scenario. This vignette describes the hemorrhaging patient after extensive pelvic trauma which 98 % respondents considered typical. This patient must be treated as expeditiously as possible to prevent exsanguination. The operator is working as quickly as humanly possible under extreme conditions and intensity. This explains the decrease in intra service time to **90 minutes**. The KRS 37182 was again chosen.

The expert panel recommends the median **RVW of 17.00** despite the lower intra service time. It is the expert panel's assertion that 37237244 likely represents one of the most challenging, stressful therapies in the endovascular family warranting a high RVW and IWPUT (0.168).

**Reference Service Codes**

Further, the most common and key reference service chosen for all four codes was CPT Code 61624 *transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, any method; central nervous system (intracranial, spinal cord)*. We included this code on our RSL. The RUC database has the source as "RUC", there are updated times and RUC meeting dates. However, there is a note that says "Do Not Use to Validate for Physician Work". As such, we included the 2<sup>nd</sup> most selected reference code as our key reference code.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. These four new CPT codes bundle 37204/37210 and the corresponding radiological supervision and interpretation codes into new bundled procedures. Access will be gained by using one of the existing catheterization codes, which are separately reportable.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) CPT codes 37204, 75894 and 75898

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Interventional Radiology	How often? Commonly
Specialty Diagnostic Radiology	How often? Commonly
Specialty Vascular Surgery	How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National Frequency Data is Not Available

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 6,296

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The new codes will represent 100% of the instances where 37204 is now used (30,764) and 100% of the instances where 37210 is now used (357). We estimate that uses of 75894 (36,341) will decline sharply, but that code will still be used with CPT codes 61624 & 61626.

Specialty Vascular Surgery	Frequency 945	Percentage 15.00 %
----------------------------	---------------	--------------------

Specialty Radiology	Frequency 5352	Percentage 85.00 %
---------------------	----------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 37204

## SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	Z	AA
12	ISSUE:	Embolization and Occlusion Procedures																				
13	TAB: 8																					
14						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	npt/sam	
15	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	38	39
16	REF	37182	Insertion of TI	7	0.104			16.97			210	30					150			30		
17	CURRENT	37204	Transcatheter occlus		0.065			18.11			370	60	15	20			240			35		
18	CURRENT	75894	Transcatheter therap		0.052			1.31			25						25					
19	CURRENT	75898	Angiography throug		0.053			1.65			31						31					
20	SVY	37241	Vascular embol	75	0.100	5.31	9.00	11.50	16.45	25.00	210	60	15	15	30	60	90	120	140	30		
21	REC				0.083	9.00					161	33	3	5			90			30		
22																						

AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs

**Global Period:** 000

**Meeting Date:** April 2013

**CPT Long Descriptor:**

Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention;

**37241** *venous, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles)*

**37242** *arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)*

**37243** *for tumors, organ ischemia, or infarction*

**37244** *for arterial or venous hemorrhage or lymphatic extravasation*

(Do not report 372X1-372X4 in conjunction with 36468, 36470, 36471, 36475-36479, 75894, 75898)

**1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:**

The multispecialty organizations (SIR, ACR and SVS) convened a panel that included a number of experts familiar with these services to evaluate the direct practice expense inputs for this procedure. The panel made recommendations based on existing inputs and the new coding conventions

**2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison. You must provide an explanation for the selection of reference codes. Reference Code Rationale:**

The new surveyed codes are the result of a “reported together” screen. As such, we have included columns with the existing code’s inputs for reference. In addition to including the exiting inputs for 37210 *uterine fibroid embolization*, we included the inputs for CPT code 37224 *revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty*. CPT code 37224 has a similar process of care and was recently reviewed by the PE Subcommittee. It is typical that a selective catheter placement code would be performed along with these new embolization codes. There is no particular catheter placement code that appears in the billed together data as ‘typical’. Therefore, we have included the direct practice expense inputs for CPT Code 36247 *selective catheter placement, arterial system; initial*



*third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family, which has the highest billed together frequency with the embolization codes.*

**3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:**

Pre Service Period

We are requesting to maintain our pre service clinical time for these 000 services. The physician typically uses his/her own clinical staff to complete pre-service diagnostic/referral forms and to work with the insurance companies/radiation oncology benefits manager. They ensure all pre authorization forms are completed and forward approved forms to the appropriate personnel. Their clinical staff works with the facility to ensure that the facility is available as well as all the necessary supplies.

**4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:**

We are not requesting an increase over the current inputs.

**5. Please describe in detail the clinical activities of your staff:**

Pre-Service Clinical Labor Activities:

A clinically trained individual (RN,/LPN/MA) will review and complete all referral forms for the various insurance entities and ensure that the indication has met medical necessity for the planned procedure and forward the approved forms to the appropriate personnel including by fax if necessary. The clinical staff contacts the facility to make sure appropriate time for the room is available as well as all the supplies, which will be required for the scheduled procedure.

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

N/A

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

**Global Period:** 000

**Meeting Date:** April 2013

**CPT Long Descriptor:**

Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention;

**37241** *venous, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles)*

**37242** *arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)*

**37243** *for tumors, organ ischemia, or infarction*

**37244** *for arterial or venous hemorrhage or lymphatic extravasation*

(Do not report 37241-37244 in conjunction with 36468, 36470, 36471, 36475-36479, 75894, 75898)

**1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:**

The multispecialty organizations (SIR, ACR and SVS) convened a panel that included a number of experts familiar with these services to evaluate the direct practice expense inputs for this procedure. The panel made recommendations based on existing inputs and the new coding conventions

**2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison. You must provide an explanation for the selection of reference codes. Reference Code Rationale:**

The new surveyed codes are the result of a “reported together” screen. As such, we have included columns with the existing code’s inputs for reference. In addition to including the exiting inputs for 37210 *uterine fibroid embolization*, we included the inputs for CPT code 37224 *revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty*. CPT code 37224 has a similar process of care and was recently reviewed by the PE Subcommittee. It is typical that a selective catheter placement code would be performed along with these new embolization codes. There is no particular catheter placement code that appears in the billed together data as ‘typical’. Therefore, we have included the direct practice expense inputs for CPT Code 36247 *selective catheter placement, arterial system; initial*

*third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family, which has the highest billed together frequency with the embolization codes.*

**3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:**

Pre Service Period

*Complete pre-service diagnostic and referral forms:*

A clinically trained individual (RN,/LPN/MA) will review and complete all referral forms for the various insurance entities and ensure that the indication has met medical necessity for the planned procedure.

*Coordinate pre-surgery services:*

Clinical staff member ensures that all appropriate labs (CBC, CHEM7, etc.) are drawn and results are acceptable.

*Follow-up phone calls and prescriptions:*

Clinical staff will contact the patient prior to the procedure to ensure that they will be NPO, answer any questions the patient may have regarding the scheduled procedure, confirm their arrival time, review allergies and call the pharmacy with any prescription if needed, such as medication for contrast allergy or poor renal function.

Service Period

*Prepare Room, Equipment, Supplies*

Interventional technologist checks imaging equipment to make sure that it is turned on, warmed up, functioning properly, enters the patient demographics, opens the sterile tray and sets it up, goes to the storage room to pull all the supplies that will be used for the procedure, and brings them to the procedure room. The standard for prepare room is 2 minutes and the standard for prepare scope is 5 minutes. We are essentially accepting two standards on one line. We are 'preparing imaging equipment' as the second part of the prepare room, equipment and supplies line.

*Prepare and Position Patient*

Once the patient is brought into the procedure room, time is taken to ensure appropriate position of the patient on the procedure table. Care is taken to ensure the patient's comfort as they will be required to remain still for a long period of time. Time is taken to ensure an unobstructed the field of view over the targeted areas of interest; this involves making sure that nursing monitoring and other equipment that could obstruct the images is clear. The area around the angiographic imaging equipment is cleared to allow for manipulation of the equipment throughout the procedure. These activities take more than the standard of 2 minutes.

**4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:**

The procedures described by the new embolization codes were previously reported with base surgical codes 37204 or 37210. CPT code 37204 is currently not priced in the office (NF) setting. CPT code 37210 does currently have direct practice expense inputs. We are requesting that all four of these new embolization codes be priced in the office, though we acknowledge that 44 usage

will be extremely rare in a Non facility setting. Nonetheless, 44 patient care scenarios in the office are conceivable and our belief is that it is appropriate to establish non-facility inputs for 44 at this time.

### Compelling Evidence

#### *Changes in site-of-service*

When the embolization codes were created, they were not performed in the office. The 2011 Medicare data, however, now indicates that 13% of the procedures are preformed in the office setting. These procedures in general are safely done on an outpatient basis currently and are expected to have a transition into the office setting for appropriate patients.

### Increase In Current Clinical Staff Time

#### *Pre service Education*

The clinical staff educates the patient regarding the procedure, what to expect in the procedure room, reviews the risk of contrast and radiation, and obtains consent for the above.

#### *Addition of Clinical Staff*

The existing inputs currently have a nurse for sedation and scrubbed in angio tech (100%). We are requesting an additional individual who is not scrubbed who will assist with the imaging equipment and with opening supplies. This is the current standard for endovascular procedures performed in an angio suite. This is the blended staff type, which per prior discussions has been a blend of 75% angio tech, 25% of RN/ LVN / MTA (L037D) (therefore there are 3 FTEs present during the entire procedure.).

### Increase In Current Supplies

We are making recommendations to modify the clinical supplies for these new codes. Many of the supplies included in the existing inputs remain unchanged (Lines 89-119). We have deleted some of the existing inputs (Lines 127 -130). We are also recommending increases in quantity for the following items (Lines 82-86):

- **Surgical Masks, Caps and Shoe Covers**  
Four surgical masks with face shields, four caps and four sets of shoe covers are required for the physician, the scrubbed in angiography technologist, the RN who is providing IV sedation and monitoring to the patient, and the radiology technologist who is assisting with the imaging. Every person in the angio suite is required to don this attire as it is a sterile setting.
- **X-ray developer solution and x-ray fixer solution**  
While it is known that the film to digital workgroup will soon be making the appropriate conversions for radiology codes, the changes to these inputs are to reflect what has been the standard inputs in recently angiography vetted codes. (e.g. 37197, 37191-37193, 36251-36254).  
*(The new Embolization codes will bundle the S&I codes. So, we have included the film inputs from the existing S&I codes.)*  
*(As digital imaging inputs become available these inputs will be replaced.)*

We are recommending **adding** the following items (Lines 70-79):

➤ Detachable coils (***Invoice Attached***)

Detachable coils will be used for 41, 42 and 44

- *37241: Used to precisely deposit and reposition a coil in the superior aspect of the gonadal vein. This allows for a large coil to be placed that will prevent any of the pelvic coils from embolizing into the lungs and will allow repositioning if the coil protrudes into the renal vein.*
- *37242: Used to deposit and reposition the coils in the splenic artery distal to the aneurysm, in the aneurysm itself, and proximal to the aneurysm to ensure occlusion of the aneurysm.*
- *37244: Precisely deposit and reposition into multiple branches of pelvic arteries to control bleeding.*

➤ Non-Detachable coils (***Invoice Attached***)

NonDetachable coil will be used for 41

Non-detachable embolization coils are deposited in multiple pelvic branches of the gonadal vein and in entire length of the main gonadal vein. An additional detachable coil is used at the superior aspect of the gonadal vein just before it enters the renal vein, in order to position and reposition the coil such that it does not extends into renal vein and to ensure that it is large enough to prevent any of the coils lower in the pelvis from embolizing in the pulmonary circulation.

➤ LC Beads (***Invoice Attached***)

LC Beads will be used for 43

LC Beads are the standard embolic agent used for treatment of hypervascular tumors.

➤ Syringes

- *5cc syringes*  
*Three, smaller, 5cc syringes are needed for use with the microcatheter for injections of saline and, contrast. .*
- *10cc standard syringes*  
*Four 10cc standard syringes are used for injection of contrast by hand during the procedures as well as any intra-arterial medication required.*
- *20cc syringes*  
*Four 20cc standard syringes are used for saline flushes of the sheath and catheters during the procedure*
- *Presssure*  
*A specifically shaped and sized disposable syringe is used, in combination with high pressure tubing, to perform large volume contrast injections via a power injectorto obtain DSA (digital subtraction angiography) images with adequate filling of the vascular structures.*

➤ Hemostatic Patch

To obtain hemostasis of the venous puncture site a topical hemostatic patch is used.

- Closure Device  
To obtain hemostasis of the arterial puncture site a suture based closure device is typically used.
- High Pressure Tubing  
Used in combination with the pressure syringe, as mentioned above.
- Sterile Radio-opaque ruler  
A sterile ruler is required to accurately determine size of the target vessel so that correct size stents, PTA balloons, (or embolic) are chosen.

#### Increase In Equipment

We are including time for patient recovery on a stretcher. We recognize that a 'stretcher' is not an approved conscious sedation standard. However, the patient needs a stretcher/table in the recovery period. We are looking for feedback from the PE subcommittee and/or CMS regarding patient recovery stretchers/tables.

### **5. Please describe in detail the clinical activities of your staff:**

#### Pre-Service Clinical Labor Activities:

Complete pre-service diagnostic and referral forms: a clinically trained individual (RN, LPN/MA) will review and complete all referral forms for the various insurance entities and ensure that the indication has met medical necessity for the planned procedure and forward the approved forms to the appropriate personnel including by fax if necessary. Coordinate pre-surgery services: Clinical staff member ensures that all appropriate labs (CBC, CHEM7, etc.) are drawn and results are acceptable. Follow-up phone calls and prescriptions: Clinical staff will contact the patient prior to the procedure to ensure that they will be NPO, answer any questions the patient may have regarding the scheduled procedure, confirm their arrival time, review allergies and call the pharmacy with any prescription if needed, such as medication for contrast allergy or poor renal function. Other clinical activities: The angiography technologist prior to the patient's arrival will retrieve any prior imaging exams, hang or display these exams for the physician to review, verify orders, review the chart to incorporate any relative clinical information and confirm contrast protocol.

#### Intra-Service Clinical Labor Activities:

Greet patient, provide gowning, and ensure appropriate medical records are available: Patient is greeted by the clinical staff, escorted to the intake area, provided with gowning and given assistance with changing into the gown if needed. Obtain vital signs: blood pressure, heart rate, respiratory rate, temperature, rhythm strip and pulse oximetry, are all obtained. Provide pre-service education/obtain consent: the clinical staff educates the patient regarding the procedure, what to expect in the procedure room, reviews the risk of contrast and radiation, and obtains consent for the above. Prepare room, equipment, supplies: Interventional technologist checks imaging equipment to make sure that it is turned on, warmed up, functioning properly, enters the patient demographics, and sets baseline imaging protocols. The technologist also opens the sterile tray and sets it up, goes to the storage room to pull all the supplies that will be used for the

procedure, and brings them to the procedure room. Prepare and position patient/Monitor patient/Setup IV. Intra-service Time of varying clinical personnel: there is an RN that is present with the patient the entire time for monitoring for sedation, an angio tech is scrubbed next to the physician the entire case, an additional 3<sup>rd</sup> individual who is not scrubbed will assist with the imaging equipment and opening supplies. Monitor patient following service/Check tubes, monitors, drains. The standard recommendation of CMS is that patients are recovered at a ratio of 1 nurse for 4 patients. Check dressings and wound/home care instructions/coordinated office visits/prescriptions. In addition to checking the dressings and reviewing at home instructions the clinical staff will also discuss pain prescriptions for the patients and review the medications with them. Other clinical activities: The angiography tech post procedure annotates the images, processes them, and then either hangs the films for interpretation or sends digital images to PACS and ensures they are received.

Post-Service Clinical Labor Activities:

Conducts phone calls/call in prescription: the clinical staff calls the patient the day after the procedure to make sure that there are no complications, answers any questions, ensures that pain control is adequate, and calls in additional prescriptions if needed.

	A	B	C	D	E	L	M	N	O
1	Meeting Date: April 2013								
2	Tab: 8			37210		37241		37242	
3	Specialty: Interventional Radiology, Diagnostic Radiology and Vascular Surgery			Uterine fibroid embolization (UFE, embolization of the uterine arteries to treat uterine fibroids, leiomyomata), percutaneous approach inclusive of vascular access, vessel selection, embolization, and all		vascular embolization or occlusion, inclusive of intraprocedural roadmapping, and imaging guidance			
4	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.	CMS Code	Staff Type			venous, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles)		arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms,	
5	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6	GLOBAL PERIOD			000		000		000	
7	TOTAL CLINICAL LABOR TIME			287	20	373	6	419	6
8	TOTAL PRE-SERV CLINICAL LABOR TIME			12	10	15	6	15	6
9		L037D	RN/LPN/MTA	6	10	9	6	9	6
10		L041A	Angio Tech	6		6		6	
11	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			272	0	355	0	401	0
12		L037D	RN/LPN/MTA	11		38		41	
13		L041A	Angio Tech	104		178		195	
14			RadTech						
15		L051A	RN	157		140		165	
16	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	3	0	3	0	3	0
17	PRE-SERVICE								
18	Start: Following visit when decision for surgery or procedure made								
19	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	3	5	3	3	3	3
20	Coordinate pre-surgery services					3		3	
21	Schedule space and equipment in facility	L037D	RN/LPN/MTA	3	5		3		3
22	Provide pre-service education/obtain consent								
23	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA			3		3	
24	*Other Clinical Activity - specify: pull prior studies, hang,	L041A	Angio Tech	6		6		6	
25	End: When patient enters office/facility for surgery/procedure								
26	SERVICE PERIOD								
27	Start: When patient enters office/facility for surgery/procedure:								
28	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	3		3		3	
29	Obtain vital signs	L037D	RN/LPN/MTA	5		5		5	
30	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA			5		5	
31	Prepare room, equipment, supplies	L041A	RadTech	2		7		7	
32	Setup scope (non facility setting only)								
33	Prepare and position patient/ monitor patient/ set up IV	L041A	RadTech	2		5		5	
34	Sedate/apply anesthesia	L051A	RN	2		2		2	
35	*Other Clinical Activity - specify:								
36	Intra-service								
37	Assist physician in performing procedure	L041A	Angio Tech	90		90		100	
38	Assist physician in performing procedure	L051A	RN	90		90		100	
39	Assisting with flouroscopy/image acquisition (75%)	L041A	RadTech			68		75	
40	Circulating throughout procedure (25%)	L037D	RN/LPN/MTA			22		25	
41	Post-Service								
42	Monitor pt. following service/check tubes, monitors, drains	L051A	RN	60		45		60	
43	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	3		3		3	
44	Clean Scope								
45	Clean Surgical Instrument Package								
46	Complete diagnostic forms, lab & X-ray requisitions								
47	Review/read X-ray, lab, and pathology reports	L041A	RadTech	5		3		3	
48	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	3		3		3	
49	*Other Clinical Activity - specify: post procedure image processing	L041A	Rad Tech	7		5		5	
53	End: Patient leaves office								
54	POST-SERVICE Period								
55	Start: Patient leaves office/facility								
56	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	3		3		3	
64	*Other Clinical Activity - specify:								
65	End: with last office visit before end of global period								



	A	B	C	D	E	L	M	N	O
1	Meeting Date: April 2013								
2	Tab: 8			37210		37241		37242	
3	Specialty: Interventional Radiology, Diagnostic Radiology and Vascular Surgery			Uterine fibroid embolization (UFE, embolization of the uterine arteries to treat uterine fibroids, leiomyomata), percutaneous approach inclusive of vascular access, vessel selection, embolization, and all		vascular embolization or occlusion, inclusive of intraprocedural roadmapping, and imaging guidance			
4	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.	CMS Code	Staff Type			venous, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles)		arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms,	
5	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6	GLOBAL PERIOD			000		000		000	
66	MEDICAL SUPPLIES**	CODE	UNIT						
67	pack, minimum multi-specialty visit	SA048	pack	1		1		1	
68	pack, conscious sedation	SA044	pack	1		1		1	
69	ADDED ITEMS								
70	Detachable Coils	NEW	each			1		5	
71	Embolic Bead	NEW	vial						
72	NonDetachable Coil	NEW	each			7			
73	suture device for vessel closure (Perclose A-T)*	SD207	item					1	
74	Hemostatic patch	SG095	item			1			
75	Sterile Radio-opaque ruler	SD249	item						
76	syringe 5-6ml	SC057	item			3		3	
77	syringe 10-12ml	SC051	item			4		4	
78	syringe 20ml	SC053	item			4		4	
79	syringe, pressure (radiology)	SC060	item			1		1	
80	tubing, pressure injection line (angiography)	SD211	item			1		1	
81									
82	EXISTING ITEMS - INCREASED AMOUNTS								
83	cap, surgical	SB001	item	2		4		4	
84	mask, surgical, with face shield	SB034	item	2		4		4	
85	shoe covers, surgical	SB039	pair	2		4		4	
86	x-ray developer solution	SK089	oz	3		6		6	
87	x-ray fixer solution	SK092	oz	3		6		6	
88									
89	EXISTING ITEMS - NO CHANGE								
90	catheter microcatheter selective*	SD154	item	1		1		1	
91	guidewire (Transcend)*	SD175	item	1		1		1	
92	applicator, sponge-tipped	SG009	item	4		4		4	
93	Betadine	SJ041	ml	60		60		60	
94	blade, surgical (Bard-Parker)	SF007	item	1		1		1	
95	catheter (Glide)	SD147	item	1		1		1	
96	catheter (SIM2F1)	SD148	item	1		1		1	
97	catheter, angiographic, pig-tail	SC008	item	1		1		1	
98	closed flush system, angiography	SC010	item	1		1		1	
99	computer media, dvd	SK013	item	1		1		1	
100	drape-towel, sterile 18inx26in	SB019	item	4		4		4	
101	drape, sterile, femoral	SB009	item	1		1		1	
102	dressings 3 X 4 wound care telfa	SG035	item	2		2		2	
103	gauze, sterile 4in x 4in	SG055	item	2		2		2	
104	gloves, sterile	GB024	pair	3		3		3	
105	gown, surgical, sterile	SB028	item	2		2		2	
106	guidewire, (Bentson)	SD172	item	1		1		1	
107	guidewire, hydrophilic (GlideWire)	SD089	item	1		1		1	
108	heparin 1,000 units-ml inj	SH039	ml	5		5		5	
109	kit, AccuStick II Introducer System with RO Marker	SA071	kit	1		1		1	
110	kit, IV starter	SA019	kit	1		1		1	
111	lidocaine 1%-2% inj (Xylocaine)	SH047	ml	10		10		10	
112	sodium chloride 0.9% flush syringe	SH065	item	2		2		2	
113	steri-strip (6 strip uou)	SG074	item	1		1		1	
114	syringe w-needle, OSHA compliant (SafetyGlide)	SC058	item	2		2		2	
115	tape, surgical paper 1in (Micropore)	SG079	item	6		6		6	
116	Tegaderm dressing	SG037	item	1		1		1	
117	tray, shave prep	SA067	tray	1		1		1	
118	underpad 2ftx3ft (Chux)	SB044	item	1		1		1	
119	vascular sheath	SD136	item	1		1		1	
120	x-ray envelope	SK091	item	1		1		1	
121									
122	EXISTING ITEMS - REDUCED QUANTITY								
123	disinfectant, surface (Envirocide, Sanizide)	SM013	oz	6		1		1	
124	film, x-ray 14inx17in	SK034	item	6		1		1	
125	sterile bowl	SD171	item	2		1		1	
126									
127	EXISTING ITEMS - DELETED								
128	Agent, embolic, 2ml uou*	SD219	vial	5					
129	kit, guidewire introducer (Micro-Stick)	SA016	item	1					
130	drape, sterile, c-arm, fluoro	SB008	item	1					
131	catheter, curved (Headhunter)	SD153	item	1					
132									
133	Selective Catheter Placement Item (Unique on this list)								
134	brush, protected airway specimen	SD141	item						
135									
136	FemPop LE Items (not on surveyed codes)								
137	catheter, balloon, low profile PTA	SD151	item						
138	Quick Cross Catheter	SC096	item						
139	nitroglycerin injection USP 5 mg/ml	SH096							
140	protamine sulfate 10 mg/ml	SH095							
141	guidewire, Amplatz wire 260cm	SD252	item						
142	guidewire, STIFF	SD090	item						
143	introducer sheath, Ansel	SD250							
144	x-ray ID card	SK093	item						
145	EQUIPMENT	CODE							
146	Angiographic room minutes	E51082		95		107		117	
147	film alternator	ER029		7		5		5	
148	IV Infusion pump	EQ032		332		272		342	
149	ECG, 3-channel (with SpO2, NIBP)	EQ011		332		272		342	
150	Table, instrument, mobile	EF027		332		272		342	
151	film printer laser	ED032		7		5		5	
152	printer, dye sublimation	ED031							

AMA/Specialty Society RVS Update Committee Summary of Recommendations  
*MPC List Screen*

October 2012/January 2013/April 2013

**Esophagoscopy**

In September 2011, several esophagoscopy codes were identified through the CMS Multi-Specialty Points of Comparison (MPC) List screen as potentially misvalued. The specialties agreed to survey the entire family of codes (43200-43232). In developing vignettes, it was determined that the codes required revision at CPT to differentiate the approach (ie, rigid transoral, flexible transoral, flexible transnasal). In May 2012, the CPT Editorial Panel approved six new codes to report rigid transoral esophagoscopy (43191-6), two new codes to report flexible transnasal esophagoscopy (43197-8), revision to codes 43200-43232 to describe flexible transoral esophagoscopy and one new code for flexible transoral esophagoscopy (43206). In review of the family of esophagoscopy codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In October 2012, the CPT Editorial Panel approved further revised guidelines along with an additional five codes within the esophagoscopy family of services. These five codes were reviewed at the January 2013 RUC meeting. Finally, in January 2013, the RUC agreed with the specialty societies that the survey data for 43231 and 43232 were anomalous and should be resurveyed and presented at the April 2013 RUC meeting.

After survey of the procedures for April, the specialty societies noted that the esophagoscopy with EUS procedures (43231 and 43232) are not inherently performed with moderate sedation by the same physician. However, due to CMS' consistent position, at the April meeting and in multiple Medicare Physician Payment Rules, that the Agency is looking for larger bundling of services, not unbundling of services, the moderate sedation for these services will remain bundled. Therefore, these two services will remain on Appendix G in the CPT codebook.

**Rigid Esophagoscopy Services**

The Otolaryngologists presented compelling evidence for the six rigid transoral esophagoscopy codes. There were two compelling evidence arguments given: a change in physician work due to technique and incorrect assumptions made at the time of the previous review. First, since these new procedures now refer only to rigid esophagoscopy procedures, the typical patient and typical provider of these services have changed from the previous codes that were either rigid or flexible. A service using a rigid scope is only performed by a surgeon in the facility setting, under general anesthesia, since the typical patient is either a cancer patient or has a foreign body or other stricture that requires more intense work compared to a patient receiving a flexible esophagoscopy. Second, incorrect assumptions were made in the initial valuation of these services because Otolaryngologists were not surveyed. For three of the previously reported codes (43200, 43202 and 43215) only Harvard values exist, which excluded Otolaryngologists in the review process. For two of the previously reported codes (43220 and 43226) a RUC survey was completed, but the vignette only specified flexible esophagoscopy. For the final previously reported service (43201), a RUC survey was completed only by Gastroenterologists. Therefore, these new services as described, have never been properly valued to account for the typical provider and equipment. The RUC agreed with the compelling evidence that there is potential misvaluation for these services.

**43191 Esophagoscopy, rigid, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed**

The RUC reviewed the survey results from 59 Otolaryngologists and agreed with the specialty society that the survey respondents, at the median level, accurately accounted for the time it takes to perform this service. The RUC recommends pre-service time of 51 minutes, intra-service time of 20 minutes and immediate post-service time of 15 minutes. Package 4 Difficult patient/Difficult procedure was deemed appropriate for this code because the typical patient has cancer and is receiving this service under general anesthesia in the facility setting. Furthermore, 3 additional minutes for positioning is required to properly position the patient in the supine position, place a shoulder roll, ensure security and, working with the anesthetist, position the endotracheal tube.

The RUC reviewed the survey respondents' estimated work RVU and agreed with the specialty that the survey's 25<sup>th</sup> percentile, 2.78 work RVUs, is an accurate value for the physician work involved in this service. The RUC reviewed the key reference service CPT code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed* (work RVU= 2.78) and noted that while the reference code has 10 more minutes of intra-service time compared to 43191, the surveyed code has greater total time, 86 minutes compared to 65 minutes. Therefore, the RUC agreed that the recommended work RVU of 2.78 is appropriate for code 43191. To further justify this value, the RUC reviewed MPC code 51102 *Aspiration of bladder; with insertion of suprapubic catheter* (work RVU= 2.70) and noted that both the reference code and surveyed code have identical intra-service times and comparable physician work. Given these reference codes and compelling evidence that the previous work RVU for this service was misvalued, the RUC agreed that a work RVU of 2.78 accurately values 43191 relative to both the family of services and other similar services across the RBRVS. **The RUC recommends a work RVU of 2.78 for CPT code 43191.**

**43192 Esophagoscopy, rigid, transoral; with directed submucosal injection(s), any substance**

The RUC reviewed the survey results from 31 Otolaryngologists and agreed with the specialty society that the survey respondents, at the median level, accurately accounted for the time it takes to perform this service. The RUC recommends pre-service time of 56 minutes, intra-service time of 23 minutes and immediate post-service time of 20 minutes. Package 4 Difficult patient/Difficult procedure was deemed appropriate for this code because the typical patient has cancer and is receiving this service under general anesthesia in the facility setting. The RUC agreed that 3 additional minutes for positioning is required to properly position the patient in the supine position, place a shoulder roll, ensure security and, working with the anesthetist, position the endotracheal tube. The RUC agreed that 5 additional minutes of evaluation time to prepare the injection is required for CPT code 43192 compared to code 43191.

The RUC reviewed the survey respondents' estimated work RVU and agreed with the specialty that the survey's 25<sup>th</sup> percentile, 3.21 work RVUs, is an accurate value for the physician work involved in this service. The RUC reviewed the key reference service CPT code 31625 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites* (work RVU= 3.36) and noted that the reference code has 7 more minutes of intra-service time compared to 43192, and is slightly more intense, thus substantiating a slightly higher work value. To further justify a work RVU of 3.21, the RUC reviewed CPT code 32551 *Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open* (work RVU= 3.29) and noted that while the surveyed code has 3 additional minutes of intra-service time compared to the reference code, 32551 is a more intense procedure and should be valued slightly higher than 43192. Finally, the RUC compared 43192 to the diagnostic code 43191 and agreed that the increase of 3 minutes, 23 minutes compared to 20 minutes, in intra-service time for 43192 is accurate because of the additional time necessary to inject the wall of the esophagus. Furthermore, the addition of 5 minutes in the post-service period for 43192 is appropriate because these patients often have increased bleeding due to the injection

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

and require more post-operative management compared to the diagnostic procedure. Given these reference codes and time differences, the RUC concurred that a work RVU of 3.21 accurately values 43192 relative to both the family of services and other similar services across the RBRVS. **The RUC recommends a work RVU of 3.21 for CPT code 43192.**

**43193 Esophagoscopy, rigid, transoral; with biopsy, single or multiple**

The RUC reviewed the survey results from 35 Otolaryngologists and agreed with the specialty society that the survey respondents, at the median level, accurately accounted for the time it takes to perform this service. The RUC recommends pre-service time of 56 minutes, intra-service time of 30 minutes and immediate post-service time of 20 minutes. Package 4 Difficult patient/Difficult procedure was deemed appropriate for this code because the typical patient has cancer and is receiving this service under general anesthesia in the facility setting. The RUC agreed that 3 additional minutes for positioning is required to properly position the patient in the supine position, place a shoulder roll, ensure security and, working with the anesthetist, position the endotracheal tube. The RUC agreed that 5 minutes of additional evaluation time to prepare the biopsy equipment is required for CPT code 43193 compared to code 43191.

The RUC reviewed the survey respondents' estimated work RVU and agreed with the specialty that the survey's 25<sup>th</sup> percentile, 3.36 work RVUs, is an accurate value for the physician work involved in this service. The RUC reviewed the key reference service CPT code 31625 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites* (work RVU= 3.36) and noted that both the reference code and the surveyed code have identical intra-service times and should be valued identically. To further justify a work RVU of 3.36, the RUC reviewed CPT code 50386 *Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation* (work RVU= 3.30) and agreed that with identical intra-service times the two services should be valued similarly. Finally, the RUC compared 43193 to the injection code 43192 and agreed that 7 additional minutes, 30 minutes compared to 23 minutes, of intra-service time is accurate as several biopsies are taken to ensure an adequate sample and bleeding must be monitored. The specialty noted that this additional time is intense procedure time and not just waiting for an initial pathology report. Given these reference codes and time differences, the RUC concurred that a work RVU of 3.36 accurately values 43193 relative to both the family of services and other similar services across the RBRVS. **The RUC recommends a work RVU of 3.36 for CPT code 43193.**

**43194 Esophagoscopy, rigid, transoral; with removal of foreign body**

The RUC reviewed the survey results from 34 Otolaryngologists and agreed with the specialty society that the survey respondents, at the median level, accurately accounted for the time it takes to perform this service. The RUC recommends pre-service time of 49 minutes, intra-service time of 30 minutes and immediate post-service time of 28 minutes. Package 3 Straightforward patient/Difficult procedure was deemed appropriate for this service because while the typical patient no longer has cancer, the procedure is very intense resulting from the emergent need to remove a large, sharp object from the patients' esophagus. The RUC agreed that 3 additional minutes for positioning is required to properly position the patient in the supine position, place a shoulder roll, ensure security and, working with the anesthetist, position the endotracheal tube.

The RUC reviewed the survey respondents' estimated work RVU and agreed with the specialty that the survey's 25<sup>th</sup> percentile, 3.99 work RVUs, is an accurate value for the physician work involved in this service. The RUC reviewed the key reference service CPT code 31638 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required)* (work RVU= 4.88) and noted that while the reference code has more intra-service time than the surveyed code, 60 minutes compared to 30 minutes, the survey respondents indicated that code 43194 is more intense and complex procedure than code

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

31638. Therefore, the recommended work RVU of 3.99 for code 43194 is accurately valued in comparison to the reference code. To further justify this value, the RUC reviewed CPT code 20660 *Application of cranial tongs, caliper, or stereotactic frame, including removal* (work RVU= 4.00) and agreed that with identical intra-service time as the surveyed code, 30 minutes, the two codes should be valued similarly. Finally, the RUC compared 43194 to the other codes in the rigid esophagoscopy family and agreed that this emergent procedure requiring the removal of a foreign body is the most intense and complex procedure in the family because there is relatively little ramp up or ramp down in the intensity of physician work for this service. Given these reference codes, the RUC concurred that a work RVU of 3.99 accurately values 43194 relative to both the family of services and other similar services across the RBRVS. **The RUC recommends a work RVU of 3.99 for CPT code 43194.**

***43195 Esophagoscopy, rigid, transoral; with balloon dilation (less than 30 mm diameter)***

The RUC reviewed the survey results and agreed with the specialty society that the survey respondents, at the median level, accurately accounted for the time it takes to perform this service. The RUC recommends pre-service time of 49 minutes, intra-service time of 30 minutes and immediate post-service time of 15 minutes. Package 3 Straightforward patient/Difficult procedure was deemed appropriate for this service because while the typical patient no longer has cancer, the procedure is still intense and performed in the facility setting under general anesthesia. The RUC agreed that 3 additional minutes for positioning is required to properly position the patient in the supine position, place a shoulder roll, ensure security and, working with the anesthetist, position the endotracheal tube.

The RUC reviewed the survey respondents' estimated work RVU and agreed with the specialty that the respondents overestimated the work value of this service relative to similar services in the family of rigid esophagoscopy codes. To determine an appropriate value, the RUC compared code 43195 to 43192 (RUC recommended work RVU= 3.21) and noted that while 43195 has greater intra-service time compared to 43192, 30 minutes and 23 minutes, respectively, code 43195 has less total time in comparison. Therefore, the RUC agreed that these two services represent similar physician work and should both be valued at 3.21 work RVUs. To validate this work RVU, the RUC reviewed the key reference service CPT code 31625 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites* (work RVU= 3.36) and noted that both services have identical intra-service time, 30 minutes, and should be valued similarly. The RUC also reviewed CPT code 31296 *Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation)* (work RVU= 3.29) and agreed that with identical intra-service and analogous total times, both codes should be valued similarly. **The RUC recommends a work RVU of 3.21 for CPT code 43195.**

***43196 Esophagoscopy, rigid, transoral; with insertion of guide wire followed by dilation over guide wire***

The RUC reviewed the survey results and agreed with the specialty society that the survey respondents, at the median level, accurately accounted for the time it takes to perform this service. The RUC recommends pre-service time of 49 minutes, intra-service time of 33 minutes and immediate post-service time of 20 minutes. Package 3 Straightforward patient/Difficult procedure was deemed appropriate for this service because while the typical patient no longer has cancer, the procedure is still intense and performed in the facility setting under general anesthesia. The RUC agreed that 3 additional minutes for positioning is required to properly position the patient in the supine position, place a shoulder roll, ensure security and, working with the anesthetist, position the endotracheal tube.

The RUC reviewed the survey respondents' estimated work RVU and agreed with the specialty that the respondents overestimated the work value of this service relative to similar services in the family of rigid esophagoscopy codes. To determine an appropriate value, the RUC compared code 43196 to 43193 (RUC recommended work RVU= 3.36) and noted that while 43196 has slightly more intra-service time compared to 43192, 33 minutes and 30 minutes, respectively, code 43196 has less total time in comparison. Therefore, the RUC agreed that these two services represent CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

similar physician work and should both be valued at 3.36 work RVUs. To validate this work RVU, the RUC compared 43196 to CPT code 31625 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites* (work RVU= 3.36) and noted that both 31625 and the surveyed code have similar intra-service times, 30 and 33 minutes, respectively, and should be valued identically. To further justify a work RVU of 3.36, the RUC reviewed CPT code 50386 *Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation* (work RVU= 3.30) and agreed that with similar intra-service times, 30 and 33 minutes respectively, the two services should be valued similarly. **The RUC recommends a work RVU of 3.36 for CPT code 43196.**

#### **Flexible Esophagoscopy Services- Transnasal**

##### ***43197 Esophagoscopy, flexible, transnasal; diagnostic, includes collection of specimen(s) by brushing or washing, when performed***

The RUC reviewed the survey results from 74 otolaryngologists and gastroenterologists and agreed with the specialty society that the survey respondents, at the median level, accurately accounted for the time it takes to perform this service. The RUC recommends pre-service time of 25 minutes, intra-service time of 15 minutes and immediate post-service time of 10 minutes. The RUC determined Package 6 Non-facility procedure with anesthesia was appropriate for this service with 2 additional minutes of scrub, dress, wait time to spray the topical anesthetic on the nostrils and then place and remove pledgets.

The RUC reviewed the survey respondents' estimated work RVU and agreed with the specialty that the respondents overestimated the work value of this service relative to the previous value for reporting this procedure, code 43200 (work RVU= 1.59). Therefore the RUC agreed with the specialty that the current work RVU of 1.59 is an appropriate value for code 43197. To justify this value, the RUC reviewed the key reference service CPT code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed* (work RVU= 2.78) and noted that the reference code has double the intra-service time compared to the surveyed code, 30 minutes and 15 minutes, respectively. Therefore, the RUC agreed that the reference code should be valued higher and a work value of 1.59 for code 43197 maintains proper relativity with this similar service. The RUC also compared CPT code 62284 *Injection procedure for myelography and/or computed tomography, spinal (other than C1-C2 and posterior fossa)* (work RVU= 1.54) to the surveyed code and agreed that with identical intra-service time and analogous total times, these two codes should be valued similarly. **The RUC recommends and work RVU of 1.59 for CPT code 43197.**

##### ***43198 Esophagoscopy, flexible, transnasal; with biopsy, single or multiple***

The RUC reviewed the survey results from 75 otolaryngologists and gastroenterologists and agreed with the specialty society that the survey respondents, at the median level, accurately accounted for the time it takes to perform this service. The RUC recommends pre-service time of 25 minutes, intra-service time of 20 minutes and immediate post-service time of 10 minutes. The RUC determined Package 6 Non-facility procedure with anesthesia was appropriate for this service with 2 additional minutes of scrub, dress, wait time to spray the topical anesthetic on the nostrils and then place and remove pledgets.

The RUC reviewed the survey respondents' estimated work RVU and agreed with the specialty that the respondents overestimated the work value of this service relative to the previous value for reporting this procedure, code 43202 (work RVU= 1.89). Therefore, the RUC agreed with the specialty that the current work RVU of 1.89 is an appropriate value for code 43198. To justify this value, the RUC reviewed the key reference service CPT code 31625 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with bronchial or endobronchial biopsy(s), single or multiple sites* (work RVU= 3.36) and noted that reference code has 10 more minutes of intra-service time compared to the surveyed code. Therefore, the RUC

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

agreed that the reference code should be valued higher and a work value of 1.89 for code 43198 maintains proper relativity with this similar service. The RUC also compared CPT code 57455 *Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix* (work RVU= 1.99) to the surveyed code and agreed that with identical intra-service time the two codes should be valued similarly. Finally, the RUC compared code 43198 to code 43197 and noted that the additional work increment associated with 5 more intra-service minutes to perform the biopsy places 43198 in proper relativity to the family of services. **The RUC recommends a work RVU of 1.89 for CPT code 43198.**

### **Flexible Esophagoscopy Services- Transoral**

The specialties societies presented compelling evidence for the remaining flexible esophagoscopy family of services. There were two compelling evidence arguments given: a change in physician work since the last valuation and incorrect assumptions made during the last valuation. Physician work for these procedures used to be performed using fiberoptic instruments and it is now standard to use high-definition video endoscopes and high definition video monitors. Furthermore, during the previous valuation of these codes, there were no regulations and/or requirements for a complete history and physical of the patient within 30 days of the procedure now there are numerous documentation requirements (e.g. pre-sedation assessment and documentation of a comprehensive examination updated on the day of procedure) to meet various local, state, payor and Medicare accreditation, quality standards, and/or patient safety requirements. Incorrect assumptions were also made during previous reviews of the codes. Since the adoption of pre-service time packages by the RUC in 2008 the physician work of moderate sedation is now captured in the pre-service work rather than the intra-service work. Additionally, the Harvard review and subsequent CMS review only included gastroenterologists, although otolaryngologists and general surgeons also perform these services. The RUC agreed with the compelling evidence that there is potential misvaluation for these services of codes.

Prior to reviewing the transoral flexible esophagoscopy family of services the specialty societies explained the survey methodology used to obtain physician time and RVU recommendations. In May 2012, the AGA, ASGE and SAGES requested that the Research Subcommittee consider a mini-survey methodology for this and the other codes in the 43200-43232 family, which was approved. The Research Subcommittee required a standard survey be conducted of the new base code for flexible transoral esophagoscopy, 43200, specifically including the elements of pre- and post-service physician work. For the remaining codes that were surveyed in the 43201-43232 family, the mini-survey instrument only asked the physician to address the intra-service work component for the procedure. Accordingly, the RUC agreed with the same pre- and post- service times for all of the codes in 43201-43232 as for the revised base code for flexible trans-oral esophagoscopy, 43200.

The RUC observed that the specialty societies recommended two different pre-service time packages one for a straightforward patient and one for a more complex patient. However, neither of the specialties' recommendations are greater than the median survey times for each code. Therefore, while the pre-service packages change within the family, it is uniform and stays within the median response from the survey respondents. In addition, the specialty recommended that the median post-service time of 10 minutes inadequately accounts for the typical post-operative physician work. The RUC, however, noted that considering the high number of respondents, 121, the survey's median post-service time of 10 minutes should be standard throughout the series of codes.

**43200 Esophagoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing when performed**

The RUC reviewed the survey results of 121 gastroenterologists, otolaryngologists, and gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 27 minutes, intra-service time of 15 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that pre-service package 1B *Facility straightforward patient under sedation* was appropriate with two additional minutes of pre-service time over the package is necessary to properly position the patient.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialties that a work RVU of 1.59, the current value and less than the survey 25<sup>th</sup> percentile, is appropriate for 43200. To justify this value, the RUC reviewed MPC code 57452 *Colposcopy of the cervix including upper/adjacent vagina* (work RVU=1.50) and determined that while both the reference code and surveyed code have identical intra-service time, 43200 requires work because moderate sedation is inherent and should be valued higher than 57452. The RUC also reviewed 91035 *Esophagus, gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation* (work RVU=1.59) and agreed that since both codes have similar intra-service and total times these services should be valued identically. **The RUC recommends a work RVU of 1.59 for CPT code 43200.**

**43201 Esophagoscopy, flexible, transoral; with directed submucosal injection(s), any substance**

The RUC reviewed the survey results of 121 gastroenterologists gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 27 minutes, intra-service time of 15 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that pre-service package 1B *Facility straightforward patient under sedation* was appropriate with two additional minutes to properly position the patient.

The RUC first discussed the difference in the current survey median intra-service time, 15 minutes, compared to the previous intra-service time of 25 minutes. The specialties explained that this time change is due to the creation of pre-service time packages that has shifted the reporting of moderate sedation work from the intra-service to the pre-service. However, the RUC noted, and the specialties agreed, that the typical patient has changed from a patient with a stricture to a patient with achalasia and that the current value may not be appropriate. The RUC and the specialties also agreed that the current work RVU of 2.09 was too high and would create a rank order anomaly in this family of esophagoscopy codes. The RUC determined that although the times were the same as 43200, the intensity and complexity of work for 43201 would be greater and therefore the work RVU should be higher. To determine an accurate work value, the RUC reviewed MPC code 64483 *Injection, anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level* (work RVU=1.90) and code 54150 *Circumcision, using clamp or other device with regional dorsal penile or ring block* (work RVU=1.90) and agreed that both reference codes and the surveyed code have identical intra-service time of 15 minutes, with similar total times. Therefore, the RUC determined, and the specialty agreed, that a work RVU of 1.90, a direct crosswalk to CPT code 64483 and 54150, correctly ranks 43201 within the family of services. **The RUC recommends a work RVU of 1.90 for CPT code 43201.**

**43202 Esophagoscopy, flexible, transoral; with biopsy, single or multiple**

The RUC reviewed the survey results of 120 gastroenterologists, otolaryngologists, and gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 27 minutes, intra-service time of 15 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that pre-service package 1B *Facility straightforward patient under sedation* was appropriate with two additional minutes to properly position the patient.



The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialties that the survey median work RVU and 25<sup>th</sup> percentile work RVU both overstated the work included in this service. The specialties argued and the RUC agreed that the work and time to perform this service has not changed and that 15 minutes of intra-time is appropriate. The RUC discussed the difference in the survey intra-service time compared to the current Harvard time and noted that it is due to the shift in reporting moderate sedation work in pre-service time rather than the intra-service time. Therefore, the current work RVU of 1.89 should be maintained for code 43202. To justify this value, the RUC reviewed MPC code 64483 *Injection, anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level* (work RVU=1.90) and code 54150 *Circumcision, using clamp or other device with regional dorsal penile or ring block* (work RVU=1.90) and determined that since these codes have identical intra-service times, 15 minutes, and similar total time their work RVUs should be analogous. The RUC also reviewed code 49084 *Peritoneal lavage, including imaging guidance, when performed* (work RVU=2.00, 23/20/15) and determined that code 43202 was more complex due to moderate sedation, but was slightly less total work because of the intra-time difference. Finally, the RUC agreed that the work of code 43202 and 43201, with identical time components, should be valued similarly. **The RUC recommends a work RVU of 1.89 for CPT code 43202.**

#### **43204 Esophagoscopy, flexible, transoral; with injection sclerosis of esophageal varices**

The RUC reviewed the survey results of 95 gastroenterologists and gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 33 minutes, intra-service time of 20 minutes and post-service time of 10 minutes. The RUC also accepted pre-service package 2B *Facility difficult patient under sedation* with two additional minutes to properly position the patient.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty that the current work RVU of 3.76, the survey median, overestimated the physician work involved in this service. The RUC determined that a work RVU of 2.89, the survey 25<sup>th</sup> percentile, is an accurate measure of the physician work to perform code 43204. To justify this value, the RUC reviewed MPC code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (work RVU=2.78) and determined that the intensity and total physician work of 43204 is greater compared to the reference code because of a more complex patient. The RUC also noted that the higher intra-time in 31622 was due to moderate sedation work being included in the intra-time instead of pre-time component. In addition, the RUC reviewed code 49452 *Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (work RVU=2.86) and noted that both codes have identical intra-service times and similar total times. The RUC reviewed code 93503 *Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes* (work RVU=2.91, 12/15/10), which has less total time, but higher intensity than code 43204. Finally, the RUC agreed with the specialties that this service was among the highest intensity services of this family of esophagoscopy codes because the patients undergoing this service are actively bleeding at the time of examination and treatment and typically have decompensated liver disease, as described in the vignette. The specialties noted, and the RUC agreed, that the difference in the current survey intra-time and Harvard intra-time is due to a shift of reporting moderate sedation work from the intra-service to the pre-service component. **The RUC recommends a work RVU of 2.89 for CPT code 43204.**

#### **43205 Esophagoscopy, flexible, transoral; with band ligation of esophageal varices**

The RUC reviewed the survey results of 108 gastroenterologists and gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 33 minutes, intra-service time of 20 minutes and post-service time of 10 minutes. The RUC also accepted pre-service package 2B *Facility difficult patient under sedation* with two additional minutes to properly position the patient.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty that the current work RVU of 3.78, slightly above the survey median, overestimated the physician work involved in this service. The RUC determined that a work RVU of 3.00, the survey 25<sup>th</sup> percentile, is an accurate measure of the physician work to perform code 43205. To justify this value, the RUC reviewed MPC code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (work RVU=2.78) and determined that the intensity and total physician work of 43205 is greater compared to the reference code because of a more complex patient. The RUC also noted that the higher intra-time in 31622 was due to moderate sedation work being included in the intra-time instead of pre-time component. In addition, the RUC reviewed code 49452 *Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (work RVU=2.86), which has identical intra-service time compared to code 43205, but includes less intense guidance work. The RUC reviewed code 93503 *Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes* (work RVU=2.91, 12/15/10), which has less total time, but higher intensity than code 43205. Finally, the RUC agreed with the specialties that this service was among the highest intensity services of this family of esophagoscopy codes because the patients undergoing this service are actively bleeding at the time of examination and treatment and typically have decompensated liver disease, as described in the vignette. The RUC determined that the difference in the current survey intra-time and previous RUC survey in 1993 is due to a shift of reporting moderate sedation work from the intra-service to the pre-service component. The RUC also compared the intensity difference between 43205 and 43204 and noted that the physician work was more intense for code 43205 due to increased complexity of banding varices in an actively bleeding patient. **The RUC recommends a work RVU of 3.00 for CPT code 43205.**

#### **43206 Esophagoscopy, flexible, transoral; with optical endomicroscopy**

The RUC reviewed the survey results of 109 gastroenterologists and gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 27 minutes, intra-service time of 30 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that pre-service package 1B *Facility straightforward patient under sedation* was appropriate with two additional minutes to properly position the patient.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialties that both the survey median and 25<sup>th</sup> percentile work RVUs overstated the work included in this service. To determine an appropriate value, the RUC reviewed CPT code 12006 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 20.1 cm to 30.0 cm* (work RVU=2.39) and determined that with identical intra-service time of 30 minutes, this service would require similar total physician work even though 43206 includes moderate sedation and 12006 includes local anesthesia. Therefore, the RUC determined, and the specialty agreed, that a work RVU of 2.39, a direct crosswalk to code 12006, correctly ranks this new code to the base code 43200. In addition, the RUC considered that 43206 includes a diagnostic esophagoscopy followed by further diagnostic work utilizing an optical endomicroscope. This service is similar to two diagnostic services and that by applying the multiple procedure rule, would be equal to 2.39 work RVUs (1.59 + 1.59/2). **The RUC recommends a work RVU of 2.39 for CPT code 43206.**

#### **43215 Esophagoscopy, flexible, transoral; with removal of foreign body**

The RUC reviewed the survey results of 102 gastroenterologists, otolaryngologists, and gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 33 minutes, intra-service time of 20 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that patients undergoing sclerotherapy of esophageal varices are considered difficult because of the underlying co-morbidities from cirrhosis, cancer, encephalopathy, and/or coagulopathy that are typical. The RUC also accepted pre-service package 2B *Facility difficult patient under sedation* with two additional minutes to properly position the patient.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

The RUC reviewed the survey respondents' estimated work RVUs and agreed with the specialty that they overestimated the work value at the 25<sup>th</sup> percentile. Therefore, the RUC determined that a work RVU of 2.60, the current value and less than the survey 25<sup>th</sup> percentile, is appropriate for CPT code 43215. To justify this value, the RUC reviewed three codes: MPC code 51102 *Aspiration of bladder; with insertion of suprapubic catheter* (work RVU=2.70); CPT code 52281 *Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female* (work RVU=2.75) and CPT code 31295 *Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa* (work RVU=2.70). Each of these reference codes have identical intra-service time, 20 minutes, compared to the surveyed code and provide ample support that the current work RVU of 2.60 accurately values code 43215 relative to services across the RBRVS. Finally, the RUC discussed the differences in Harvard time compared to the current survey time. The specialties argued and the RUC agreed that the work to perform this service has not changed and that 20 minutes of intra-time is appropriate. The specialties noted that the difference in the current survey intra-time and Harvard intra-time is due to a shift of reporting moderate sedation work from the intra-service to the pre-service component. In addition, it was noted that the Harvard study did not include a typical patient and that code descriptor can represent a variety of foreign bodies. **The RUC recommends a work RVU of 2.60 for CPT code 43215.**

**43216 *Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery***

The RUC reviewed the survey results of 99 gastroenterologists and gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 33 minutes, intra-service time of 22 minutes and post-service time of 10 minutes. The specialties argued and the RUC agreed that the work to perform this service has not changed and that 22 minutes of intra-time is appropriate. The specialties noted that the time data included in the RUC database is asterisked to "not use for validation of physician work." As described in the RUC rationale, the value for this code is based on independent work by CMS to value the increment and not on survey data. The RUC also accepted pre-service package 2B *Facility difficult patient under sedation* with two additional minutes to properly position the patient.

The RUC reviewed the survey respondents' estimated work RVUs and agreed with the specialty that they overestimated the work value at the 25<sup>th</sup> percentile. Therefore, the RUC determined that a work RVU of 2.40, the current value and less than the survey 25<sup>th</sup> percentile, is appropriate for CPT code 43216. To justify this value, the RUC reviewed MPC code 52000 *Cystourethroscopy (separate procedure)* (work RVU=2.23) and noted that the reference code has 7 minutes less intra-service time compared to the surveyed code and should be valued less. The RUC also reviewed two additional codes that bracket the recommended work value for 43216: CPT code 45341 *Sigmoidoscopy, flexible; with endoscopic ultrasound examination* (work RVU=2.60, intra-service time= 30 minutes) and CPT code 57454 *Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage* (work RVU=2.33, intra-service time= 20 minutes). Finally, the RUC compared code 43216 to code 43215, *flexible foreign body removal*, and agreed that while 43216 has 2 more minutes of intra-service time, the physician work is less intense and should be valued slightly less. The current work RVU of 2.40 is also relative to CPT code 43202, *flexible biopsy*, (RUC recommended work RVU= 1.89) as 43216 has 7 additional intra-service minutes. **The RUC recommends a work RVU of 2.40 for CPT code 43216.**

**43217 *Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique***

The RUC reviewed the survey results of 90 gastroenterologists and gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 33 minutes, intra-service time of 30 minutes and post-service time of 10 minutes. The specialties argued and the RUC agreed that the work to perform this service has not changed and that 30 minutes of intra-time is appropriate. The RUC also accepted pre-service package 2B *Facility difficult patient under sedation* with two additional minutes to properly position the patient.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

The RUC reviewed the survey respondents' estimated work RVUs and agreed with the specialty that they overestimated the work value at the 25<sup>th</sup> percentile. Therefore, the RUC determined that a work RVU of 2.90, the current value and less than the survey 25<sup>th</sup> percentile, is appropriate for CPT code 43217. To justify this value, the RUC reviewed MPC code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (work RVU=2.78) and agreed that given both services have identical intra-service time, 30 minutes, both codes should have similar work values. The RUC also reviewed two codes that bracket the recommended work RVUs: CPT code 49452 *Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (work RVU=2.86, intra-service time= 20 minutes) is a less intense procedure and should be valued slightly less and CPT code 50386 *Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation* (work RVU=3.30, intra-service time= 30 minutes) is a more intense procedure and should be valued higher than code 43217. Finally, the RUC noted that the recommended work value appropriately ranks code 43217 to 43216, *flexible lesion removal by hot biopsy*, as 43217 has 8 additional minutes of intra-service time. **The RUC recommends a work RVU of 2.90 for CPT code 43217.**

#### **43211 Esophagoscopy, flexible, transoral; with endoscopic mucosal resection**

The RUC reviewed the survey results from 62 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 45 minutes and post-service time= 18 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this new code, with a survey 25<sup>th</sup> percentile work RVU of 4.91. Consistent with the RUC approved EGD recommendations in January 2013, the RUC agreed that, to remain consistent, code 43211 should be valued less than the equivalent EGD code 43254 (recommended work RVU= 5.25). To define the appropriate reduction, the RUC determined the established increment between the base EGD code, 43235 (recommended work RVU= 2.26), and the base esophagoscopy code, 43200 (recommended work RVU= 1.59). Therefore, the resulting incremental difference of 0.67 work RVUs was subtracted from 43254, for a recommended work RVU of 4.58. To validate a work RVU of 4.58, the RUC compared the surveyed code to CPT code 20902 *Bone graft, any donor area; major or large* (work RVU= 4.58) and agreed that since both codes have identical intra-service time, 45 minutes, and analogous physician work, both codes should be valued identically. In addition, the RUC reviewed CPT code 36251 *Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral* (work RVU= 5.35) and noted that while both codes have identical intra-service time, the reference code is a more intense procedure and has more total time than 43211. Therefore, the RUC agreed that the reference code should be valued higher. **The RUC recommends a work RVU of 4.58 for CPT code 43211.**

**43212 Esophagoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)**

The RUC reviewed the survey results from 53 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 30 minutes and post-service time= 15 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this new code, with a survey 25<sup>th</sup> percentile work RVU of 4.36. Consistent with the RUC approved EGD recommendations in January 2013, the RUC agreed that, to remain consistent, code 43212 should be valued less than the equivalent EGD code 43266 (recommended work RVU= 4.40). To define the appropriate reduction, the RUC determined the established increment between the base EGD code, 43235 (recommended work RVU= 2.26), and the base esophagoscopy code, 43200 (recommended work RVU= 1.59). Therefore, the resulting incremental difference of 0.67 work RVUs was subtracted from 43266, for a recommended work RVU of 3.73. To validate a work RVU of 3.73, the RUC compared the surveyed code to CPT code 31296 *Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation)* (work RVU= 3.29) and noted that while both codes have identical intra-service time, 30 minutes, 43212 should be valued higher due to greater intensity and complexity. The RUC also reviewed CPT code 20660 *Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure)* (work RVU= 4.00) and noted that this reference code is more intense than 43212 and should be valued slightly higher. Finally, the RUC compared 43212 to 43214 and agreed that with almost identical physician time, the two services are correctly valued similarly. **The RUC recommends a work RVU of 3.73 for CPT code 43212.**

**43220 Esophagoscopy, flexible, transoral; with balloon dilation (less than 30 mm diameter)**

The RUC reviewed the survey results of 109 gastroenterologists and gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 27 minutes, intra-service time of 20 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that pre-service package 1B *Facility straightforward patient under sedation* was appropriate with two additional minutes to properly position the patient.

The RUC reviewed the survey respondents' estimated work RVUs and agreed with the specialty that they overestimated the work value at the 25<sup>th</sup> percentile. Therefore, the RUC determined that a work RVU of 2.10, the current value and less than the survey 25<sup>th</sup> percentile, is appropriate for CPT code 43220. To justify this value, the RUC reviewed CPT code 57421 *Colposcopy of the entire vagina, with cervix if present; with biopsy(s) of vagina/cervix* (work RVU=2.20) and noted that both codes have identical intra-service time, 20 minutes, and therefore, should be valued similarly. The RUC also reviewed CPT code 69801 *Labyrinthotomy, with perfusion of vestibuloactive drug(s); transcanal* (work RVU=2.06) and agreed that while reference code has 5 minutes less intra-service time compared to 43220, the surveyed code has much greater total time and should be valued slightly higher. CPT code 52000 *Cystourethroscopy (separate procedure)* (work RVU= 2.23) was also reviewed and the RUC agreed that with less total time compared to the surveyed code, 42 minutes and 57 minutes, respectively, the reference code is appropriately valued less than 43220. Finally, the RUC compared code 43220 to other similar codes in the family with 20 minutes of intra-service time and agreed that a work RVU of 2.10 accurately values this service relative to the other services. **The RUC recommends a work RVU of 2.10 for CPT code 43220.**

***43213 Esophagoscopy, flexible, transoral; with dilation of esophagus, by balloon or dilator, retrograde (includes fluoroscopic guidance, when performed)***

The RUC reviewed the survey results from 45 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 45 minutes and post-service time= 15 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that since there is no equivalent esophagoscopy crosswalk to determine the incremental physician work, the survey's 25<sup>th</sup> percentile work RVU of 5.00 is appropriate. To validate this work value, the RUC compared the surveyed code to CPT code 20902 *Bone graft, any donor area; major or large* (work RVU= 4.58) and agreed that while both services have identical intra-service time, 45 minutes, the surveyed code is a more intense procedure and should be valued slightly higher. The RUC also reviewed CPT code 36251 *Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral* (work RVU= 5.35) and noted that this reference code has greater total time than the surveyed code, 116 minutes and 101 minutes, respectively. Therefore, 43213 is appropriately valued slightly less than 36251. **The RUC recommends a work RVU of 5.00 for CPT code 43213.**

***43214 Esophagoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)***

The RUC reviewed the survey results from 42 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 30 minutes and post-service time= 16 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this new code, with a survey 25<sup>th</sup> percentile work RVU of 3.86. Consistent with the RUC approved EGD recommendations in January 2013, the RUC agreed that, to remain consistent, code 43214 should be valued less than the equivalent EGD code 43233 (recommended work RVU= 4.45). To define the appropriate reduction, the RUC determined the established increment between the base EGD code, 43235 (recommended work RVU= 2.26), and the base esophagoscopy code, 43200 (recommended work RVU= 1.59). Therefore, the resulting incremental difference of 0.67 work RVUs was subtracted from 43233, for a recommended work RVU of 3.78. To validate a work RVU of 3.78, the RUC compared the surveyed code to 50386 *Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation* (work RVU= 3.30) and noted that while both codes have identical intra-service time, 30 minutes, 43214 should be valued higher due to greater intensity and complexity. In addition, the RUC reviewed CPT code 32550 *Insertion of indwelling tunneled pleural catheter with cuff* (work RVU= 4.17) and agreed that the reference code is a slightly more intense service compared to the surveyed code and is appropriately valued higher. **The RUC recommends a work RVU of 3.78 for CPT code 43214.**

**43226 Esophagoscopy, flexible, transoral; with insertion of guide wire followed by dilation over guide wire**

The RUC reviewed the survey results of 114 gastroenterologists, otolaryngologists, and gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 27 minutes, intra-service time of 25 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that pre-service package 1B *Facility straightforward patient under sedation* was appropriate with two additional minutes to properly position the patient.

The RUC reviewed the survey respondents' estimated work RVUs and agreed with the specialty that they overestimated the work value at the 25<sup>th</sup> percentile. Therefore, the RUC determined that a work RVU of 2.34, the current value and less than the survey 25<sup>th</sup> percentile, is appropriate for CPT code 43226. To justify this value, the RUC reviewed CPT code 49083 *Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance* (work RVU= 2.00) and agreed that while both services have identical intra-service time, code 43226 is a more intense and complex procedure to perform and should be valued higher. In addition, the RUC reviewed CPT code 57454 *Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage* (work RVU=2.33) and agreed that since the surveyed code has more intra-service time it should be valued slightly higher than the reference code. CPT code 69801 *Labyrinthotomy, with perfusion of vestibuloactive drug(s); transcanal* (work RVU= 2.06) was also reviewed and the RUC agreed that with less total time compared to the surveyed code, 43 minutes and 57 minutes, respectively, the reference code is appropriately valued less than 43226. Finally, code 43226 was compared to code 43220 *flexible with balloon dilation* (RUC recommended work RVU= 2.10) and the RUC agreed that 43226 should be valued higher due to 5 more minutes of intra-service time. **The RUC recommends a work RVU of 2.34 for CPT code 43226.**

**43227 Esophagoscopy, flexible, transoral; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)**

The RUC reviewed the survey results of 87 gastroenterologists and gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 33 minutes, intra-service time of 30 minutes and post-service time of 10 minutes. The RUC also accepted pre-service package 2B *Facility difficult patient under sedation* with two additional minutes to properly position the patient.

The RUC reviewed the survey respondents' estimated work RVUs and agreed with the specialty that they overestimated the work value at the median level. Therefore, the RUC determined that the survey 25<sup>th</sup> percentile work RVU of 3.26, less than the current value, is appropriate for CPT code 43226. To justify this value, the RUC reviewed CPT code 31625 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites* (work RVU=3.36) and noted that both services have identical intra-service time, 30 minutes, and should be valued similarly. In addition, the RUC compared 43227 to CPT code 58555 *Hysteroscopy, diagnostic (separate procedure)* (work RVU=3.33) and agreed that while the reference code has 5 minutes less intra-service time, it has greater total time and should be valued slightly higher than code 43227. The RUC also reviewed MPC code 15002 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children* (work RVU=3.65, intra= 20 minutes) and noted that although the surveyed code has 10 minutes more intra-service time, the reference code has much greater total time, 102 minutes compared to 73 minutes, and is appropriately valued higher than 43227. Finally, the RUC agreed with the specialties that this service was among the highest intensity services of this family of esophagoscopy codes because the patients undergoing this service are actively bleeding at the time of examination and treatment, as described in the vignette. The specialties noted, and the RUC agreed, that the difference in the current survey intra-time and Harvard intra-time is due to a shift of reporting moderate sedation work from the intra-service to the pre-service component. **The RUC recommends a work RVU of 3.26 for CPT code 43227.**

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

***43229 Esophagoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)***

The RUC reviewed the survey results from 51 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 40 minutes, intra-service time= 45 minutes and post-service time= 15 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this new code, with a survey 25<sup>th</sup> percentile work RVU of 4.68. Consistent with the RUC approved EGD recommendations in January 2013, the RUC agreed that, to remain consistent, code 43229 should be valued less than the equivalent EGD code 43270 (recommended work RVU= 4.39). To define the appropriate reduction, the RUC determined the established increment between the base EGD code, 43235 (recommended work RVU= 2.26), and the base esophagoscopy code, 43200 (recommended work RVU= 1.59). Therefore, the resulting incremental difference of 0.67 work RVUs was subtracted from 43270, for a recommended work RVU of 3.72. To validate a work RVU of 3.72, the RUC compared the surveyed code to CPT code 19105 *Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma* (work RVU= 3.69) and agreed that since both codes have 45 minutes of intra-service time and almost identical total time, the two services should be valued similarly. The RUC also reviewed 31626 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple* (work RVU= 4.16) and noted that the reference code is a more intense procedure and should be valued higher than 43229. Finally, the RUC compared 43229 to 43212 and 43214 and agreed that while 43229 has 15 minutes more intra-service time compared to these two codes, this surveyed code should be valued similarly as it is a less intense services comparably. **The RUC recommends a work RVU of 3.72 for CPT code 43229.**

***43231 Esophagoscopy, flexible, transoral; with endoscopic ultrasound examination***

The RUC reviewed the survey results from 45 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 30 minutes and post-service time= 20 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the survey respondents' physician work values estimates and agreed with the specialty societies that they were overvalued. The RUC noted that the median intra-service time of 30 minutes is less than the current time of 40 minutes. However, the previous survey valued this procedure with moderate sedation inherent in the intra-service time. With the subsequent establishment of pre-service time packages, moderate sedation is now considered pre-service time. Removing 10 minutes of intra-service time, accounting for the moderate sedation, from the previous survey, provides a reasonable comparison to the new survey, and suggests that the recommended intra-service time of 30 minutes is accurate. Given this information and the fact that the physician work has not changed since the previous valuation, the RUC agreed with the specialty societies that the current work RVU of 3.19 is appropriate for this procedure. To justify this work value, the RUC compared the surveyed code to CPT codes 36200 *Introduction of catheter, aorta* (work RVU= 3.02, intra time= 30 minutes) and 50386 *Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation* (work RVU= 3.30, intra time= 30 minutes) and noted that both reference services have identical intra-service time compared to the surveyed code, with comparable physician work. Therefore, the recommended work RVU of 3.19 is accurately valued between these two services. **The RUC recommends a work RVU of 3.19 for CPT code 43231.**

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.



**43232 Esophagoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)**

The RUC reviewed the survey results from 38 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 45 minutes and post-service time= 20 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the survey respondents' physician work values estimates and agreed with the specialty societies that they were overvalued. To ensure that the recommendation remains consistent with the equivalent fine needle aspiration procedure in the EGD family, the RUC applied the incremental approach to value this service. As the base value, the RUC started with the RUC recommended EGD fine needle aspiration code (43238, RUC recommended work RVU= 4.50) and subtracted out the difference between the base EGD (43235, RUC recommended work RVU= 2.26) and esophagoscopy (43200, RUC recommended work RVU= 1.59) codes = 0.67 work RVUs. This ensures that the value contains only the esophagoscopy incremental work and not the increased work associated with EGD procedure. The RUC agreed that the resultant work value of 3.83 (4.50 - 0.67) was appropriate for 43232. To justify a work value of 3.83, the RUC first noted that the established increment of fine needle aspiration in the EGD family is 0.67 (43238, recommended work RVU= 4.50 – 43237, recommended work RVU= 3.85), validating the increment used in this methodology. Additionally, the RUC compared the surveyed code to CPT codes 32553 *Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple* (work RVU= 3.80, intra time= 45 minutes) and 11044 *Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less* (work RVU= 4.10, intra time= 45 minutes) and noted that both services have identical intra-service time and comparable physician work to the surveyed code. Therefore, the RUC agreed that the recommended value of 3.83 is appropriately placed between these two reference services. **The RUC recommends a work RVU of 3.83 for CPT code 43232.**

**Practice Expense:**

At the October 2012 RUC meeting the PE Subcommittee reviewed the direct practice expense inputs recommended by the specialties and made modifications to the clinical staff times, medical supplies, and equipment items and time. In addition, several items listed as new equipment were reclassified as supplies with existing codes and equipment minutes were converted from units to minutes. The RUC accepted the direct practice expense inputs for these codes as modified by the Practice Expense Subcommittee.

At the January 2013 RUC meeting the practice expense for these services was a direct crosswalk to the approved practice expense for the related esophagoscopy codes approved at the October 2012 RUC meeting. At the January 2013 RUC meeting the Practice Expense Subcommittee recommended and the RUC approved the following changes to the practice expense for esophagogastroduodenoscopy and the specialty requests that the changes be applied to the esophagoscopy codes that were previously approved at the October 2012 RUC meeting.

- Addition of 3 minutes to “Prepare room, equipment, supplies” (L037D) for code 43252 (Esophagogastroduodenoscopy; with optical endomicroscopy) for the technician to turn on the optical endomicroscope processor unit system added to its esophagoscopy counterpart, 43206 (Esophagoscopy, flexible, transoral; with optical endomicroscopy)
- At the last meeting the Practice Expense Subcommittee used equipment practice expense input EQ322 Radiofrequency generator (Angiodynamics), liver RFA as a proxy. The specialty will identify a more appropriate RF ablation system for 43270 (Esophagogastroduodenoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)) and provide an invoice for this equipment. It should also be added to its esophagoscopy

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

counterpart 43229 (Esophagoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)) which replaced 43228

- Addition of “Instrument pack basic (\$500 - \$1,499)” (EQ137) for 43248 (Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by dilation of passage of dilator(s) through esophagus over guide wire) added to its esophagoscopy counterpart 43226 (Esophagoscopy, flexible, transoral; with insertion of guide wire followed by dilation over guide wire)
- Addition of “Pack, cleaning, surgical instruments” (SA043) for 43248 (Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by dilation of passage of dilator(s) through esophagus over guide wire) for cleaning the dilators added to its counterpart 43226 (Esophagoscopy, flexible, transoral; with insertion of guide wire followed by dilation over guide wire)

In April 2013, the RUC recommends the direct practice expense for the two facility only codes, 43231 and 43232, as submitted by the specialty societies and approved by the Practice Expense Subcommittee.

#### Work Neutrality:

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

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<p>For endoscopic procedures, code appropriate endoscopy of each anatomic site examined.</p> <p><u>When bleeding occurs as a result of an endoscopic procedure, control of bleeding is not reported separately during the same operative session.</u></p> <p><u>Esophagoscopy includes examination from the cricopharyngeus muscle (upper esophageal sphincter) to and including the gastroesophageal junction. It may also include examination of the-proximal region of the stomach via retroflexion when performed.</u> Surgical endoscopy always includes diagnostic endoscopy.</p>				
●43191	C1	<p>Esophagoscopy, rigid, transoral; diagnostic, including collection of specimen(s) by brushing or washing when performed</p> <p><u>(To report transnasal esophagoscopy, see 43197-43198)</u></p> <p><u>(For diagnostic flexible transoral esophagoscopy, use 43200)</u></p>	000	2.78

●43192	C2	<p>with directed submucosal injection(s), any substance  <u>(For flexible transoral esophagoscopy with directed submucosal injection(s), use 43201)</u>  <u>(For flexible transoral esophagoscopy with injection sclerosis of esophageal varices, use 43204)</u>  <u>(For rigid transoral esophagoscopy with injection sclerosis of esophageal varices, use 43499)</u></p>	000	3.21
●43193	C3	<p>with biopsy, single or multiple  <u>(For flexible transoral esophagoscopy with collection of specimen or biopsy, see 43200, 43202)</u></p>	000	3.36
●43194	C4	<p>with removal of foreign body  <u>(For radiological supervision and interpretation, use 74235)</u>  <u>(For flexible transoral esophagoscopy with removal of foreign body, use 43215)</u></p>		3.99
●43195	C5	<p>with balloon dilation (less than 30 mm diameter)  <u>(If imaging guidance is performed, use 74360)</u>  <u>(For esophageal dilation with balloon 30 mm diameter or larger, see 43214 - 43233)</u>  <u>(For dilation without endoscopic visualization, see 43450, 43453)</u>  <u>(For flexible transoral esophagoscopy with balloon dilation [less than 30 mm diameter], use 43220)</u></p>	000	3.21
●43196	C6	<p>with insertion of guide wire followed by dilation over guide wire  <u>(For radiological supervision and interpretation, use 74360)</u>  <u>(For flexible transoral esophagoscopy with insertion of guide wire followed by dilation over guide wire, use 43226)</u></p>	000	3.36

●43197	C7	Esophagoscopy, flexible, transnasal; diagnostic, includes collection of specimen(s) by brushing or washing, when performed <u>(Do not report 43197 in conjunction with 31575, 43191, 43192, 43193, 43194, 43195, 43196, 43200-43232, 43235-43259, 92511)</u> <u>(For transoral esophagoscopy with biopsy or collection of specimen, see 43191, 43193, 43200, 43202)</u> <u>(Do not report 43197 in conjunction with 31231 unless separate type of endoscope [eg, rigid endoscope] is used)</u>	000	1.59
●43198	C8	with biopsy, single or multiple <u>(For transoral esophagoscopy with biopsy or collection of specimen, see 43191, 43193, 43200, 43202)</u> <u>(Do not report 43198 in conjunction with 31575, 43191, 43192, 43193, 43194, 43195, 43196, 43200-43232, 43235-43259, 92511)</u> <u>(Do not report 43198 in conjunction with 31231 unless separate type of endoscope [eg, rigid endoscope] is used)</u>	000	1.89
◎▲43200	C9	Esophagoscopy, <del>rigid or</del> flexible, transoral; diagnostic, <del>with or without</del> including collection of specimen(s) by brushing or washing, when performed <del>(separate procedure)</del> <u>(For diagnostic rigid transoral esophagoscopy, use 43191)</u> <u>(For diagnostic flexible transnasal esophagoscopy, use 43197)</u> <u>(For diagnostic upper gastrointestinal endoscopy, use 43235)</u>	000	1.59 (No Change)

◎ ▲ 43201	C11	<p>with directed submucosal injection(s), any substance  <u>(For rigid transoral esophagoscopy with directed submucosal injection(s), use 43192)</u>          (For <u>flexible transoral esophagoscopy with injection sclerosis of esophageal varices</u>, use 43204)  <u>(For rigid transoral esophagoscopy with injection sclerosis of esophageal varices, use 43499)</u>  <u>(Do not report 43201 in conjunction with 43211, 43204, 43227)</u></p>	000	1.90
◎ ▲ 43202	C12	<p>with biopsy, single or multiple  <u>(For rigid transoral esophagoscopy with biopsy, use 43193)</u>  <u>(For flexible transnasal esophagoscopy with biopsy, use 43198)</u>  <u>(For upper gastrointestinal endoscopy with biopsy or collection of specimen, see 43235, 43239)</u></p>	000	1.89 (No Change)
◎ ▲ 43204	C13	<p>with injection sclerosis of esophageal varices  <u>(For rigid transoral esophagoscopy with injection sclerosis of esophageal varices, use 43499)</u>  <u>(Do not report 43204 in conjunction with 43201, 43227)</u></p>	000	2.89
◎ ▲ 43205	C14	<p>with band ligation of esophageal varices  <u>(Do not report 43205 in conjunction with 43211, 43227)</u></p>	000	3.00
◎ ▲ 43206	C10	<p>with optical endomicroscopy          (Report supply of contrast agent separately)          (Do not report 43206 in conjunction with 88375)  <u>(Code is out of numerical sequence. See 43191-43232)</u></p>	000	2.39

◎▲43215	C15	with removal of foreign body (For radiological supervision and interpretation, use 74235) <u>(For rigid transoral esophagoscopy with removal of foreign body, use 43194)</u> <u>(For upper gastrointestinal endoscopy with removal of foreign body, use 43247)</u>	000	2.60 (No Change)
◎▲43216	C16	with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	000	2.40 (No Change)
◎▲43217	C17	with removal of tumor(s), polyp(s), or other lesion(s) by snare technique <u>(For upper gastrointestinal endoscopy with removal of tumor(s), polyp(s), or other lesion(s) by snare technique, use 43251)</u> <u>(Do not report 43217 in conjunction with 43211)</u>	000	2.90 (No Change)
#◎●43211	C25	with endoscopic mucosal resection <u>(Do not report 43211 in conjunction with 43201, 43205, 43217)</u> <u>(Do not report 43211 in conjunction with 43202 when biopsy is performed on the same lesion)</u>	000	4.58
D43219	C18	<del>with insertion of plastic tube or stent</del> <u>(43219 has been deleted. To report, use 43212)</u>	000	N/A
#◎●43212	C26	with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed) <u>(Do not report 43212 in conjunction with 43220, 43226)</u>	000	3.73

◎▲43220	C19	<p>with <u>transendoscopic</u> balloon dilation (less than 30 mm diameter)  <u>(For rigid transoral esophagoscopy with balloon dilation [less than 30 mm diameter], use 43195)</u>          (If imaging guidance is performed, use 74360)          (For <u>esophageal endoscopic</u> dilation with balloon 30 mm diameter or larger, use 43458<u>43214</u>)          (For dilation without <u>endoscopic</u> visualization, <u>see 43450, 43453</u>)  <del>(For diagnostic fiberoptic esophagogastrosocopy, use 43200, 43235)</del>  <del>(For fiberoptic esophagogastrosocopy with biopsy or collection of specimen, see 43200, 43202, 43235, 43239)</del>  <del>(For fiberoptic esophagogastrosocopy with removal of foreign body, use 43215, 43247)</del>  <del>(For fiberoptic esophagogastrosocopy with removal of polyp(s), use 43217, 43251)</del>  <u>(Do not report 43220 in conjunction with 43212, 43226, 43229)</u></p>	000	2.10 (No Change)
#◎●43213	C27	<p>with dilation of esophagus, by balloon or dilator, retrograde          (includes fluoroscopic guidance, when performed)  <u>(Do not report 43213 in conjunction with 74360, 76000, 76001)</u></p>	000	5.00
#◎●43214	C28	<p>with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)  <u>(Do not report 43214 in conjunction with 74360, 76000, 76001)</u></p>	000	3.78
◎▲43226	C20	<p>with insertion of guide wire followed by <u>dilation passage of dilator(s)</u> over guide wire          (For radiological supervision and interpretation, use 74360)  <u>(For rigid transoral esophagoscopy with insertion of guide wire followed by dilation over guide wire, use 43196)</u>  <u>(Do not report 43226 in conjunction with 43212, 43229)</u></p>	000	2.34 (No Change)

◎▲43227	C21	with control of bleeding, any method ( <del>eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator</del> )  (Do not report 43227 in conjunction with 43204, 43205)	000	3.26
D43228	C22	<del>with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique</del>  (43228 has been deleted. To report, use 43229)	000	N/A
#◎●43229	C29	with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)  (Do not report 43229 with 43220, 43226)  (For esophagoscopy photodynamic therapy, report <del>43228</del> 43229 in conjunction with 96570, 96571 as appropriate)	000	3.72
◎▲43231	C23	with endoscopic ultrasound examination  (Do not report 43231 in conjunction with 76975)	000	3.19 (No Change)
◎▲43232	C24	with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)  (Do not report 43232 in conjunction with <u>43231</u> , 76942, 76975) (For interpretation of specimen, see 88172-88173) (Code is out of numerical sequence. See 43235-43273)	000	3.83
D43234		<del>Upper gastrointestinal endoscopy, simple primary examination (eg, with small diameter flexible endoscope) (separate procedure);</del>  (43234 has been deleted. To report <u>esophagogastrosocopy</u> , see 43197, use <u>43200</u> , <u>43235</u> )	000	N/A



**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43191      Tracking Number C1      Original Specialty Recommended RVU: **2.78**  
 Presented Recommended RVU: **2.78**  
 Global Period: 000      RUC Recommended RVU: **2.78**

CPT Descriptor: Esophagoscopy, rigid, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed.

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 60 year-old man with newly diagnosed squamous cell carcinoma of the oral cavity presents with dysphagia. A rigid esophagoscopy is performed for further evaluation.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 24%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 2%

**Description of Pre-Service Work:**

After the decision is made to perform a diagnostic rigid esophagoscopy the physician must perform the following steps to prepare the patient and the room for the procedure.

- Select and order the appropriate antibiotic(s) and confirm timing and administration.
- Assure appropriate selection, timing, and administration of DVT prophylaxis.
- Assess need for beta-blockers, order as required.
- Review medical history, pathology, and radiology report.
- Review radiographic images.
- Review results of preoperative testing (labs, EKG, CXR).
- Review reports of consultants providing preoperative assessment and clearance as indicated.
- Meet with patient and family to review planned procedure and postoperative management.
- Reexamine patient to ensure that physical findings have not changed and dictate history and physical.
- Obtain informed consent.
- Review airway and medical management with anesthesiologist.
- Review planned procedure with OR staff.
- Verify that all required instruments and supplies are available, set up scopes, suction, light source, and photodocumentation equipment and ensure functionality.
- Change into scrub clothes.
- Observe/wait during induction of anesthesia and intubation.
- Monitor/assist with positioning of the patient (supine, shoulder roll, ensure security and position of endotracheal tube).

- Ensure that radiographic images are available in the OR.
- Monitor/assist with draping.
- Scrub and gown.
- Operating table is turned with head toward endoscopist.
- Perform surgical "time out" with operating surgical team.

#### Description of Intra-Service Work:

The mouth is opened and teeth/gums protected. Suction pharyngeal secretions. The rigid esophagoscope is introduced and passed through mouth, behind the endotracheal tube and larynx into cricopharyngeus and into the esophagus. The esophagoscope is advanced to the distal esophagus, the scope and patient position are readjusted as needed to ensure safe and smooth passage of the scope and suctioning secretions. The mucosa (lining) is evaluated and photodocumentation recorded. The esophagoscope is removed and the pharynx examined for bleeding and suctioned free of secretions. The patient is returned to the anesthesia position.

#### Description of Post-Service Work:

- Monitor patient during reversal of anesthesia. Monitor transport of patient from OR to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff. Write postoperative orders. Discuss procedure and operative findings with family and the patient.
- Write postoperative note. Dictate operative note and copy to referring physician.
- Monitor patient progress. Chart notes.
- Monitor overall medical condition of the patient including fluid balance, vital signs, and urinary function
- Assess pain scores and adequacy of analgesia.
- Discuss post-discharge management with nursing staff and answer questions
- Home restrictions (i.e., diet, activity) are discussed with the patient, family members and discharging nurse.
- Write prescriptions for medications and supplies needed post-discharge
- Perform medication reconciliation
- All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	10/2012				
<b>Presenter(s):</b>	Wayne Koch, MD				
<b>Specialty(s):</b>	AAO-HNS				
<b>CPT Code:</b>	43191				
<b>Sample Size:</b>	687	<b>Resp N:</b>	59	<b>Response:</b> 8.5 %	
<b>Description of Sample:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	5.00	20.00	30.00	120.00
<b>Survey RVW:</b>	1.80	2.78	3.00	3.57	10.00
<b>Pre-Service Evaluation Time:</b>			35.00		
<b>Pre-Service Positioning Time:</b>			10.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10.00		
<b>Intra-Service Time:</b>	5.00	15.00	20.00	30.00	60.00
<b>Immediate Post Service-Time:</b>	<b>15.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

4 - FAC Difficult Patient/Difficult Procedure

<b>CPT Code:</b>	43191	<b>Recommended Physician Work RVU: 2.78</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		35.00	40.00	-5.00
<b>Pre-Service Positioning Time:</b>		6.00	3.00	3.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		10.00	20.00	-10.00
<b>Intra-Service Time:</b>		20.00		
<b>Immediate Post Service-Time:</b>	<b>15.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31622	000	2.78	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; diagnostic, with or without cell washing (separate procedure).

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
51102	000	2.70	RUC Time	14,057

CPT Descriptor 1 Aspiration of bladder; with insertion of suprapubic catheter.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
19103	000	3.69	RUC Time	116,377

CPT Descriptor 2 Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31623	000	2.88	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with brushing or protected brushings.

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 35      % of respondents: 59.3 %**

**TIME ESTIMATES (Median)**

	<u>CPT Code:</u> <u>43191</u>	<u>Key Reference CPT Code:</u> <u>31622</u>	<u>Source of Time</u> <u>RUC Time</u>
Median Pre-Service Time	51.00	20.00	
Median Intra-Service Time	20.00	30.00	
Median Immediate Post-service Time	15.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

<b>Median Total Time</b>	<b>86.00</b>	<b>65.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.26	3.26
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.14	3.14
--	------	------

Urgency of medical decision making	3.09	3.29
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.37	3.37
--------------------------	------	------

Physical effort required	2.97	2.91
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.66	3.29
---	------	------

Outcome depends on the skill and judgment of physician	3.51	3.37
--	------	------

Estimated risk of malpractice suit with poor outcome	3.91	3.40
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.94	3.00
----------------------------------	------	------

Intra-Service intensity/complexity	3.31	3.17
------------------------------------	------	------

Post-Service intensity/complexity	2.89	2.86
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Why is this code being reviewed?**

The esophagoscopy family of codes 43200-43232 was identified in the CY 2012 Final Physician Fee Schedule by CMS as potentially misvalued services. In response to this request, several Gastroenterology societies proposed a schedule for review all of the gastrointestinal endoscopic services, during the January RAW subcommittee meeting. This action plan was approved. Subsequently, a code change proposal was submitted for the May 2012 CPT meeting which created 8 new codes to describe transoral approach with a rigid scope and transnasal approach with a flexible scope. These services were previously reported using the 43200 (Esophagoscopy, rigid or flexible; with directed submucosal injection(s), any substance) code. The 43200 series of codes were revised to limit use to esophagoscopies performed using a transoral approach with a flexible scope. This revised family of codes is now being presented for valuation by the AMA RUC at the October 2012 meeting.

### **Description of Random Survey Sample**

Our physician work RVU recommendation was derived by conducting a random survey of our Membership, using the standard 000 global survey instrument. Surveys were sent to nearly 700 Otolaryngologists, including the subspecialties of laryngology and broncoesophagology, as well as to the Academy's leadership and key committees, such as the Airway and Swallowing and Voice, which contain clinicians who were most likely to be familiar with the services under review.

### **Physician Time**

#### **Pre-Time**

Regarding physician time, we recommend using pre-service package 4 (difficult patient/difficult procedure) which includes 40 minutes of evaluation, 3 minutes of positioning, and 20 minutes of scrub, dress, and wait time. Our expert panel felt this package was most appropriate given that the vignette for this service represents an elderly patient with cancer who requires a rigid esophagoscopy procedure. Our experts believed this patient is often sicker and more complex than a standard patient undergoing flexible, transoral esophagoscopy. In addition, this procedure is only performed in the facility setting and must be done under general anesthesia. Therefore, prepackage 4 is most appropriate for the preservice work required for the typical patient. While our experts felt that the 40 minutes of evaluation time associated with prepackage 4 was appropriate for this procedure, our survey respondents only indicated 35 minutes of evaluation time, therefore we are recommending a reduction of 5 minutes of evaluation time in order to maintain consistency with our survey data. Similarly, our panel reviewed the 20 minutes of scrub dress and wait time assigned by the prepackage and felt this amount of time was not necessary for this procedure. Therefore we recommend reducing this to 10 minutes for scrub, dress and wait which is also consistent with our survey responses. In contrast, we believe that the package time of 3 minutes for positioning is not sufficient for patients undergoing this procedure and therefore, recommend adding 3 minutes of positioning time. We believe this increase in positioning time is justified, given that the physician must position the patient in the supine position, place a shoulder roll, ensure security and position the endotracheal tube together with the anesthetist. Prior to beginning the procedure, the operating table must also be turned so that the patient's head is facing the endoscopist. These modifications result in an overall pre-service time recommendation of 35/6/10 for 43191.

#### **Intra Time**

Our expert panel agreed with our surveyees regarding the time for intra service work and are recommending the survey median time of 20 minutes for intra service work.

#### **Post Time**

Likewise, our experts felt that the survey's post time was an accurate reflection of the post time required for this procedure and are recommending the median post time of 15 minutes. This results in a request for a total of 86 minutes of physician work time for CPT 43191.

### **Physician Work / Compelling Evidence**

After concluding the survey, the results were analyzed by our expert panel and it was determined that for the newly developed rigid esophagoscopy codes (43191-6) the existing work RVUs were not sufficient for the amount of work being done for procedures where the physician is using a rigid scope in the facility setting, under general anesthesia. In addition, it has come to our attention that the previous code used to bill this service, 43200, is a Harvard valued code which was surveyed by 21 Gastroenterologists. Therefore, given that no Otolaryngologists participated in the original survey of the 43200 code, it is unlikely that the work for diagnostic esophagoscopy using a rigid scope has ever been properly valued or even considered as part of the survey for 43200, as Gastroenterologists do not perform esophagoscopy procedures using a rigid endoscope.

Thus, we believe there is compelling evidence for re-valuation of the new CPT code 43191 given that incorrect assumptions were made in previous valuations of the service where the dominant provider of rigid esophagoscopy services,

Otolaryngology, were not included in the initial survey of the former combination code (43200). Upon review of this history, our expert panel determined that the work RVUs for the service (Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)) are not sufficient to value the work performed when an esophagoscopy is administered in the facility setting, using a rigid scope, under general anesthesia. Our expert panel therefore, recommends that the RVW for the new code 43191 (Esophagoscopy, rigid, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed) should be increased based on the compelling evidence outlined above to more accurately represent the correct specialty mix for rigid esophagoscopy procedures as well as the more intense and complex work of performing an esophagoscopy procedure in the facility setting with a rigid scope, under general anesthesia. **Therefore, we are recommending an increased work RVU of 2.78 for CPT 43191 which is above the existing RVU of 1.59, and equals the survey's 25<sup>th</sup> percentile.**

We believe the above recommendation is also supported by the key reference code, 31622, which has an identical work RVU of 2.78 and which survey respondents indicated was similar in intensity and complexity to the new 4319X1 CPT code. We are also providing the following reference tables which include recently reviewed services which support our requested values for physician time and work for CPT 43191.

#### Comparison to key reference code

<u>CPT Code</u>	<u>RVW</u>	<u>IWPUT</u>	<u>Total Time</u>	<u>Eval</u>	<u>Posit</u>	<u>SDW</u>	<u>INTRA</u>	<u>Post</u>
<b>43191</b>	2.78	0.0722	86	35	6	10	20	15
<b>31622</b>	2.78	0.0689	65	10	5	5	30	15

#### Comparison to MPC codes

<u>CPT Code</u>	<u>Descriptor</u>	<u>RVW</u>	<u>IWPUT</u>	<u>Total Time</u>	<u>Eval</u>	<u>Posit</u>	<u>SDW</u>	<u>INTRA</u>	<u>Post</u>
<b>51102</b>	Aspiration of bladder; with insertion of suprapubic catheter	2.70	0.0938	60	19	1	5	20	15
<b>43191</b>	Esophagoscopy, rigid transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed.	2.78	0.0722	86	35	6	10	20	15
<b>19103</b>	Biopsy of breast; percutaneous, automated vacuum assisted or rotating	3.69	0.0969	65	20	0	0	30	15

The table below compares the survey code to other RUC reviewed codes of similar time and work, providing further support that the recommended value for 4319X1 is appropriate.

<u>RUC Reviewed</u>	<u>CPT Code</u>	<u>Descriptor</u>	<u>RVW</u>	<u>IWPUT</u>	<u>Total Time</u>	<u>Eval</u>	<u>Posit</u>	<u>SDW</u>	<u>INTRA</u>	<u>Post</u>
2003	<b>36556</b>	Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older	2.50	0.1192	50	15	5	5	15	10
2007	<b>49452</b>	Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s),	2.86	0.1017	60	20	5	5	20	10
2003	<b>31623</b>	Bronchoscopy, rigid or flexible, including fluoroscopic guidance	2.88	0.0661	70	20	0	0	30	20
2010	<b>52007</b>	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation,	3.02	0.0614	82	19	5	5	32.5	20

#### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☒ Other reason (please explain) Diagnostic evaluation under anesthesia of a patient with cancer in the upper aerodigestive tract often includes both laryngoscopy and esophagoscopy using different instruments for evaluation of distinct regions.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Diagnostic rigid esophagoscopy would typically be reported with one of the following laryngoscopy codes. See clinical explanation above. When coded together, the primary procedure or service will be reported as listed. The additional procedure or service will be identified by appending modifier 51 to the additional procedure or service code.

CPT Code	Global	Work RVU	Pre time	Intra	Post
43191	000	2.78	51	20	15
31525	000	2.63	14	19	14
31526	000	2.57	30	32	16
31535	000	3.16	35	24	13
31536	000	3.55	32	39	12

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43200

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otolaryngology                      How often? Commonly

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 18957

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This is based on several assumptions. First, that 71 percent of the existing 43200 will continue to be attributable to Otolaryngology. Second, that 60 percent of the Otolaryngology portion of the existing 43200 volume will be reported using the new 4319X1 code, 30 percent will be attributed to the revised 43200 code, and 10 percent will be attributed to the new 4319X7 code. In addition, we have assumed that the national volume will be three times that of the Medicare volume given that about 1/3 of the patient population with cancer will be elderly and Medicare patients.

Specialty Otolaryngology                      Frequency 18957                      Percentage 100.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %



Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 6,319

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is based on the assumption that 60 percent of the current Otolaryngology volume for existing CPT 43200 will be represented by the new CPT code 43191.

Specialty Otolaryngology	Frequency 6319	Percentage 100.00 %
--------------------------	----------------	---------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 31575

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43192      Tracking Number C2      Original Specialty Recommended RVU: **3.21**  
 Presented Recommended RVU: **3.21**  
 Global Period: 000      RUC Recommended RVU: **3.21**

CPT Descriptor: Esophagoscopy, rigid, transoral; with directed submucosal injection(s), any substance.

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 75-year-old man with a history of radiation therapy for lung cancer has difficulty swallowing due to an esophageal stricture. A rigid esophagoscopy is performed and the stenotic area is injected with steroid solution.

Percentage of Survey Respondents who found Vignette to be Typical: 81%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 26%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 3%

**Description of Pre-Service Work:**

- Select and order the appropriate antibiotic(s) and confirm timing and administration.
- Assure appropriate selection, timing, and administration of DVT prophylaxis.
- Assess need for beta-blockers, order as required.
- Review medical history, pathology, and radiology report
- Review radiographic images
- Review results of preoperative testing (labs, EKG, CXR)
- Review reports of consultants providing preoperative assessment and clearance as indicated
- Meet with patient and family to review planned procedure and postoperative management
- Reexamine patient to ensure that physical findings have not changed and dictate history and physical
- Obtain informed consent
- Review airway and medical management with anesthesiologist
- Review planned procedure with OR staff
- Verify that all required instruments and supplies are available, set up scopes, suction, light source, injection needle, steroid/medication) to ensure readiness
- Change into scrub clothes
- Observe/wait during induction of anesthesia and intubation
- Monitor/assist with positioning of the patient (supine, shoulder roll, ensure security and position of endotracheal tube)
- Ensure that radiographic images are available in the OR
- Monitor/assist with draping
- Scrub and gown

- Operating table is turned with head toward endoscopist
- Perform surgical "time out" with operating surgical team.

#### Description of Intra-Service Work:

The mouth is opened and teeth/gums protected. Suction pharyngeal secretions. Rigid esophagoscope is introduced and passed through mouth, behind the endotracheal tube and larynx into cricopharyngeus and into the esophagus. The esophagoscope is advanced, the mucosa is evaluated, and a stricture is encountered and visualization optimized, readjusting scope and patient position as needed to ensure safe and smooth passage of the scope and suctioning secretions. Photodocumentation is obtained. The stenotic ring is injected in several locations under direct vision and blood is removed with suction, observing the injection site while bleeding dissipates. Hemostatic treatment is provided as needed. The esophagoscope is removed and the pharynx examined for bleeding and suctioned free of secretions. The patient is returned to the anesthesia position.

#### Description of Post-Service Work:

- Monitor patient during reversal of anesthesia. Monitor transport of patient from OR to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff. Write postoperative orders. Discuss procedure and operative findings with family and the patient.
- Write postoperative note. Dictate operative note and copy to referring physician.
- Monitor patient progress. Chart notes.
- Monitor overall medical condition of the patient including fluid balance, vital signs, and urinary function
- Assess pain scores and adequacy of analgesia.
- Discuss post-discharge management with nursing staff and answer questions
- Home restrictions (i.e., diet, activity) are discussed with the patient, family members and discharging nurse.
- Write prescriptions for medications and supplies needed post-discharge
- Perform medication reconciliation
- All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	10/2012				
<b>Presenter(s):</b>	Wayne Koch, MD				
<b>Specialty(s):</b>	AAO-HNS				
<b>CPT Code:</b>	43192				
<b>Sample Size:</b>	709	<b>Resp N:</b>	31	<b>Response:</b> 4.3 %	
<b>Description of Sample:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	2.00	5.00	10.00	30.00
<b>Survey RVW:</b>	2.45	3.21	3.45	4.50	11.11
<b>Pre-Service Evaluation Time:</b>			40.00		
<b>Pre-Service Positioning Time:</b>			10.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10.00		
<b>Intra-Service Time:</b>	10.00	20.00	23.00	38.00	60.00
<b>Immediate Post Service-Time:</b>	<b>20.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

4 - FAC Difficult Patient/Difficult Procedure

<b>CPT Code:</b>	43192	<b>Recommended Physician Work RVU: 3.21</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		40.00	40.00	0.00
<b>Pre-Service Positioning Time:</b>		6.00	3.00	3.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		10.00	20.00	-10.00
<b>Intra-Service Time:</b>		23.00		
<b>Immediate Post Service-Time:</b>	<b>20.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00		

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31625	000	3.36	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, with or without fluroscopic guidance; with bronchial or endobronchial biopsy(s), single or multiple sites.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
31622	000	2.78	RUC Time	83,622

CPT Descriptor 1 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
19103	000	3.69	RUC Time	116,377

CPT Descriptor 2 Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
50386	000	3.30	RUC Time

CPT Descriptor Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of systoscopy, including radiological supervision and interpretation

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 15      % of respondents: 48.3 %**

**TIME ESTIMATES (Median)**

	<b>CPT Code: 43192</b>	<b>Key Reference CPT Code: 31625</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	56.00	25.00	
Median Intra-Service Time	23.00	30.00	
Median Immediate Post-service Time	20.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>99.00</b>	<b>70.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.40	3.27
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.33	3.20
Urgency of medical decision making	3.20	3.20

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.73	3.53
Physical effort required	3.53	3.33

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.87	3.47
Outcome depends on the skill and judgment of physician	3.67	3.53
Estimated risk of malpractice suit with poor outcome	3.87	3.27

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.20	3.07
Intra-Service intensity/complexity	3.67	3.53
Post-Service intensity/complexity	2.80	2.93

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Why is this code being reviewed?**

The esophagoscopy family of codes 43200-43232 was identified in the CY 2012 Final Physician Fee Schedule by CMS as potentially misvalued services. In response to this request, several Gastroenterology societies proposed a schedule for review of all the gastrointestinal endoscopic services, during the January RAW subcommittee meeting. This action plan was approved. Subsequently, a code change proposal was submitted for the May 2012 CPT meeting which created 8 new codes to describe transoral approach with a rigid scope and transnasal approach with a flexible scope. These services were previously reported using the 43200 series of (Esophagoscopy, rigid or flexible) codes. The 43200 series of codes were revised to limit use to esophagoscopies performed using a transoral approach with a flexible scope. This revised family of codes is now being presented for valuation by the AMA RUC at the October 2012 meeting

### **Physician Time**

#### **Pre Time**

Regarding physician time, we recommend using pre-service package 4 (difficult patient/difficult procedure) which includes 40 minutes of evaluation, 3 minutes of positioning, and 20 minutes of scrub, dress, and wait time. Our expert panel felt this package was most appropriate given that the vignette for this service represents an elderly patient with cancer who requires a rigid esophagoscopy procedure. Our experts believed this patient is often sicker and more complex than a standard patient undergoing flexible, transoral esophagoscopy. In addition, this procedure is only performed in the facility setting and must be done under general anesthesia. Therefore, prepackage 4 is most appropriate for the preservice work required for the typical patient. Our experts felt that the 40 minutes of evaluation time associated with prepackage 4 was appropriate for this procedure. This was also supported by our survey responses. Therefore we recommend the prepackage 4 standard of 40 minutes for evaluation. In contrast, our panel reviewed the 20 minutes of scrub dress and wait time assigned by the prepackage and felt this amount of time was not necessary for this procedure. Therefore we recommend reducing this to 10 minutes for scrub, dress and wait which is also consistent with our survey responses. In addition, we believe that the package time of 3 minutes for positioning is not sufficient for patients undergoing this procedure and therefore, recommend adding 3 minutes of positioning time. We believe this increase in positioning time is justified, given that the physician must position the patient in the supine position, places a shoulder roll, ensure security and position the endotracheal tube together with the anesthetist. Prior to beginning the procedure, the operating table must also be turned so that the patient's head is facing the endoscopist. These modifications result in an overall pre-service time recommendation of 40/6/10 for 43192.

#### **Intra Time**

Our expert panel agreed with our surveyees regarding the time for intra service work and are recommending the survey median time of 23 minutes for intra service work.

#### **Post Time**

Likewise, our experts felt that the survey's post time was an accurate reflection of the post time required for this procedure and are recommending the median post time of 20 minutes. This results in a request for a total of 99 minutes of physician work time for CPT 43192.

### **Physician Work / Compelling Evidence**

After concluding the survey, the results were analyzed by our expert panel and it was determined that for the newly developed rigid esophagoscopy codes (43191-6) the existing work RVUs were not sufficient for the amount of work being done for procedures where the physician is using a rigid scope in the facility setting, under general anesthesia. While the existing code, 43201, was surveyed in 2002, no Otolaryngologists participated in the survey due to the dominant providers of the existing code being Gastroenterology (55%) and the extremely low volume of this service (506 in 2011). Therefore, it is unlikely that the work for Esophagoscopy, rigid, transoral; with directed submucosal injection(s), any substance has ever been properly valued, or even considered, as part of the survey for 43201, as Gastroenterologists do not perform esophagoscopy procedures using a rigid endoscope.

Thus, we believe there is compelling evidence for re-valuation of the new CPT code 43192 given that incorrect assumptions were made in previous valuations of the service where the dominant provider of rigid esophagoscopy services, Otolaryngology, were not included in the survey of the former combination code (43201). Upon review of this history, our expert panel determined that the work RVU for the existing service (Esophagoscopy, rigid or flexible; with directed submucosal injection(s), any substance) is not sufficient to value the work performed when the procedure is administered in the facility setting, using a rigid scope, under general anesthesia. Our expert panel therefore, recommends that the RVW for the new code 43192 (Esophagoscopy, rigid, transoral; with directed submucosal injection(s), any substance) should be increased based on the compelling evidence, outlined above, to more accurately represent the correct specialty mix for rigid esophagoscopy procedures as well as the more intense and complex work of performing an esophagoscopy procedure in

the facility setting with a rigid scope, under general anesthesia. **Therefore, we are recommending an increased work RVU of 3.21 for CPT 43192 which is above the existing RVU of 2.09, but equals the 25<sup>th</sup> percentile value indicated by our survey.**

This recommendation is supported by the key reference code 31625 which survey respondents said was slightly less intense and complex than the new code, 43192, being reviewed. 31625 includes a work RVU of 3.36 and less total physician time (65 minutes). We are also providing the following reference tables which include recently reviewed services which support our requested values for physician time and work for CPT 43192.

**Comparison to key reference code**

<u>CPT Code</u>	<u>RVW</u>	<u>IWPUT</u>	<u>Total Time</u>	<u>Eval</u>	<u>Posit</u>	<u>SDW</u>	<u>INTRA</u>	<u>Post</u>
<b>43192</b>	3.21	0.0718	99	40	6	10	23	20
<b>31625</b>	3.36	0.0869	70	10	5	10	30	15

**Comparison to MPC codes**

<u>CPT Code</u>	<u>Descriptor</u>	<u>RVW</u>	<u>IWPUT</u>	<u>Total Time</u>	<u>Eval</u>	<u>Posit</u>	<u>SDW</u>	<u>INTRA</u>	<u>Post</u>
<b>31622</b>	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed	2.78	0.0689	65	10	5	5	30	15
<b>43192</b>	Esophagoscopy, rigid, transoral; with directed submucosal injection(s), any substance.	3.21	0.0718	99	40	6	10	23	20
<b>19103</b>	Biopsy of breast; percutaneous, automated vacuum assisted or rotating	3.69	0.0969	65	20	0	0	30	15

The table below compares the survey code to other RUC reviewed codes of similar time and work, providing further support that the recommended value for 43192 is appropriate.

<u>RUC Reviewed</u>	<u>CPT Code</u>	<u>Descriptor</u>	<u>RVW</u>	<u>IWPUT</u>	<u>Total Time</u>	<u>Eval</u>	<u>Posit</u>	<u>SDW</u>	<u>INTRA</u>	<u>Post</u>
2007	<b>49452</b>	Replacement of gastro-jejunoscopy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	2.86	0.1018	60	20	5	5	20	10
2010	<b>52007</b>	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation,	3.02	0.0614	82	19	5	5	32.5	20
2007	<b>50368</b>	Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach	3.30	0.0699	90	25	10	10	30	15
2011	<b>15273</b>	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm	3.50	0.0925	100	40	10	10	20	20

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.



- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43201

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otolaryngology                      How often? Sometimes

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 383

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This is based on several assumptions. First, that 36 percent of the existing 43200 will continue to be attributable to Otolaryngology. Second, that 70 percent of the Otolaryngology portion of 43200 will be reported using the new 43192 code and 30 percent will be reported with the revised 43201 code. In addition, we have assumed that the national volume of the new 43192 code will be three times that of the Medicare volume given that about 1/3 of the patient population with cancer will be elderly and Medicare age patients.

Specialty Otolaryngology                      Frequency 383                      Percentage 100.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 128

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is based on the assumption that 70 percent of the current Otolaryngology volume for existing CPT 43201 will be represented by the new CPT code 43192.

Specialty Otolaryngology                      Frequency 128                      Percentage 100.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? No

## Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 31575

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43193      Tracking Number   C3      Original Specialty Recommended RVU: **3.36**  
 Presented Recommended RVU: **3.36**  
 Global Period: 000      RUC Recommended RVU: **3.36**

CPT Descriptor: Esophagoscopy, rigid, transoral; with biopsy, single or multiple.

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 60 year-old man with newly diagnosed squamous cell carcinoma of the oral cavity presents with dysphagia. A rigid esophagoscopy is performed revealing a lesion in mid esophagus. A biopsy of the lesion is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 31%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 3%

**Description of Pre-Service Work:**

- Select and order the appropriate antibiotic(s) and confirm timing and administration.
- Assure appropriate selection, timing, and administration of DVT prophylaxis.
- Assess need for beta-blockers, order as required.
- Review medical history, pathology, and radiology report
- Review radiographic images
- Review results of preoperative testing (labs, EKG, CXR)
- Review reports of consultants providing preoperative assessment and clearance as indicated
- Meet with patient and family to review planned procedure and postoperative management
- Reexamine patient to ensure that physical findings have not changed and dictate history and physical
- Obtain informed consent
- Review airway and medical management with anesthesiologist
- Review planned procedure with OR staff
- Verify that all required instruments and supplies are available, set up scopes, suction, light source, biopsy forceps) to ensure readiness
- Change into scrub clothes
- Observe/wait during induction of anesthesia and intubation.
- Monitor/assist with positioning of the patient (supine, shoulder roll, ensure security and position of endotracheal tube)
- Ensure that radiographic images are available in the OR
- Monitor/assist with draping

- Scrub and gown
- Operating table is turned with head toward endoscopist
- Perform surgical "time out" with operating surgical team.

#### Description of Intra-Service Work:

The mouth is opened and teeth/gums protected. Suction pharyngeal secretions. Rigid esophagoscope is introduced and passed through mouth, behind the endotracheal tube and larynx into cricopharyngeus and into the esophagus. The esophagoscope is advanced to the stomach and visualization optimized, readjusting scope and patient position as needed to ensure safe and smooth passage of the scope and suctioning secretions. A suspicious lesion is visualized and the location (distance from the upper incisors) documented along with photodocumentation. Biopsy forceps are passed through the esophagoscope under direct vision and several samples obtained and placed in specimen containers. Blood is removed with suction, observing the biopsy site while bleeding dissipates. Hemostatic treatment is performed as needed. The esophagoscope is removed and the pharynx examined for bleeding and suctioned free of secretions. The patient is returned to the anesthesia position. Pathology requisition form is reviewed and signed.

#### Description of Post-Service Work:

- Monitor patient during reversal of anesthesia. Monitor transport of patient from OR to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff. Write postoperative orders. Discuss procedure and operative findings with family and the patient.
- Write postoperative note. Dictate operative note and copy to referring physician.
- Monitor patient progress. Chart notes.
- Monitor overall medical condition of the patient including fluid balance, vital signs, and urinary function
- Assess pain scores and adequacy of analgesia.
- Discuss post-discharge management with nursing staff and answer questions
- Home restrictions (i.e., diet, activity) are discussed with the patient, family members and discharging nurse.
- Write prescriptions for medications and supplies needed post-discharge
- Perform medication reconciliation
- All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	10/2012				
<b>Presenter(s):</b>	Wayne Koch, MD				
<b>Specialty(s):</b>	AAO-HNS				
<b>CPT Code:</b>	43193				
<b>Sample Size:</b>	709	<b>Resp N:</b>	35	<b>Response:</b> 4.9 %	
<b>Description of Sample:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	3.00	8.00	17.50	150.00
<b>Survey RVW:</b>	3.00	3.36	3.36	4.08	11.11
<b>Pre-Service Evaluation Time:</b>			40.00		
<b>Pre-Service Positioning Time:</b>			10.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10.00		
<b>Intra-Service Time:</b>	10.00	20.00	30.00	30.00	60.00
<b>Immediate Post Service-Time:</b>	<b>20.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

4 - FAC Difficult Patient/Difficult Procedure

<b>CPT Code:</b>	43193	<b>Recommended Physician Work RVU: 3.36</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		40.00	40.00	0.00
<b>Pre-Service Positioning Time:</b>		6.00	3.00	3.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		10.00	20.00	-10.00
<b>Intra-Service Time:</b>		30.00		
<b>Immediate Post Service-Time:</b>	<b>20.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00		

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31625	000	3.36	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, with or without fluroscopic guidance; with bronchial or endobronchial biopsy(s), single or multiple sites.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
31622	000	2.78	RUC Time	83,622

CPT Descriptor 1 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
19103	000	3.69	RUC Time	116,377

CPT Descriptor 2 Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
50386	000	3.30	RUC Time

CPT Descriptor Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 24      % of respondents: 68.5 %**

**TIME ESTIMATES (Median)**

	<b>CPT Code: 43193</b>	<b>Key Reference CPT Code: 31625</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	56.00	25.00	
Median Intra-Service Time	30.00	30.00	
Median Immediate Post-service Time	20.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>106.00</b>	<b>70.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.58	3.42
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.38
Urgency of medical decision making	3.42	3.29

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.67	3.58
Physical effort required	3.46	3.29

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.08	3.67
Outcome depends on the skill and judgment of physician	3.75	3.58
Estimated risk of malpractice suit with poor outcome	4.04	3.58

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.33	3.33
Intra-Service intensity/complexity	3.58	3.46
Post-Service intensity/complexity	3.33	3.21

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Why is this code being reviewed?**

The esophagoscopy family of codes 43200-43232 was identified in the CY 2012 Final Physician Fee Schedule by CMS as potentially misvalued services. In response to this request, several Gastroenterology societies proposed a schedule for review of all of the gastrointestinal endoscopic services, during the January RAW subcommittee meeting. This action plan was approved. Subsequently, a code change proposal was submitted for the May 2012 CPT meeting which created 8 new codes to describe transoral approach with a rigid scope and transnasal approach with a flexible scope. These services were previously reported using the 43200 series of (Esophagoscopy, rigid or flexible) codes. The 43200 series of codes were revised to limit use to esophagoscopies performed using a transoral approach with a flexible scope. This revised family of codes is now being presented for valuation by the AMA RUC at the October 2012 meeting.

## **Physician Time**

### **Pre Time**

Regarding physician time, we recommend using pre-service package 4 (difficult patient/difficult procedure) which includes 40 minutes of evaluation, 3 minutes of positioning, and 20 minutes of scrub, dress, and wait time. Our expert panel felt this package was most appropriate given that the vignette for this service represents an elderly patient with cancer who requires a rigid esophagoscopy procedure. Our experts believed this patient is often sicker and more complex than a standard patient undergoing flexible, transoral esophagoscopy. In addition, this procedure is only performed in the facility setting and must be done under general anesthesia. Therefore, prepackage 4 is most appropriate for the preservice work required for the typical patient. Our experts felt that the 40 minutes of evaluation time associated with prepackage 4 was appropriate for this procedure. This was also supported by our survey responses. Therefore we recommend the prepackage 4 standard of 40 minutes for evaluation. In contrast, our panel reviewed the 20 minutes of scrub dress and wait time assigned by the prepackage and felt this amount of time was not necessary for this procedure. Therefore we recommend reducing this to 10 minutes for scrub, dress and wait which is also consistent with our survey responses. In addition, we believe that the package time of 3 minutes for positioning is not sufficient for patients undergoing this procedure and therefore, recommend adding 3 minutes of positioning time. We believe this increase in positioning time is justified, given that the physician must position the patient in the supine position, places a shoulder roll, ensure security and position the endotracheal tube together with the anesthetist. Prior to beginning the procedure, the operating table must also be turned so that the patient's head is facing the endoscopist. These modifications result in an overall pre-service time recommendation of 40/6/10 for 43193.

### **Intra Time**

Our expert panel agreed with our surveyees regarding the time for intra service work and are recommending the survey median time of 30 minutes for intra service work.

### **Post Time**

Likewise, our experts felt that the survey's post time was an accurate reflection of the post time required for this procedure and are recommending the median post time of 20 minutes. This results in a request for a total of 106 minutes of physician work time for CPT 43193.

## **Physician Work / Compelling Evidence**

After concluding the survey, the results were analyzed by our expert panel and it was determined that for the newly developed rigid esophagoscopy codes (43191-6) the existing work RVUs were not sufficient for the amount of work being done for procedures where the physician is using a rigid scope in the facility setting, under general anesthesia. In addition, it has come to our attention that the previous code used to bill this service, 43202, is a Harvard valued code which was surveyed by 21 Gastroenterologists. Therefore, given that no Otolaryngologists participated in the original survey of the 43202 code, it is unlikely that the work for Esophagoscopy, rigid, transoral; with biopsy, single or multiple has ever been properly valued or even considered as part of the survey for 43202, as Gastroenterologists do not perform esophagoscopy procedures using a rigid endoscope.

Thus, we believe there is compelling evidence to increase the value of the new CPT code 43193 given that incorrect assumptions were made in previous valuations of the service where the dominant provider of rigid esophagoscopy services, Otolaryngology, were not included in the initial survey of the former combination code (43202). Upon review of this history, our expert panel determined that the work RVU for the existing service (Esophagoscopy, rigid or flexible; with biopsy, single or multiple) is not sufficient to value the work performed when the procedure is provided in the facility setting, using a rigid scope, under general anesthesia. Our expert panel therefore, recommends that the RVW for the new code 43193 (Esophagoscopy, rigid, transoral; with biopsy, single or multiple) should be re-valued based on the compelling evidence outlined above to more accurately represent the correct specialty mix for rigid esophagoscopy procedures as well as the more intense and complex work of performing an esophagoscopy procedure in the facility setting with a rigid scope,



under general anesthesia. **Therefore, we are recommending an increased work RVU of 3.36 for CPT 43193 which is above the existing RVU of 1.89, but equals the 25<sup>th</sup> percentile value recommended by survey respondents.**

This recommendation is supported by the key reference code 31625 which survey respondents said was less intense and complex which is valued at 3.36 work RVUs, but has significantly less time with 70 total minutes. We are also providing the following reference tables which include recently reviewed services that support our requested values for physician time and work for CPT 43193.

#### **Comparison to key reference code**

<b><u>CPT Code</u></b>	<b><u>RVW</u></b>	<b><u>IWPUT</u></b>	<b><u>Total Time</u></b>	<b><u>Eval</u></b>	<b><u>Posit</u></b>	<b><u>SDW</u></b>	<b><u>INTRA</u></b>	<b><u>Post</u></b>
<b>43193</b>	3.36	0.0600	106	40	6	10	30	20
<b>31625</b>	3.36	0.0869	70	10	5	10	30	15

#### **Comparison to MPC codes**

<b><u>CPT Code</u></b>	<b><u>Descriptor</u></b>	<b><u>RVW</u></b>	<b><u>IWPUT</u></b>	<b><u>Total Time</u></b>	<b><u>Eval</u></b>	<b><u>Posit</u></b>	<b><u>SDW</u></b>	<b><u>INTRA</u></b>	<b><u>Post</u></b>
<b>31622</b>	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic	2.78	0.0689	65	10	5	5	30	15
<b>43193</b>	Esophagoscopy, rigid, transoral; with biopsy, single or multiple.	3.36	0.0600	106	40	6	10	30	20
<b>19103</b>	Biopsy of breast; percutaneous,	3.69	0.0968	65	20	0	0	30	15

The table below compares the survey code to other RUC reviewed codes of similar time and work, providing further support that the recommended value for 43193 is appropriate.

<b><u>RUC Reviewed</u></b>	<b><u>CPT Code</u></b>	<b><u>Descriptor</u></b>	<b><u>RVW</u></b>	<b><u>IWPUT</u></b>	<b><u>Total Time</u></b>	<b><u>Eval</u></b>	<b><u>Posit</u></b>	<b><u>SDW</u></b>	<b><u>INTRA</u></b>	<b><u>Post</u></b>
2007	<b>49452</b>	Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	2.86	0.1018	60	20	5	5	20	10
2008	<b>62267</b>	Percutaneous aspiration within the nucleus pulposus, intervertebral disc, or paravertebral tissue for diagnostic purposes	3.00	0.0682	79	14	10	10	30	15
2007	<b>50386</b>	Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy,	3.30	0.0699	90	25	10	10	30	15
2000	<b>19103</b>	Biopsy of breast; percutaneous,	3.69	0.0968	65	20	0	0	30	15
2003	<b>31629</b>	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s),	4.09	0.1038	80	10	10	10	30	20

---

#### **SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☒ Other reason (please explain) Diagnostic evaluation under anesthesia of a patient with cancer in the upper aerodigestive tract often includes both laryngoscopy and esophagoscopy using different instruments for evaluation of distinct regions.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Diagnostic rigid esophagoscopy would typically be reported with one of the following laryngoscopy codes. See clinical explanation above. When coded together, the primary procedure or service will be reported as listed. The additional procedure or service will be identified by appending modifier 51 to the additional procedure or service code.

CPT Code	Global	Work RVU	Pre time	Intra	Post
43193	000	3.36	56	30	20
31525	000	2.63	14	19	14
31526	000	2.57	30	32	16
31535	000	3.16	35	24	13
31536	000	3.55	32	39	12

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43202

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otolaryngology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 2148

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This is based on several assumptions. First, that 31 percent of the existing 43203 will continue to be attributable to Otolaryngology. Second, that 60 percent of the Otolaryngology portion of 43203 volume will be reported using the new 43193 code, 30 percent will be reported using the revised 43203 code, and 10 percent will be attributed to the new 43198 code. In addition, we have assumed that the national volume of the new 43193 code will be three times that of the Medicare volume given that about 1/3 of the patient population with cancer will be elderly and Medicare patients.

Specialty Otolaryngology Frequency 2148 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 716  
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is based on the assumption that 60 percent of the current Otolaryngology volume for existing CPT 43203 will be represented by the new CPT code 43193.

Specialty Otolaryngology	Frequency 716	Percentage 100.00 %
--------------------------	---------------	---------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 31575

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43194      Tracking Number C4      Original Specialty Recommended RVU: **3.99**  
 Presented Recommended RVU: **3.99**  
 Global Period: 000      RUC Recommended RVU: **3.99**

CPT Descriptor: Esophagoscopy, rigid, transoral; with removal of foreign body.

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 40 year-old woman is eating chicken and feels pain in her upper neck and chest, suspicious for having swallowed a bone. A rigid esophagoscopy is performed with the bone visualized in the distal esophagus. The foreign body is removed.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 26%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

**Description of Pre-Service Work:**

- Review history and examination.  
Select and order the appropriate antibiotic(s) and confirm timing and administration.
- Review medication history, and radiology report
- Review radiographic images
- Review results of preoperative testing (labs, EKG, CXR)
- Review reports of consultants providing preoperative assessment and clearance as indicated
- Meet with patient and family to review planned procedure and postoperative management
- Obtain informed consent
- Review airway and medical management with anesthesiologist
- Review planned procedure with OR staff
- Verify that all required instruments and supplies are available, set up scopes, optical forceps, suction, light source,) to ensure readiness
- Change into scrub clothes
- Observe/wait during induction of anesthesia and intubation.
- Monitor/assist with positioning of the patient (supine, shoulder roll, ensure security and position of endotracheal tube)
- Ensure that radiographic images are available in the OR
- Monitor/assist with draping
- Scrub and gown
- Operating table is turned with head toward endoscopist

- Perform surgical "time out" with operating surgical team.

#### Description of Intra-Service Work:

The mouth is opened and teeth/gums protected. Suction pharyngeal secretions. Rigid esophagoscope is introduced and passed through mouth, behind the endotracheal tube and larynx into cricopharyngeus and into the esophagus. The esophagoscope is advanced to the foreign body and visualization optimized and the location (distance from the upper incisors) is documented. The scope and patient position are adjusted as needed to ensure safe and smooth passage of the scope and suctioning secretions. Select appropriate instrument for removal of foreign body and pass through the esophagoscope under direct vision to grasp the object. Remove the foreign body (through the scope for small object, with the scope for large objects). Revisualize the site of foreign body impaction. Blood is removed with suction, observing the site for damage and while bleeding dissipates. Photodocumentation is obtained. The esophagoscope is removed and the pharynx examined for bleeding and suctioned free of secretions. The patient is returned to the anesthesia position. Pathology requisition form is reviewed and signed.

#### Description of Post-Service Work:

- Monitor patient during reversal of anesthesia. Monitor transport of patient from OR to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff. Write postoperative orders. Discuss procedure and operative findings with family and the patient.
- Order chest xray, wait for xray to become available, review films with radiologist.
- Write postoperative note. Dictate operative note and copy to referring physician.
- Monitor patient progress. Chart notes.
- Monitor overall medical condition of the patient including fluid balance, vital signs, and urinary function
- Assess pain scores and adequacy of analgesia.
- Discuss post-discharge management with nursing staff and answer questions
- Home restrictions (i.e., diet, activity) are discussed with the patient, family members and discharging nurse.
- Write prescriptions for medications and supplies needed post-discharge
- Perform medication reconciliation
- All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	10/2012				
<b>Presenter(s):</b>	Wayne Koch, MD				
<b>Specialty(s):</b>	AAO-HNS				
<b>CPT Code:</b>	43194				
<b>Sample Size:</b>	709	<b>Resp N:</b>	34	<b>Response:</b> 4.7 %	
<b>Description of Sample:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	2.25	5.00	10.00	25.00
<b>Survey RVW:</b>	3.00	3.99	4.74	4.88	28.00
<b>Pre-Service Evaluation Time:</b>			40.00		
<b>Pre-Service Positioning Time:</b>			10.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10.00		
<b>Intra-Service Time:</b>	10.00	20.00	30.00	45.00	90.00
<b>Immediate Post Service-Time:</b>	<b>28.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

3 -FAC Straightforward Patient/Difficult Procedure

<b>CPT Code:</b>	43194	<b>Recommended Physician Work RVU: 3.99</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		33.00	33.00	0.00
<b>Pre-Service Positioning Time:</b>		6.00	3.00	3.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		10.00	15.00	-5.00
<b>Intra-Service Time:</b>		30.00		
<b>Immediate Post Service-Time:</b>	<b>28.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31638	000	4.88	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, with or without fluroscopic guidance; with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required).

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
19103	000	3.69	RUC Time	116,377

CPT Descriptor 1 Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
52276	000	4.99	RUC Time	11,155

CPT Descriptor 2 Cystourethroscopy with direct vision internal urethrotomy

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
20660	000	4.00	RUC Time

CPT Descriptor Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure)

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 14      % of respondents: 41.1 %**

**TIME ESTIMATES (Median)**

	<b>CPT Code: 43194</b>	<b>Key Reference CPT Code: 31638</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	49.00	50.00	
Median Intra-Service Time	30.00	60.00	
Median Immediate Post-service Time	28.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
<b>Median Total Time</b>	<b>107.00</b>	<b>140.00</b>	

Other time if appropriate		
---------------------------	--	--

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.14	3.43
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.29	3.43
--	------	------

Urgency of medical decision making	3.93	3.64
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.43	4.21
--------------------------	------	------

Physical effort required	3.71	3.57
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.36	4.14
---	------	------

Outcome depends on the skill and judgment of physician	4.36	4.21
--	------	------

Estimated risk of malpractice suit with poor outcome	4.14	3.86
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.64	3.43
----------------------------------	------	------

Intra-Service intensity/complexity	3.93	3.79
------------------------------------	------	------

Post-Service intensity/complexity	3.50	3.36
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Why is this code being reviewed?**

The esophagoscopy family of codes 43200-43232 was identified in the CY 2012 Final Physician Fee Schedule by CMS as potentially misvalued services. In response to this request, several Gastroenterology societies proposed a schedule for review of all of the gastrointestinal endoscopic services, during the January RAW subcommittee meeting. This action plan



was approved. Subsequently, a code change proposal was submitted for the May 2012 CPT meeting which created 8 new codes to describe transoral approach with a rigid scope and transnasal approach with a flexible scope. These services were previously reported using the 43200 series of (Esophagoscopy, rigid or flexible) codes. The 43200 series of codes were revised to limit use to esophagoscopies performed using a transoral approach with a flexible scope. This revised family of codes is now being presented for valuation by the AMA RUC at the October 2012 meeting

## **Physician Time**

### **Pre Time**

Regarding physician time, we recommend using pre-service package 3 (Straightforward Patient/Difficult Procedure) which includes 33 minutes of evaluation, 3 minutes of positioning, and 15 minutes of scrub, dress, and wait time. Our expert panel felt this package was most appropriate given that the vignette for this service represents a middle aged patient who most likely presents in the emergency room setting and requires a rigid esophagoscopy procedure. Our experts believed this procedure is more complex than a standard flexible, transoral esophagoscopy due to the fact that it is performed using a rigid scope under general anesthesia. Therefore, prepackage 3 is the most appropriate for the preservice work required for the typical patient. Our experts felt the 33 minutes of evaluation time associated with prepackage 3 was appropriate for this procedure, and in fact, our survey respondents indicated they required 40 minutes for evaluation of the patient undergoing this procedure. Despite this, our expert panel recognized that it is the policy of the RUC to accept preservice package times in scenarios where the survey exceeds the prepackage allotted time. Therefore, we recommend the standard 33 minutes for evaluation. Similarly, our panel reviewed the 15 minutes of scrub dress and wait time assigned by the prepackage and felt this amount of time was not necessary for this procedure. Therefore we recommend reducing this to 10 minutes for scrub, dress and wait which is also consistent with our survey responses. In contrast, we believe that the package time of 3 minutes for positioning is not sufficient for patients undergoing this procedure and therefore, recommend adding 3 minutes of positioning time. We believe this increase in positioning time is justified, given that the physician must position the patient in the supine position, places a shoulder roll, ensure security and position the endotracheal tube together with the anesthetist. Prior to beginning the procedure, the operating table must also be turned so that the patient's head is facing the endoscopist. These modifications result in an overall pre-service time recommendation of 33/6/10 for 43194.

### **Intra Time**

Our expert panel agreed with our surveyees regarding the time for intra service work and are recommending the survey median time of 30 minutes for intra service work.

### **Post Time**

Likewise, our experts felt that the survey's post time was an accurate reflection of the post time required for this procedure and are recommending the median post time of 28 minutes. This results in a request for a total of 107 minutes of physician work time for CPT 43194.

## **Physician Work / Compelling Evidence**

After concluding the survey, the results were analyzed by our expert panel and it was determined that for the newly developed rigid esophagoscopy codes (43191-6) the existing work RVUs were not sufficient for the amount of work being done for procedures where the physician is using a rigid scope in the facility setting, under general anesthesia. In addition, it has come to our attention that the previous code used to bill this service, 43215, is a Harvard valued code which was surveyed by 21 Gastroenterologists. Therefore, given that no Otolaryngologists participated in the original survey of the 43215 code, it is unlikely that the work for Esophagoscopy, rigid, transoral; with removal of foreign body has ever been properly valued, or even considered, as part of the survey for 43215, as Gastroenterologists do not perform esophagoscopy procedures using a rigid endoscope.

Thus, we believe there is compelling evidence for re-valuation of the new CPT code 43194 given that incorrect assumptions were made in previous valuations of the service where the dominant provider of rigid esophagoscopy services, Otolaryngology, were not included in the initial survey of the former combination code (43215). Upon review of this history, our expert panel determined that the work RVU for the existing service (Esophagoscopy, rigid or flexible; with removal of foreign body) is not sufficient to value the work performed when the procedure is provided in the facility setting, using a rigid scope, under general anesthesia. Our expert panel therefore, recommends that the RVW for the new code 43194 (Esophagoscopy, rigid, transoral; with removal of foreign body) should be increased based on the compelling evidence outlined above to more accurately represent the correct specialty mix for rigid esophagoscopy procedures as well as the more intense and complex work of performing an esophagoscopy procedure in the facility setting with a rigid scope, under general anesthesia. **Therefore, we are recommending an increased work RVU of 3.99 for CPT 43194 which is higher than the existing RVU of 2.60, but equals the survey's 25<sup>th</sup> percentile.**

This recommendation is supported by the key reference code 31638 which survey respondents said was similar in intensity and complexity, but is valued at a higher work RVU of 4.88 and includes additional physician time equaling 140 minutes. We are also providing the following reference tables which include recently reviewed services that support our requested values for physician time and work for CPT 43194.

#### Comparison to key reference code

<u>CPT Code</u>	<u>RVW</u>	<u>IWPUT</u>	<u>Total Time</u>	<u>Eval</u>	<u>Posit</u>	<u>SDW</u>	<u>INTRA</u>	<u>Post</u>
<b>43194</b>	3.99	0.0806	107	33	6	10	30	28
<b>31638</b>	4.88	0.0550	140	20	15	15	60	30

#### Comparison to MPC codes

<u>CPT Code</u>	<u>Descriptor</u>	<u>RVW</u>	<u>IWPUT</u>	<u>Total Time</u>	<u>Eval</u>	<u>Posit</u>	<u>SDW</u>	<u>INTRA</u>	<u>Post</u>
<b>19103</b>	Biopsy of breast; percutaneous,	3.69	0.0968	65	20	0	0	30	15
<b>43194</b>	Esophagoscopy, rigid, transoral; with removal of foreign body.	3.99	0.0806	107	33	6	10	30	28
<b>52276</b>	Cystourethroscopy with direct vision internal urethrotomy	4.99	0.1041	95	30	0	0	35	30

The table below compares the survey code to other RUC reviewed codes of similar time and work, providing further support that the recommended value for 43194 is appropriate.

<u>RUC Reviewed</u>	<u>CPT Code</u>	<u>Descriptor</u>	<u>RVW</u>	<u>IWPUT</u>	<u>Total Time</u>	<u>Eval</u>	<u>Posit</u>	<u>SDW</u>	<u>INTRA</u>	<u>Post</u>
2007	<b>50386</b>	Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy,	3.30	0.0699	90	25	10	10	30	15
2004	<b>19296</b>	Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy,	3.63	0.0545	119	30	10	15	30	34
2007	<b>20660</b>	Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure)	4.00	0.0933	90	20	0	10	30	30
2004	<b>32550</b>	Insertion of indwelling tunneled pleural catheter with cuff	4.17	0.0989	90	15	15	10	30	20

#### **SERVICES REPORTED WITH MULTIPLE CPT CODES**

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.

- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43215

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otolaryngology                      How often? Sometimes

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1028

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This is based on several assumptions. First, that 18 percent of the existing 43215 will continue to be reported by Otolaryngology. Second, that 70 percent of the Otolaryngology portion of 43215 will be reported using the new 43194 code and 30 percent will be reported using the revised 43215 code. In addition, we have assumed that the national volume of the new 43194 code will be four times that of the Medicare volume due to the patient population representing a middle aged, or younger patient, rather than predominantly Medicare age patients.

Specialty Otolaryngology                      Frequency 1028                      Percentage 100.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 206

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is based on the assumption that 70 percent of the current Otolaryngology volume for existing CPT 43215 will be represented by the new CPT code 43194.

Specialty Otolaryngology                      Frequency 206                      Percentage 100.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? No

## Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 31575

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43195      Tracking Number C5      Original Specialty Recommended RVU: **3.48**  
 Presented Recommended RVU: **3.21**  
 Global Period: 000      RUC Recommended RVU: **3.21**

CPT Descriptor: Esophagoscopy, rigid, transoral; with balloon dilation (less than 30 mm diameter)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: An elderly patient with a peptic stricture of the distal esophagus presents with increasing dysphagia. A rigid esophagoscopy and a balloon dilation of the stricture are performed.

Percentage of Survey Respondents who found Vignette to be Typical: 71%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 29%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 4%

**Description of Pre-Service Work:**

- Select and order the appropriate antibiotic(s) and confirm timing and administration.
- Assure appropriate selection, timing, and administration of DVT prophylaxis.
- Assess need for beta-blockers, order as required.
- Review medical history, pathology, and radiology report
- Review radiographic images
- Review results of preoperative testing (labs, EKG, CXR)
- Review reports of consultants providing preoperative assessment and clearance as indicated
- Meet with patient and family to review planned procedure and postoperative management
- Reexamine patient to ensure that physical findings have not changed and dictate history and physical
- Obtain informed consent
- Review airway and medical management with anesthesiologist
- Review planned procedure with OR staff
- Verify that all required instruments and supplies are available, set up scopes, suction, light source, balloon catheters) to ensure readiness
- Change into scrub clothes
- Observe/wait during induction of anesthesia and intubation.
- Monitor/assist with positioning of the patient (supine, shoulder roll, ensure security and position of endotracheal tube)
- Ensure that radiographic images are available in the OR
- Monitor/assist with draping
- Scrub and gown

- Operating table is turned with head toward endoscopist
- Perform surgical "time out" with operating surgical team.

#### Description of Intra-Service Work:

The mouth is opened and teeth/gums protected. Suction pharyngeal secretions. Rigid esophagoscope is introduced and passed through mouth, behind the endotracheal tube and larynx into cricopharyngeus and into the esophagus. The esophagoscope is advanced to the distal esophageal stricture and visualization optimized, the location (distance from the upper incisor) is documented. The scope and patient position is readjusted as needed to ensure safe and smooth passage of the scope and suctioning secretions. Photodocumentation is performed. A balloon catheter is selected and inserted under direct vision. The balloon is inflated with saline adjusting position as needed. The balloon is deflated and the effect of dilation viewed, repeating the inflation of balloon as indicated. The balloon is removed and blood is removed with suction, observing the dilation site while bleeding dissipates. Hemostatic treatment is performed as needed. The esophagoscope is removed and the pharynx examined for bleeding and suctioned free of secretions. The patient is returned to the anesthesia position.

#### Description of Post-Service Work:

- Monitor patient during reversal of anesthesia. Monitor transport of patient from OR to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff. Write postoperative orders. Discuss procedure and operative findings with family and the patient.
- Write postoperative note. Dictate operative note and copy to referring physician.
- Monitor patient progress. Chart notes.
- Monitor overall medical condition of the patient including fluid balance, vital signs, and urinary function
- Assess pain scores and adequacy of analgesia.
- Discuss post-discharge management with nursing staff and answer questions
- Home restrictions (i.e., diet, activity) are discussed with the patient, family members and discharging nurse.
- Write prescriptions for medications and supplies needed post-discharge
- Perform medication reconciliation
- All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	10/2012				
<b>Presenter(s):</b>	Wayne Koch, MD				
<b>Specialty(s):</b>	AAO-HNS				
<b>CPT Code:</b>	43195				
<b>Sample Size:</b>	710	<b>Resp N:</b>	24	<b>Response:</b> 3.3 %	
<b>Description of Sample:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	2.00	6.00	16.25	40.00
<b>Survey RVW:</b>	3.00	3.48	4.45	4.88	11.11
<b>Pre-Service Evaluation Time:</b>			40.00		
<b>Pre-Service Positioning Time:</b>			10.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10.00		
<b>Intra-Service Time:</b>	15.00	23.75	30.00	45.00	75.00
<b>Immediate Post Service-Time:</b>	<b>15.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

3 -FAC Straightforward Patient/Difficult Procedure

<b>CPT Code:</b>	43195	<b>Recommended Physician Work RVU: 3.21</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		33.00	33.00	0.00
<b>Pre-Service Positioning Time:</b>		6.00	3.00	3.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		10.00	15.00	-5.00
<b>Intra-Service Time:</b>		30.00		
<b>Immediate Post Service-Time:</b>	<b>15.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31625	000	3.36	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with bronchial or endobronchial biopsy(s), single or multiple sites.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
31622	000	2.78	RUC Time	83,622

CPT Descriptor 1 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
19103	000	3.69	RUC Time	116,377

CPT Descriptor 2 Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
50386	000	3.30	RUC Time

CPT Descriptor Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation.

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 9      % of respondents: 37.5 %**

**TIME ESTIMATES (Median)**

	<b>CPT Code: 43195</b>	<b>Key Reference CPT Code: 31625</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	49.00	25.00	
Median Intra-Service Time	30.00	30.00	
Median Immediate Post-service Time	15.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	



Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>94.00</b>	<b>70.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.11	2.89
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.33	3.00
--	------	------

Urgency of medical decision making	3.00	3.00
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.56	3.11
--------------------------	------	------

Physical effort required	3.00	2.78
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.89	3.11
---	------	------

Outcome depends on the skill and judgment of physician	3.78	3.11
--	------	------

Estimated risk of malpractice suit with poor outcome	4.00	3.00
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.11	2.89
----------------------------------	------	------

Intra-Service intensity/complexity	3.22	2.89
------------------------------------	------	------

Post-Service intensity/complexity	3.22	2.89
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Why is this code being reviewed?**

The esophagoscopy family of codes 43200-43232 was identified in the CY 2012 Final Physician Fee Schedule by CMS as potentially misvalued services. In response to this request, several Gastroenterology societies proposed a schedule for review of all the gastrointestinal endoscopic services, during the January RAW subcommittee meeting. This action plan was approved. Subsequently, a code change proposal was submitted for the May 2012 CPT meeting which created 8 new codes to describe transoral approach with a rigid scope and transnasal approach with a flexible scope. These services were previously reported using the 43200 series of (Esophagoscopy, rigid or flexible) codes. The 43200 series of codes were revised to limit use to esophagoscopies performed using a transoral approach with a flexible scope. This revised family of codes is now being presented for valuation by the AMA RUC at the October 2012 meeting

## **Physician Time**

### **Pre Time**

Regarding physician time, we recommend using pre-service package 3 (Straightforward Patient/Difficult Procedure) which includes 33 minutes of evaluation, 3 minutes of positioning, and 15 minutes of scrub, dress, and wait time. Our expert panel felt this package was most appropriate given that the vignette for this service indicates only that the patient is elderly and requiring rigid esophagoscopy, but does not indicate that they are presenting with cancer as was the case for new codes 43191-43193. Despite this, our experts noted this procedure is still more complex than a standard flexible, transoral esophagoscopy due to the fact that it is performed using a rigid scope under general anesthesia. Therefore, prepackage 3 is most appropriate for the preservice work required for the typical patient. Our experts felt the 33 minutes of evaluation time associated with prepackage 3 was appropriate for this procedure, and in fact our survey respondents indicated they required 40 minutes for evaluation of the patient undergoing this procedure. Despite this, our expert panel recognized that it is the policy of the RUC to accept preservice package times in scenarios where the survey exceeds the prepackage allotted time. Therefore, we recommend the standard 33 minutes for evaluation. Similarly, our panel reviewed the 15 minutes of scrub dress and wait time assigned by the prepackage and felt this amount of time was not necessary for this procedure. Therefore we recommend reducing this to 10 minutes for scrub, dress and wait which is also consistent with our survey responses. In contrast, we believe that the package time of 3 minutes for positioning is not sufficient for patients undergoing this procedure and therefore, recommend adding 3 minutes of positioning time. We believe this increase in positioning time is justified, given that the physician must position the patient in the supine position, places a shoulder roll, ensure security and position the endotracheal tube together with the anesthetist. Prior to beginning the procedure, the operating table must also be turned so that the patient's head is facing the endoscopist. These modifications result in an overall pre-service time recommendation of 33/6/10 for 43195.

### **Intra Time**

Our expert panel agreed with our surveyees regarding the time for intra service work and are recommending the survey median time of 30 minutes for intra service work.

### **Post Time**

Likewise, our experts felt that the survey's post time was an accurate reflection of the post time required for this procedure and are recommending the median post time of 15 minutes. This results in a request for a total of 94 minutes of physician work time for CPT 43195.

## **Physician Work / Compelling Evidence**

After concluding the survey, the results were analyzed by our expert panel and it was determined that for the newly developed rigid esophagoscopy codes (43191-6) the existing work RVUs were not sufficient for the amount of work being done for procedures where the physician is using a rigid scope in the facility setting, under general anesthesia. While the existing code, 43220, was surveyed in 1993, following significant coding changes to the gastrointestinal endoscopy section of CPT. However, the vignette used during that survey described only a flexible scope and no Otolaryngologists participated in the survey (the code was surveyed by GI and General Surgery) because the dominant providers of the existing code being Gastroenterology (49%) and the extremely low volume of this service (3,041 in 2011). Therefore, it is clear, based on the vignette used for the 1993 survey, that the work for Esophagoscopy, rigid, transoral; with balloon dilation (less than 30mm diameter), has ever been properly valued, or even considered, as part of the survey for 43220, as Gastroenterologists do not perform esophagoscopy procedures using a rigid endoscope and the vignette used did not consider the provision of this service using a rigid scope.

Thus, we believe there is compelling evidence for re-valuation of new CPT code 43195 given that incorrect assumptions were made in previous valuations of the service where the dominant provider of rigid esophagoscopy services, Otolaryngology, were not included in the survey of the former combination code (43220), and a vignette was used for survey that did not consider the use of a rigid scope. Upon review of this history, our expert panel determined that the

work RVU for the existing service (Esophagoscopy, rigid or flexible; with balloon dilation (less than 30mm diameter)) is not sufficient to value the work performed when the procedure is administered in the facility setting, using a rigid scope, under general anesthesia. Our expert panel therefore, recommends that the RVW for the new code, 43195, (Esophagoscopy, rigid, transoral; with balloon dilation (less than 30mm diameter) should be increased based on the compelling evidence, outlined above, to accurately represent the correct specialty mix and the use of a rigid scope for this procedure which represents more intense and complex work where a provider provides an esophagoscopy procedure in the facility setting, with a rigid scope, under general anesthesia. **Therefore, we are recommending an increased work RVU of 3.21 for CPT 43195 which is higher than the existing RVU of 2.10, but below the survey's 25<sup>th</sup> percentile.**

We arrived at this value in response to the discussion held at the pre-facilitation meeting for this family of codes, and determined that in order to maintain relativity among the new rigid, transoral esophagoscopy codes, the value for 43195 should be reduced below the 25<sup>th</sup> percentile to more accurately coincide with services in the rigid esophagoscopy group with similar work. We note that the work of 43195 is very similar to that of 43192. Specifically, the 43192 and 43195 code have similar intraservice and total time and although 43192 has fewer intraservice minutes, 43195 involves service provided to a less acute patient, and has slightly fewer total minutes. Therefore, we believe that 43195 involves very similar work to 43192 and these two codes should be valued the same. This recommendation is supported by the key reference code 31625 which survey respondents said was slightly less intense and complex, but similarly valued with a work RVU of 3.36 and with physician time of 70 total minutes; as well as several other comparator codes. The comparator codes used to support the value of 3.21 RVUs for 43195 are: 31296, nasal/sinus endoscopy with an RVU of 3.29, intra time of 30 minutes and total time of 88 minutes; as well as 50386, removal of internally dwelling ureteral stent, also with 30 minutes of intra time and 90 minutes of total time.

We are also providing the following reference tables which include recently reviewed services which support our requested values for physician time and work for CPT 43195.

#### **Comparison to key reference code**

<b><u>CPT Code</u></b>	<b><u>RVW</u></b>	<b><u>IWPUT</u></b>	<b><u>Total Time</u></b>	<b><u>Eval</u></b>	<b><u>Posit</u></b>	<b><u>SDW</u></b>	<b><u>INTRA</u></b>	<b><u>Post</u></b>
<b>43195</b>	3.21	0.0640	94	33	6	10	30	15
<b>31625</b>	3.36	0.0869	70	10	5	10	30	15

#### **Comparison to MPC codes**

<b><u>CPT Code</u></b>	<b><u>Descriptor</u></b>	<b><u>RVW</u></b>	<b><u>IWPUT</u></b>	<b><u>Total Time</u></b>	<b><u>Eval</u></b>	<b><u>Posit</u></b>	<b><u>SDW</u></b>	<b><u>INTRA</u></b>	<b><u>Post</u></b>
<b>31622</b>	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)	2.78	0.0689	65	10	5	5	30	15
<b>43195</b>	Esophagoscopy, rigid, transoral; with balloon dilation (less than 30 mm diameter).	3.21	0.0640	94	33	6	10	30	15
<b>19103</b>	Biopsy of breast; percutaneous,	3.69	0.0968	65	20			30	15

The table below compares the survey code to other RUC reviewed codes of similar time and work, providing further support that the recommended value for 43195 is appropriate.

<b><u>RUC Reviewed</u></b>	<b><u>CPT Code</u></b>	<b><u>Descriptor</u></b>	<b><u>RVW</u></b>	<b><u>IWPUT</u></b>	<b><u>Total Time</u></b>	<b><u>Eval</u></b>	<b><u>Posit</u></b>	<b><u>SDW</u></b>	<b><u>INTRA</u></b>	<b><u>Post</u></b>
2008	<b>62267</b>	Percutaneous aspiration within the nucleus pulposus, intervertebral disc, or paravertebral tissue for diagnostic purposes	3.00	0.0682	79	14	10	10	30	15
2010	<b>52007</b>	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive	3.02	0.0613	82	19	5	5	32.5	20

		of radiologic service; with brush biopsy of ureter and/or renal pelvis								
2010	<b>31296</b>	Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg balloon dilation).	3.29	0.0711	88	30	3	10	30	15
2007	<b>50386</b>	Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation	3.30	0.0699	90	25	10	10	30	15
2004	<b>32550</b>	Insertion of indwelling tunneled pleural catheter with cuff	4.17	0.0989	90	15	15	10	30	20

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43220

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otolaryngology

How often? Sometimes

Specialty

How often?

Specialty

How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1788

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This is based on several assumptions. First, that 28 percent of the existing 43220 will continue to be reported by Otolaryngology. Second, that 70 percent of the of the Otolaryngology portion of existing 43220 will continue to be preorted using the new 43195 code and 30 percent will be reported using the revised 43220 code. In addition, we have assumed that the national volume of the new 43195 code will be three times that of the Medicare volume due to the patient population representing elderly patients which will predominantly be Medicare patients.

Specialty Otolaryngology	Frequency 1788	Percentage 100.00 %
--------------------------	----------------	---------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 596  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is based on the assumption that 70 percent of the current Otolaryngology volume for existing CPT 43220 will be represented by the new CPT code 43195.

Specialty Otolaryngology	Frequency 596	Percentage 100.00 %
--------------------------	---------------	---------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? No

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 31575

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43196      Tracking Number C6      Original Specialty Recommended RVU: **4.00**  
 Presented Recommended RVU: **3.36**  
 Global Period: 000      RUC Recommended RVU: **3.36**

CPT Descriptor: Esophagoscopy, rigid, transoral; with insertion of guide wire followed by dilation over guide wire.

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A middle-aged patient known to have a distal esophageal stricture presents with increasing dysphagia. A rigid esophagoscopy is performed. A guide wire is passed through the narrowed segment. Bougie dilators are passed over the guide wire and the stricture is dilated.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 27%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

**Description of Pre-Service Work:**

- Select and order the appropriate antibiotic(s) and confirm timing and administration.
- Assure appropriate selection, timing, and administration of DVT prophylaxis.
- Assess need for beta-blockers, order as required.
- Review medical history, pathology, and radiology report
- Review radiographic images
- Review results of preoperative testing (labs, EKG, CXR)
- Review reports of consultants providing preoperative assessment and clearance as indicated
- Meet with patient and family to review planned procedure and postoperative management
- Reexamine patient to ensure that physical findings have not changed and dictate history and physical
- Obtain informed consent
- Review airway and medical management with anesthesiologist
- Review planned procedure with OR staff
- Verify that all required instruments and supplies are available, set up scopes, suction, light source, guide wire and dilators) to ensure readiness
- Change into scrub clothes
- Observe/wait during induction of anesthesia and intubation.
- Monitor/assist with positioning of the patient (supine, shoulder roll, ensure security and position of endotracheal tube)
- Ensure that radiographic images are available in the OR
- Monitor/assist with draping

- Scrub and gown
- Operating table is turned with head toward endoscopist
- Perform surgical "time out" with operating surgical team.

#### Description of Intra-Service Work:

The mouth is opened and teeth/gums protected. Suction pharyngeal secretions. Rigid esophagoscope is introduced and passed through mouth, behind the endotracheal tube and larynx into cricopharyngeus and into the esophagus. The esophagoscope is advanced to the entry point of the stricture and visualization optimized, the location (distance from the upper incisor) is documented. The scope and patient position are adjusted as needed to ensure safe and smooth passage of the scope and suctioning secretions. The guide wire is passed via the esophagoscope through the stricture under direct vision. Small bougies are passed over the wire through the esophagoscope under direct vision, then removed, and the effect of dilation assessed by direct vision. If appropriate, the esophagoscope is then removed over the wire, and progressively larger bougies are passed over the wire to perform additional dilation. The esophagoscope is inserted again over the wire after dilation to evaluate the dilation site. Photodocumentation is performed. Blood is removed with suction, observing the site while bleeding dissipates. The esophagoscope is removed and the pharynx examined for bleeding and suctioned free of secretions. The patient is returned to the anesthesia position. Pathology requisition form is reviewed and signed.

#### Description of Post-Service Work:

- Monitor patient during reversal of anesthesia. Monitor transport of patient from OR to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff. Write postoperative orders. Discuss procedure and operative findings with family and the patient.
- Write postoperative note. Dictate operative note and copy to referring physician.
- Monitor patient progress. Chart notes.
- Monitor overall medical condition of the patient including fluid balance, vital signs, and urinary function
- Assess pain scores and adequacy of analgesia.
- Discuss post-discharge management with nursing staff and answer questions
- Home restrictions (i.e., diet, activity) are discussed with the patient, family members and discharging nurse.
- Write prescriptions for medications and supplies needed post-discharge
- Perform medication reconciliation
- All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	10/2012				
<b>Presenter(s):</b>	Wayne Koch, MD				
<b>Specialty(s):</b>	AAO-HNS				
<b>CPT Code:</b>	43196				
<b>Sample Size:</b>	710	<b>Resp N:</b>	22	<b>Response:</b> 3.0 %	
<b>Description of Sample:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	1.25	4.00	13.75	40.00
<b>Survey RVW:</b>	2.60	4.00	4.40	4.97	11.11
<b>Pre-Service Evaluation Time:</b>			40.00		
<b>Pre-Service Positioning Time:</b>			10.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			13.00		
<b>Intra-Service Time:</b>	15.00	25.00	33.00	45.00	80.00
<b>Immediate Post Service-Time:</b>	<u>20.00</u>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

3 -FAC Straightforward Patient/Difficult Procedure

<b>CPT Code:</b>	43196	<b>Recommended Physician Work RVU: 3.36</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		33.00	33.00	0.00
<b>Pre-Service Positioning Time:</b>		6.00	3.00	3.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		10.00	15.00	-5.00
<b>Intra-Service Time:</b>		33.00		
<b>Immediate Post Service-Time:</b>	<u>20.00</u>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00		



**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31638	000	4.88	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required).

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
19103	000	3.69	RUC Time	116,377

CPT Descriptor 1 Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
52276	000	4.99	RUC Time	11,155

CPT Descriptor 2 Cystourethroscopy with direct vision internal urethrotomy

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
20660	000	4.00	RUC Time

CPT Descriptor Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure)

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 8      % of respondents: 36.3 %**

**TIME ESTIMATES (Median)**

	<b>CPT Code: 43196</b>	<b>Key Reference CPT Code: 31638</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	49.00	50.00	
Median Intra-Service Time	33.00	60.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
<b>Median Total Time</b>	<b>102.00</b>	<b>140.00</b>	

Other time if appropriate		
---------------------------	--	--

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.63	3.75
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.75	3.88
--	------	------

Urgency of medical decision making	4.13	4.00
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.63	4.38
--------------------------	------	------

Physical effort required	4.00	4.00
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.63	4.50
---	------	------

Outcome depends on the skill and judgment of physician	4.63	4.25
--	------	------

Estimated risk of malpractice suit with poor outcome	4.13	3.88
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.63	3.63
----------------------------------	------	------

Intra-Service intensity/complexity	4.13	4.13
------------------------------------	------	------

Post-Service intensity/complexity	3.50	3.50
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Why is this code being reviewed?**

The esophagoscopy family of codes 43200-43232 was identified in the CY 2012 Final Physician Fee Schedule by CMS as potentially misvalued services. In response to this request, several Gastroenterology societies proposed a schedule for review of all of the gastrointestinal endoscopic services, during the January RAW subcommittee meeting. This action plan

was approved. Subsequently, a code change proposal was submitted for the May 2012 CPT meeting which created 8 new codes to describe transoral approach with a rigid scope and transnasal approach with a flexible scope. These services were previously reported using the 43200 series of (Esophagoscopy, rigid or flexible) codes. The 43200 series of codes were revised to limit use to esophagoscopies performed using a transoral approach with a flexible scope. This revised family of codes is now being presented for valuation by the AMA RUC at the October 2012 meeting.

## **Physician Time**

### **Pre Time**

Regarding physician time, we recommend using pre-service package 3 (Straightforward Patient/Difficult Procedure) which includes 33 minutes of evaluation, 3 minutes of positioning, and 15 minutes of scrub, dress, and wait time. Our expert panel felt this package was most appropriate given that the vignette for this service represents a middle aged patient who does not present with cancer, but requires a rigid esophagoscopy procedure. Our experts believed this procedure is more complex than a standard flexible, transoral esophagoscopy due to the fact that it is performed using a rigid scope under general anesthesia. Therefore, prepackage 3 is most appropriate for the preservice work required for the typical patient. Our experts felt the 33 minutes of evaluation time associated with prepackage 3 was appropriate for this procedure, and in fact our survey respondents indicated they required 40 minutes for evaluation of the patient undergoing this procedure. Despite this, our expert panel recognized that it is the policy of the RUC to accept preservice package times in scenarios where the survey exceeds the prepackage allotted time. Therefore, we recommend the standard 33 minutes for evaluation. Similarly, our panel reviewed the 15 minutes of scrub dress and wait time assigned by the prepackage and felt this amount of time was not necessary for this procedure. Therefore we recommend reducing this to 10 minutes for scrub, dress and wait which is consistent with our recommendations for all the rigid codes in this family. In contrast, we believe that the package time of 3 minutes for positioning is not sufficient for patients undergoing this procedure and therefore, recommend adding 3 minutes of positioning time. We believe this increase in positioning time is justified, given that the physician must position the patient in the supine position, places a shoulder roll, ensure security and position the endotracheal tube together with the anesthetist. Prior to beginning the procedure, the operating table must also be turned so that the patient's head is facing the endoscopist. These modifications result in an overall pre-service time recommendation of 33/6/10 for 43196.

### **Intra Time**

Our expert panel agreed with our surveyees regarding the time for intra service work and are recommending the survey median time of 33 minutes for intra service work.

### **Post Time**

Likewise, our experts felt that the survey's post time was an accurate reflection of the post time required for this procedure and are recommending the median post time of 20 minutes. This results in a request for a total of 102 minutes of physician work time for CPT 43196.

## **Physician Work / Compelling Evidence**

After concluding the survey, the results were analyzed by our expert panel and it was determined that for the newly developed rigid esophagoscopy codes (43191-6) the existing work RVUs were not sufficient for the amount of work being done for procedures where the physician is using a rigid scope in the facility setting, under general anesthesia. While the existing code, 43226, was surveyed in 1993, following significant coding changes to the gastrointestinal endoscopy section of CPT. However, the vignette used during that survey described only a flexible scope and no Otolaryngologists participated in the survey (the code was surveyed by GI and General Surgery) because the dominant providers of the existing code being Gastroenterology (59%) and the extremely low volume of this service (2,785 in 2011). Therefore, it is clear, based on the vignette used for the 1993 survey, that the work for Esophagoscopy, rigid, transoral; with insertion of guide wire followed by dilation over guide wire, has ever been properly valued, or even considered, as part of the survey for 43226, as Gastroenterologists do not perform esophagoscopy procedures using a rigid endoscope and the vignette used did not consider the provision of this service using a rigid scope.

Thus, we believe there is compelling evidence for re-valuation of new CPT code 43196 given that incorrect assumptions were made in previous valuations of the service where the dominant provider of rigid esophagoscopy services, Otolaryngology, were not included in the survey of the former combination code (43226), and a vignette was used for survey that did not consider the use of a rigid scope. Upon review of this history, our expert panel determined that the work RVU for the existing service (Esophagoscopy, rigid or flexible; with insertion of guide wire followed by dilation over guide wire) is not sufficient to value the work performed when the procedure is administered in the facility setting, using a rigid scope, under general anesthesia. Our expert panel therefore, recommends that the RVW for the new code, 43196,

(Esophagoscopy, rigid, transoral; with insertion of guide wire followed by dilation over guide wire) should be increased based on the compelling evidence, outlined above, to accurately represent the correct specialty mix and the use of a rigid scope for this procedure which represents more intense and complex work where a provider administers an esophagoscopy procedure in the facility setting, with a rigid scope, under general anesthesia. **Therefore, we are recommending an increased work RVU of 3.36 for CPT 43196 which is higher than the existing RVU of 2.34, but below the survey's 25<sup>th</sup> percentile.**

We arrived at this value in response to the discussion held at the pre-facilitation meeting for this family of codes, and determined that in order to maintain relativity among the new rigid, transoral esophagoscopy codes, the value for 43196 should be reduced below the 25<sup>th</sup> percentile to more accurately coincide with the value for 43193. We feel this is appropriate because the 43193 and 43196 codes have similar intraservice and total time and it would not be appropriate for a service provided to a less acute patient, represented by the 43196 code, to be valued higher than codes in the family with more acute patient populations, such as the 43193 code. We found the key reference service less applicable in supporting this value given its' higher value of 4.88 RVUs and substantially longer physician time of 140 total minutes, however, we believe there are several comparator codes which strongly support the recommended value for 43196. Specifically, 31625, bronchoscopy, rigid or flexible, including fluoroscopic guidance, with 3.36 RVUs, intra time of 30 minutes and 70 minutes of total time; 50386, removal of internally dwelling ureteral stent, also with 30 minutes of intra time and 90 minutes of total time; as well as 19296, placement of radiotherapy afterloading expandable catheter into the breast, with 30 minutes of intra time and 119 total minutes.

We are also providing the following reference tables which include recently reviewed services that support our requested values for physician time and work for CPT 43196.

#### **Comparison to key reference code**

<b><u>CPT Code</u></b>	<b><u>RVW</u></b>	<b><u>IWPUT</u></b>	<b><u>Total Time</u></b>	<b><u>Eval</u></b>	<b><u>Posit</u></b>	<b><u>SDW</u></b>	<b><u>INTRA</u></b>	<b><u>Post</u></b>
<b>43196</b>	3.36	0.0593	102	33	6	10	33	20
<b>31638</b>	4.88	0.0550	140	20	15	15	60	30

#### **Comparison to MPC codes.**

<b><u>CPT Code</u></b>	<b><u>Descriptor</u></b>	<b><u>RVW</u></b>	<b><u>IWPUT</u></b>	<b><u>Total Time</u></b>	<b><u>Eval</u></b>	<b><u>Posit</u></b>	<b><u>SDW</u></b>	<b><u>INTRA</u></b>	<b><u>Post</u></b>
<b>43196</b>	Esophagoscopy, rigid, transoral; with insertion of guide wire followed by dilation over guide wire.	3.36	0.0593	102	33	6	10	33	20
<b>19103</b>	Biopsy of breast; percutaneous,	3.69	0.0968	65	20	0	0	30	15
<b>52276</b>	Cystourethroscopy with direct vision internal urethrotomy	4.99	0.1042	95	30	0	0	35	30

The table below compares the survey code to other RUC reviewed codes of similar time and work, providing further support that the recommended value for 43196 is appropriate.

<b><u>RUC Reviewed</u></b>	<b><u>CPT Code</u></b>	<b><u>Descriptor</u></b>	<b><u>RVW</u></b>	<b><u>IWPUT</u></b>	<b><u>Total Time</u></b>	<b><u>Eval</u></b>	<b><u>Posit</u></b>	<b><u>SDW</u></b>	<b><u>INTRA</u></b>	<b><u>Post</u></b>
2010	<b>52007</b>	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with brush biopsy of ureter and/or renal pelvis	3.02	0.0614	82	19	5	5	32.5	20
2007	<b>50386</b>	Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological	3.30	0.0699	90	25	10	10	30	15

		supervision and interpretation								
2003	<b>31625</b>	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites.	3.36	0.0869	70	10	5	10	30	15
2004	<b>19296</b>	Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance;	3.63	0.0545	119	30	10	15	30	34
2007	<b>20660</b>	Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure)	4.00	0.0933	90	20	0	10	30	30

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.  
☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.  
☐ Multiple codes allow flexibility to describe exactly what components the procedure included.  
☐ Multiple codes are used to maintain consistency with similar codes.  
☐ Historical precedents.  
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43226

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
 If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otolaryngology

How often? Sometimes

Specialty

How often?

Specialty

How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1560

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This is based on several assumptions. First, that 20 percent of the existing 43226 will continue to be reported by Otolaryngology. Second, that 70 percent of the Otolaryngology portion of 43226 volume will be continue to be reported using the new 43196 code and 30 percent will be reported using the revised 43226 code. In addition, we have assumed that the national volume of the new 43196 code will be three times that of the Medicare volume due to the patient population representing an elderly patient which will predominantly include Medicare age patients.

Specialty Otolaryngology	Frequency 1560	Percentage 100.00 %
--------------------------	----------------	---------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 390

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is based on the assumption that 70 percent of the current Otolaryngology volume for existing CPT 43226 will be represented by the new CPT code 43196.

Specialty Otolaryngology	Frequency 390	Percentage 100.00 %
--------------------------	---------------	---------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? No

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 31638

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43197      Tracking Number C7      Original Specialty Recommended RVU: **1.59**  
 Presented Recommended RVU: **1.59**  
 Global Period: 000      RUC Recommended RVU: **1.59**

CPT Descriptor: Esophagoscopy, flexible, transnasal; diagnostic, includes collection of specimen(s) by brushing, when performed.

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 59-year-old male presents with chronic cough, hoarseness, and dysphagia. Gastroesophageal reflux is suspected. The patient's symptoms persist despite treatment with antireflux medications and lifestyle counseling. The patient undergoes transnasal esophagoscopy (TNE) for diagnostic evaluation.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 34%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 11%

Description of Pre-Service Work: After the decision is made for the need for esophagoscopy, taking into account the indications and patient factors, consideration is given to rigid esophagoscopy, sedated transoral esophagoscopy, and unsedated transnasal esophagoscopy (TNE). The decision is made to perform TNE.

- The patient is moved to a room equipped with the video tower and a protective drape is placed on the patient.
- Vital signs are obtained.
- The physician ensures that the transnasal esophagoscope, suction, air source for insufflation, and video recording equipment are available and functioning properly.
- The procedure is explained and consent obtained.
- A time out is performed.
- The physician washes hands and dons proper gloves.
- Topical decongestant and anesthetic sprays are applied to the nostrils followed by a 5 minute wait time.
- The distal nasal cavities are examined to determine the more patent nostril and further anesthetic and decongestant solutions on pledgets is applied with the nasal speculum and bayonet forceps. This is applied visually to specific areas requiring more profound anesthesia such as nasal spurs, large inferior turbinates and the middle turbinate. This is left in place for 2 minutes and the pledgets are then removed.
- The patient is positioned in the upright position in the examination chair leaning slightly forward.

Description of Intra-Service Work: The distal portion of the esophagoscope is lubricated with viscous lidocaine or surgical lubricant and then passed under direct vision into the nasal cavity. The physician is careful to avoid nasal spurs, nasal septal deviations, tubinates, nasal polyps and other areas of constriction which cause pain and bleeding and takes the most open

route to the nasopharynx. The patient is instructed to breath steadily and calmly through the nose to open the nasopharynx and the endoscope is passed into the oropharynx. The larynx is visualized and care taken not to stimulate it to avoid potential laryngospasm. The patient is asked to tilt is head towards his chest and swallow, at this moment the endoscopist advances the endoscope into the hypopharynx and through the pharyngoesophageal segment. The endoscope is then advanced under direct vision towards the gastroesophageal (GEJ) junction using a combination of air insufflation and instilling water. The region of the GEJ is evaluated in detail. The patient is asked to swallow and often given water to drink via a straw as air is insufflated to facilitate a complete examination of the mechanics and mucosa of the GEJ. The endoscope is then advanced into the stomach and a retro-flexed view is then obtained of the GEJ and gastric cardia. This is performed by full flexion of the endoscope and rotating it 180 degrees. Air is then suctioned from the stomach to alleviate any patient bloating. As the endoscope is slowly removed a complete inspection of the entire circumference of the esophageal mucosa is made using a combination of air insufflation, water instillation, and rotation of the endoscope. Near the conclusion of the endoscopy air is given to allow visualization of the post-cricoid area. The esophagoscope is then withdrawn, carefully observing the esophageal mucosa, capturing digital images of areas of interest as well as video imaging the entire examination.

#### Description of Post-Service Work:

- Monitor patient during recover period.
- Home restrictions (i.e. diet, activity), treatment and findings are explained to the patient using the procedure video recording and pointing out areas of normal anatomy and pathology.
- Subsequent evaluation and therapeutic plan are discussed.
- Write prescriptions for medications and supplies needed post-discharge
- Perform medication reconciliation.
- The examination and any still images are saved on the digital recording system. The procedure note is dictated and findings communicated to the referring physician.



**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	10/2012				
<b>Presenter(s):</b>	Wayne Koch, MD; Joel Brill, MD; Nicholas Nickl, MD				
<b>Specialty(s):</b>	AAO-HNS, AGA, ASGE				
<b>CPT Code:</b>	43197				
<b>Sample Size:</b>	4094	<b>Resp N:</b>	74	<b>Response:</b>	1.8 %
<b>Description of Sample:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	0.00	4.00	20.00	150.00
<b>Survey RVW:</b>	0.40	2.60	3.00	3.50	14.00
<b>Pre-Service Evaluation Time:</b>			28.00		
<b>Pre-Service Positioning Time:</b>			5.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			5.00		
<b>Intra-Service Time:</b>	5.00	10.00	15.00	24.75	45.00
<b>Immediate Post Service-Time:</b>	<b>10.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

6 - NF Procedure with sedation/anesthesia care

<b>CPT Code:</b>	43197	<b>Recommended Physician Work RVU: 1.59</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		17.00	17.00	0.00
<b>Pre-Service Positioning Time:</b>		1.00	1.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		7.00	5.00	2.00
<b>Intra-Service Time:</b>		15.00		
<b>Immediate Post Service-Time:</b>	<b>10.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31622	000	2.78	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; diagnostic, with or without cell washing (separate procedure).**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
31575	000	1.10	RUC Time	599,944

CPT Descriptor 1 Laryngoscopy, flexible fiberoptic; diagnostic.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
54150	000	1.90	RUC Time	147

CPT Descriptor 2 Circumcision, using clamp or other device with regional dorsal penile or ring block

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
57420	000	1.60	RUC Time

CPT Descriptor Colposcopy of the entire vagina, with cervix if present;**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 17      % of respondents: 22.9 %

**TIME ESTIMATES (Median)**

	<b>CPT Code:</b> 43197	<b>Key Reference CPT Code:</b> 31622	<b>Source of Time</b> RUC Time
Median Pre-Service Time	25.00	20.00	
Median Intra-Service Time	15.00	30.00	
Median Immediate Post-service Time	10.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
<b>Median Total Time</b>	<b>50.00</b>	<b>65.00</b>	
<b>Other time if appropriate</b>			

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered

3.00

3.00

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed

3.00

3.00

Urgency of medical decision making

3.00

3.00

**Technical Skill/Physical Effort (Mean)**

Technical skill required

4.00

3.00

Physical effort required

3.00

3.00

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality

3.00

3.00

Outcome depends on the skill and judgment of physician

4.00

3.00

Estimated risk of malpractice suit with poor outcome

3.00

3.00

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity

3.00

3.00

Intra-Service intensity/complexity

3.00

3.00

Post-Service intensity/complexity

3.00

3.00

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Why is this code being reviewed?**

The esophagoscopy family of codes 43200-43232 was identified in the CY 2012 Final Physician Fee Schedule by CMS as potentially misvalued services. In response to this request, several Gastroenterology societies proposed a schedule for review of all of the gastrointestinal endoscopic services, during the January RAW subcommittee meeting. This action plan was approved. Subsequently, a code change proposal was submitted for the May 2012 CPT meeting which created 8 new

codes to describe transoral approach with a rigid scope and transnasal approach with a flexible scope. These services were previously reported using the 43200 series of (Esophagoscopy, rigid or flexible) codes. The 43200 series of codes were revised to limit use to esophagoscopies performed using a transoral approach with a flexible scope. This revised family of codes is now being presented for valuation by the AMA RUC at the October 2012 meeting

### **Description of Random Survey**

The Otolaryngology physician work RVU recommendations were derived by conducting a random survey of the Memberships. Otolaryngology used the 000 global survey instrument with one revision instructing respondents to include time for administering topical anesthetic, where appropriate, in the pre-service time. The GI societies surveyed their members using a mini-survey due to the volume of codes they were asking surveyees to respond to. The GI survey of 43197 and 43198 did not include the revision instructing respondents to include time for administering topical anesthetic. Instead, the GI survey used the standard Question #6 for moderate sedation. Both survey instruments were approved by the Research Subcommittee in advance of distribution. Surveys were sent to nearly 700 Otolaryngologists, including the subspecialties of laryngology and broncoesophagology, as well as to the Academy's leadership and key committees such as the Airway and Swallowing and Voice which contain clinicians who were most likely to be familiar with the services under review. The AGA and ASGE conducted a random sample of their member gastroenterologists using the Census Department office regions (<http://www.census.gov/regions/>). Between 150 and 200 gastroenterologists were randomly selected in each region for a total of 2,000 gastroenterologists. The AGA and ASGE enhanced the random sample by adding 514 members of the ASGE Special Interest Groups and 786 physicians who perform esophagoscopy EUS and stent, TNE and optical endomicroscopy and ablation provided by Industry. The AGA and ASGE also added 86 volunteers who responded to the educational article on the RUC survey process that was approved by the Research Subcommittee and was distributed to all AGA and ASGE members. The AGA and ASGE's total survey sample size was 3,386. Of the 74 responses obtained for the random survey of 43197, an equivalent number of responses were received from both specialties (37 from ENT and 37 from GI).

### **Physician Time**

#### **Pre Time**

Following a review of the pre-time survey data, our expert panel determined that preservice package 6 (Non-Facility procedure with sedation/anesthesia care) was most appropriate. Prepackage 6 assigns 17 minutes for evaluation, 1 minute for positioning, and 5 minutes for scrub, dress, and wait. Our expert panel felt this was the most appropriate package given that service is predominantly provided in a physician's office and topical anesthetic and decongestant is utilized to numb the nose prior to providing a TNE procedure. The expert panel reviewed the survey pre times and determined that the prepackage evaluation time of 17 minutes was appropriate and supported by the survey. In fact, respondents indicated that they typically require 28 minutes of evaluation time, however, the panel felt it was appropriate to reduce the recommended evaluation time down to 17 in order to maintain consistency with the requested preservice package. Similarly, the survey respondents indicated 5 minutes was typical for positioning the patient for a TNE procedure. Our experts, however, felt that the standard 1 minute indicated in the package was more accurate, resulting in a recommendation of 1 minute for positioning. In contrast, our experts felt that the package's 5 minutes of scrub, dress, and wait time was insufficient to represent the work done to prepare the patient for the procedure. Therefore, we are recommend an increase to the package's scrub, dress, and wait time of 2 minutes, from 5 to 7. The additional two minutes are justified by the need to spray topical decongestant and anesthetic on the nostrils and allow 5 minutes for them to take effect. The distal nasal cavities must be examined to determine the more patent nostril and further anesthetic and decongestant solutions are applied using pledgets. This is applied to the areas requiring more profound anesthesia. Pledgets are left in place for 2 minutes and then removed. This results in a total pre-service time recommendation of 17/1/7 with 17 minutes for evaluation, 1 minute for positioning, and 7 minutes for scrub, dress, and wait.

#### **Intra Time**

Our expert panel agreed with our surveyees regarding the time for intra service work and are recommending the survey median time of 15 minutes for intra service work.

#### **Post Time**

Likewise, our experts felt that the survey's post time was an accurate reflection of the post time required for this procedure and are recommending the median post time of 10 minutes. This results in a request for a total of 50 minutes of physician work time for CPT 43197.

### **Physician Work Recommendation**

After concluding the survey, the results were analyzed by an expert panel and it was determined that for the newly developed transoral, flexible esophagoscopy code (43197) the existing work RVU is appropriate and should be maintained.

This is justified by the increased difficulty of performing the procedure on a patient who is unsedated, and often anxious and moving, during the procedure. The patient often experiences gagging and other discomfort, such as bloating, that adds to the intensity of the procedure as the physician must work to keep the patient calm and in the necessary position throughout the entire procedure. Since the transnasal esophagoscope only has one wheel to allow maneuvering of the endoscope, a great deal of endoscope rotation is usually required to perform a complete esophagoscopy which also adds to the complexity of the procedure. **Therefore, we recommend that the current work RVU of 1.59, which is below the survey's 25<sup>th</sup> percentile, be maintained for CPT 43197.**

This recommendation is supported by the key reference code 31622 which survey respondents said was similar in intensity and complexity, but has a slightly higher work RVU of 2.78 and slightly longer physician time of 65 total minutes. Our expert panel also felt CPT 31575 served as an excellent reference code for this service and has a work RVU of 1.10 and a total time of 28 minutes. We are also providing the following reference tables which include recently reviewed services which support our requested values for physician time and work for CPT 43197.

#### **Comparison to key reference code**

<b><u>CPT Code</u></b>	<b><u>RVW</u></b>	<b><u>IWPUT</u></b>	<b><u>Total Time</u></b>	<b><u>Eval</u></b>	<b><u>Posit</u></b>	<b><u>SDW</u></b>	<b><u>INTRA</u></b>	<b><u>Post</u></b>
<b>43197</b>	1.59	0.0604	50	17	1	7	15	10
<b>31622</b>	2.78	0.0689	65	10	5	5	30	15

#### **Comparison to MPC codes**

<b><u>CPT Code</u></b>	<b><u>Descriptor</u></b>	<b><u>RVW</u></b>	<b><u>IWPUT</u></b>	<b><u>Total Time</u></b>	<b><u>Eval</u></b>	<b><u>Posit</u></b>	<b><u>SDW</u></b>	<b><u>INTRA</u></b>	<b><u>Post</u></b>
<b>31575</b>	Laryngoscopy, flexible fiberoptic; diagnostic	1.10	0.0904	28	5	5	5	8	5
<b>43197</b>	Esophagoscopy, flexible, transnasal; with biopsy, single or multiple.	1.59	0.0604	50	17	1	7	15	10
<b>54150</b>	Circumcision, using clamp or other device with regional dorsal penile or ring block	1.90	0.0866	45	15	5	5	15	5

The table below compares the survey code to other RUC reviewed codes of similar time and work, providing further support that the recommended value for 43197 is appropriate.

<b><u>RUC Reviewed</u></b>	<b><u>CPT Code</u></b>	<b><u>Descriptor</u></b>	<b><u>RVW</u></b>	<b><u>IWPUT</u></b>	<b><u>Total Time</u></b>	<b><u>Eval</u></b>	<b><u>Posit</u></b>	<b><u>SDW</u></b>	<b><u>INTRA</u></b>	<b><u>Post</u></b>
2009	<b>32561</b>	Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); initial day	1.39	0.0536	45	13	1	6	15	10
2002	<b>56820</b>	Colposcopy of the vulva;	1.50	0.0626	40	15	0	0	15	10
2010	<b>62284</b>	Injection procedure for myelography and/or computed tomography, spinal	1.54	0.0576	49	13	5	6	15	10
2002	<b>57420</b>	Colposcopy of the entire vagina, with cervix if present;	1.60	0.0573	43	14.1	0	0	18.5	10
2010	<b>16025</b>	Dressings and/or debridement of partial-thickness burns, initial or subsequent; medium (eg, whole face or whole extremity, or 5% to 10% total body surface area)	1.74	0.0704	38	7	3	5	20	3
2005	<b>31579</b>	Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy	2.26	0.1059	45	5	5	5	8	5

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43200

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otolaryngology                      How often? Commonly

Specialty Gastroenterology                      How often? Rarely

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 4212

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This is based on several assumptions. First, that 71 percent of the existing 43200 will continue to be reported by Otolaryngology. Second, that 10 percent of the Otolaryngology portion of 43200 will continue to be reported using the new 43197 code, 30 percent will be reported using the revised 43200 code, and 60 percent will be reported using the new 43191 code. In addition, we have assumed that the national volume of the new 43197 code will be four times that of the Medicare volume due to the patient population representing middle aged patients who are not predominantly Medicare age patients.

Specialty Otolaryngology                      Frequency 3790                      Percentage 89.98 %

Specialty Gastroenterology                      Frequency 422                      Percentage 10.01 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,053

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is based on the assumption that 10 percent of the current Otolaryngology volume for existing CPT 43200 will be represented by the new CPT code 43197 and of that 10 percent, 90 percent of services will be provided by Otolaryngology and 10 percent will be performed by GI.

Specialty Otolaryngology	Frequency 948	Percentage 90.02 %
Specialty Gastroenterology	Frequency 105	Percentage 9.97 %
Specialty	Frequency 0	Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

### **Professional Liability Insurance Information (PLI)**

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 31575

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43198      Tracking Number C8      Original Specialty Recommended RVU: **1.89**  
 Presented Recommended RVU: **1.89**  
 Global Period: 000      RUC Recommended RVU: **1.89**

CPT Descriptor: Esophagoscopy, flexible, transnasal; with biopsy, single or multiple.

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 62-year-old female presents with chronic cough, hoarseness, and dysphagia. Despite treatment with antireflux medications and lifestyle counseling, her symptoms persist raising concern for the presence of Barrett's esophagus or esophageal neoplasm. The patient undergoes transnasal esophagoscopy (TNE) with identification and biopsy of the suspicious lesion(s).

Percentage of Survey Respondents who found Vignette to be Typical: 96%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 25%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 15%

Description of Pre-Service Work: After the decision is made for the need for esophagoscopy, taking into account the indications and patient factors, consideration is given to rigid esophagoscopy, sedated transoral esophagoscopy, and unsedated transnasal esophagoscopy (TNE). The decision is made to perform TNE.

- The patient is moved to a room equipped with the video tower and a protective drape is placed on the patient.
- Vital signs are obtained.
- The physician ensures that the transnasal esophagoscope, suction, air source for insufflation, and video recording equipment are available and functioning properly.
- The procedure is explained and consent obtained.
- A time out is performed.
- The physician washes hands and dons gloves.
- Topical decongestant and anesthetic sprays are applied to the nostrils followed by a 5 minute wait time.
- The distal nasal cavities are examined to determine the more patent nostril and further anesthetic and decongestant solutions on pledgets is applied with the nasal speculum and bayonet forceps. This is applied visually to specific areas requiring more profound anesthesia such as nasal spurs, large inferior turbinates and the middle turbinate. This is left in place for 2 minutes and the pledgets are then removed.
- The patient is positioned in the upright position in the examination chair leaning slightly forward.

Description of Intra-Service Work: The distal portion of the esophagoscope is lubricated with viscous lidocaine or surgical lubricant and then passed under direct vision into the nasal cavity. The physician is careful to avoid nasal spurs, nasal septal deviations, tubinates, nasal polyps and other areas of constriction which cause pain and bleeding and takes the most open



route to the nasopharynx. The patient is instructed to breath steadily and calmly through the nose to open the nasopharynx and the endoscope is passed into the oropharynx. The larynx is visualized and care taken not to stimulate it to avoid potential laryngospasm. The patient is asked to tilt is head towards his chest and swallow, at this moment the endoscopist advances the endoscope into the hypopharynx and through the pharyngoesophageal segment. The endoscope is then advanced under direct vision towards the gastroesophageal (GEJ) junction using a combination of air insufflation and instilling water. The region of the GEJ is evaluated. The patient is asked to swallow and often given water to drink via a straw as air is insufflated to facilitate a complete examination of the mechanics and mucosa of the GEJ. The endoscope is then advanced into the stomach and a retro-flexed view is then obtained of the GEJ and gastric cardia. This is performed by full flexion of the endoscope and rotating it 180 degrees. Air is then suctioned from the stomach to alleviate any patient bloating. As the endoscope is slowly removed a complete inspection of the entire circumference of the esophageal mucosa is made using a combination of air insufflation, water instillation, and rotation of the endoscope. Near the conclusion of the endoscopy air is given to allow visualization of the post-cricoid area.

After a lesion is noted, 2.0 mm biopsy forceps are passed through the working channel of the flexible esophagoscope. Under direct vision the endoscopist orients the endoscope to to insert the forceps into the lesion and perform the biopsy. The forceps are then removed and the specimen is removed from its jaws and placed into the marked specimen container. It is then rinsed and reinserted into the esophagoscope and passed along its 60-110 cm length. Several biopsies are taken of all noted lesions. The esophagoscope is then withdrawn, observing the esophageal mucosa, capturing digital images of areas of interest as well as video imaging the entire examination.

#### Description of Post-Service Work:

- Monitor patient during recover period.
- Home restrictions (i.e. diet, activity), treatment and findings are explained to the patient using the procedure video recording and pointing out areas of normal anatomy and pathology.
- Subsequent evaluation and therapeutic plan are discussed.
- Write prescriptions for medications and supplies needed post-discharge
- Perform medication reconciliation.
- The examination and any still images are saved on the digital recording system. The procedure note is dictated and findings communicated to the referring physician.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	10/2012				
<b>Presenter(s):</b>	Wayne Koch, MD; Joel Brill, MD; Nicholas Nickl, MD				
<b>Specialty(s):</b>	AAO-HNS, AGA, ASGE				
<b>CPT Code:</b>	43198				
<b>Sample Size:</b>	4095	<b>Resp N:</b>	75	<b>Response:</b>	1.8 %
<b>Description of Sample:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	0.00	5.00	20.00	250.00
<b>Survey RVW:</b>	0.50	2.85	3.36	4.23	14.50
<b>Pre-Service Evaluation Time:</b>			25.00		
<b>Pre-Service Positioning Time:</b>			5.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			5.00		
<b>Intra-Service Time:</b>	5.00	15.00	20.00	30.00	60.00
<b>Immediate Post Service-Time:</b>	<b>10.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

6 - NF Procedure with sedation/anesthesia care

<b>CPT Code:</b>	43198	<b>Recommended Physician Work RVU: 1.89</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		17.00	17.00	0.00
<b>Pre-Service Positioning Time:</b>		1.00	1.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		7.00	5.00	2.00
<b>Intra-Service Time:</b>		20.00		
<b>Immediate Post Service-Time:</b>	<b>10.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31625	000	3.36	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with bronchial or endobronchial biopsy(s), single or multiple sites.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
31575	000	1.10	RUC Time	599,944

CPT Descriptor 1 Laryngoscopy, flexible fiberoptic; diagnostic.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
52000	000	2.23	RUC Time	925,004

CPT Descriptor 2 Cystourethroscopy (separate procedure).

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
57455	000	1.99	RUC Time

CPT Descriptor Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 19      % of respondents: 25.3 %**

**TIME ESTIMATES (Median)**

	<b>CPT Code: 43198</b>	<b>Key Reference CPT Code: 31625</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	25.00	25.00	
Median Intra-Service Time	20.00	30.00	
Median Immediate Post-service Time	10.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
<b>Median Total Time</b>	<b>55.00</b>	<b>70.00</b>	
<b>Other time if appropriate</b>			

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.00	4.00
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	3.00
--	------	------

Urgency of medical decision making	3.00	3.00
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.00	4.00
--------------------------	------	------

Physical effort required	3.50	3.00
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.00	3.00
---	------	------

Outcome depends on the skill and judgment of physician	4.00	4.00
--	------	------

Estimated risk of malpractice suit with poor outcome	4.00	3.00
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.00	3.00
----------------------------------	------	------

Intra-Service intensity/complexity	4.00	3.00
------------------------------------	------	------

Post-Service intensity/complexity	3.00	3.00
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Why is this code being reviewed?**

The esophagoscopy family of codes 43200-43232 was identified in the CY 2012 Final Physician Fee Schedule by CMS as potentially misvalued services. In response to this request, several Gastroenterology societies proposed a schedule for review of all of the gastrointestinal endoscopic services, during the January RAW subcommittee meeting. This action plan was approved. Subsequently, a code change proposal was submitted for the May 2012 CPT meeting which created 8 new

codes to describe transoral approach with a rigid scope and transnasal approach with a flexible scope. These services were previously reported using the 43200 series of (Esophagoscopy, rigid or flexible) codes. The 43200 series of codes were revised to limit use to esophagoscopies performed using a transoral approach with a flexible scope. This revised family of codes is now being presented for valuation by the AMA RUC at the October 2012 meeting.

### **Description of Random Survey**

The Otolaryngology physician work RVU recommendations were derived by conducting a random survey of the Memberships. Otolaryngology used the 000 global survey instrument with one revision instructing respondents to include time for administering topical anesthetic, where appropriate, in the pre-service time. The GI societies surveyed their members using a mini-survey due to the volume of codes they were asking surveyees to respond to. The GI survey of 43197 and 43198 did not include the revision instructing respondents to include time for administering topical anesthetic. Instead, the GI survey used the standard Question #6 for moderate sedation. Both survey instruments were approved by the Research Subcommittee in advance of distribution. Surveys were sent to nearly 700 Otolaryngologists, including the subspecialties of laryngology and broncoesophagology, as well as to the Academy's leadership and key committees such as the Airway and Swallowing and Voice which contain clinicians who were most likely to be familiar with the services under review. The AGA and ASGE conducted a random sample of their member gastroenterologists using the Census Department office regions (<http://www.census.gov/regions/>). Between 150 and 200 gastroenterologists were randomly selected in each region for a total of 2,000 gastroenterologists. The AGA and ASGE enhanced the random sample by adding 514 members of the ASGE Special Interest Groups and 786 physicians who perform esophagoscopy EUS and stent, TNE and optical endomicroscopy and ablation provided by Industry. The AGA and ASGE also added 86 volunteers who responded to the educational article on the RUC survey process that was approved by the Research Subcommittee and was distributed to all AGA and ASGE members. The AGA and ASGE's total survey sample size was 3,386. Of the 74 responses obtained for the random survey of 43197, an equivalent number of responses were received from both specialties (37 from ENT and 37 from GI).

### **Physician Time**

#### **Pre Time**

Following a review of the pre-time survey data, our expert panel determined that preservice package 6 (Non-Facility procedure with sedation/anesthesia care) was most appropriate. Prepackage 6 assigns 17 minutes for evaluation, 1 minute for positioning, and 5 minutes for scrub, dress, and wait. Our expert panel felt this was the most appropriate package given that service is predominantly provided in a physician's office and topical anesthetic and decongestant is utilized to numb the nose prior to providing a TNE procedure. The expert panel reviewed the survey pre times and determined that the prepackage evaluation time of 17 minutes was appropriate and supported by the survey. In fact, respondents indicated that they typically require 28 minutes of evaluation time, however, the panel felt it was appropriate to reduce the recommended evaluation time down to 17 in order to maintain consistency with the requested preservice package. Similarly, the survey respondents indicated 5 minutes was typical for positioning the patient for a TNE procedure. Our experts, however, felt that the standard 1 minute indicated in the package was more accurate, resulting in a recommendation of 1 minute for positioning. In contrast, our experts felt that the package's 5 minutes of scrub, dress, and wait time was insufficient to represent the work done to prepare the patient for the procedure. Therefore, we are recommend an increase to the package's scrub, dress, and wait time of 2 minutes, from 5 to 7. The additional two minutes are justified by the need to spray topical decongestant and anesthetic on the nostrils and allow 5 minutes for them to take effect. The distal nasal cavities must be examined to determine the more patent nostril and further anesthetic and decongestant solutions are applied using pledgets. This is applied to the areas requiring more profound anesthesia. Pledgets are left in place for 2 minutes and then removed. This results in a total pre-service time recommendation of 17/1/7 with 17 minutes for evaluation, 1 minute for positioning, and 7 minutes for scrub, dress, and wait.

#### **Intra Time**

Our expert panel agreed with our surveyees regarding the time for intra service work and are recommending the survey median time of 20 minutes for intra service work.

#### **Post Time**

Likewise, our experts felt that the survey's post time was an accurate reflection of the post time required for this procedure and are recommending the median post time of 10 minutes. This results in a request for a total of 55 minutes of physician work time for CPT 43198.

### **Physician Work Recommendation**

After concluding the survey, the results were analyzed by an expert panel and it was determined that for the newly developed transoral, flexible esophagoscopy code (43198) the existing work RVU is appropriate and should be maintained. This is justified by the increased difficulty of performing the procedure on a patient who is unsedated, and often anxious and moving, during the procedure. The patient often experiences gagging and other discomfort, such as bloating, that adds to the intensity of the procedure as the physician must work to keep the patient calm and in the necessary position throughout the entire procedure. Since the transnasal esophagoscope only has one wheel to allow maneuvering of the endoscope, a great deal of endoscope rotation is usually required to perform a complete esophagoscopy which also adds to the complexity of the procedure. **Therefore, we recommend that the current work RVU of 1.89, which is below the survey's 25<sup>th</sup> percentile, be maintained for CPT 43198.**

This recommendation is supported by the key reference code 31625 which survey respondents said was similar in intensity and complexity, and has similar times of 55 minutes, but a slightly higher work RVU of 3.36. In addition, our expert panel felt CPT 31575 was an excellent alternate reference code for this service as it has a work RVU of 1.10 and a total time of 28 minutes.

#### Comparison to key reference code

<u>CPT Code</u>	<u>RVW</u>	<u>IWPUT</u>	<u>Total Time</u>	<u>Eval</u>	<u>Posit</u>	<u>SDW</u>	<u>INTRA</u>	<u>Post</u>
<b>43198</b>	1.89	0.0603	55	17	1	7	20	10
<b>31625</b>	3.36	0.0869	70	10	5	10	30	15

#### Comparison to MPC codes

<u>CPT Code</u>	<u>Descriptor</u>	<u>RVW</u>	<u>IWPUT</u>	<u>Total Time</u>	<u>Eval</u>	<u>Posit</u>	<u>SDW</u>	<u>INTRA</u>	<u>Post</u>
<b>31575</b>	Laryngoscopy, flexible fiberoptic; diagnostic	1.10	0.0904	28	5	5	5	8	5
<b>43198</b>	Esophagoscopy, flexible, transnasal; with biopsy, single or multiple.	1.89	0.0603	55	17	1	7	20	10
<b>52000</b>	Cystourethroscopy (separate procedure)	2.23	0.1131	42	10	2	5	15	10

The table below compares the survey code to other RUC reviewed codes of similar time and work, providing further support that the recommended value for 43198 is appropriate.

<u>RUC Reviewed</u>	<u>CPT Code</u>	<u>Descriptor</u>	<u>RVW</u>	<u>IWPUT</u>	<u>Total Time</u>	<u>Eval</u>	<u>Posit</u>	<u>SDW</u>	<u>INTRA</u>	<u>Post</u>
2009	<b>32561</b>	Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); initial day	1.39	0.0536	45	13	1	6	15	10
2002	<b>56820</b>	Colposcopy of the vulva;	1.50	0.06267	40	15	0	0	15	10
2010	<b>16025</b>	Dressings and/or debridement of partial-thickness burns, initial or subsequent; medium (eg, whole face or whole extremity, or 5% to 10% total body surface area)	1.74	0.07042	38	7	3	5	20	3
2011	<b>15275</b>	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	1.83	0.08292	45	13	1	6	15	10
2002	<b>57455</b>	Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix	1.99	0.0715	45	15	0	0	20	10
2005	<b>31579</b>	Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy	2.26	0.1059	45	5	5	5	8	5

2005	52204	Cystourethroscopy, with biopsy(s)	2.59	0.0805	54	10	2	5	25	12
------	-------	-----------------------------------	------	--------	----	----	---	---	----	----

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43202

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otolaryngology How often? Commonly

Specialty Gastroenterology How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 477

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This is based on several assumptions. First, that 31 percent of the existing 43203 will continue to be reported by Otolaryngology. Second, that 10 percent of the Otolaryngology portion of 43203 will continue to be reported using the new 43198 code, 30 percent will be reported using the revised 43203 code, and 60 percent will be reported using the new 43193 code. In addition, we have assumed that the national volume of the new 43198 code will be four times that of the Medicare volume due to the patient population representing middle aged patients which are not predominantly Medicare age patients.

Specialty Otolaryngology Frequency 429 Percentage 89.93 %

Specialty Gastroenterology Frequency 48 Percentage 10.06 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 119

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is based on the assumption that 10 percent of the current Otolaryngology

volume for existing CPT 43203 will be represented by the new CPT code 43198 and of that 10 percent, 90 percent of services will be provided by Otolaryngology and 10 percent will be performed by GL.

Specialty Otolaryngology	Frequency 107	Percentage 89.91 %
--------------------------	---------------	--------------------

Specialty Gastroenterology	Frequency 12	Percentage 10.08 %
----------------------------	--------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? No

---

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 31575



**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43200      Tracking Number

Original Specialty Recommended RVU: **1.59**Presented Recommended RVU: **1.59**

Global Period: 000

RUC Recommended RVU: **1.59**

CPT Descriptor: Esophagoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing when performed

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 67 year old patient with difficulty swallowing undergoes diagnostic esophagoscopy with brushings or washings

Percentage of Survey Respondents who found Vignette to be Typical: 96%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 85%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 74%

Description of Pre-Service Work: Review with the patient any symptoms and ascertain characteristics of the dysphagia problem when it is clear there is dysphagia. The patient's history is reviewed to assess for the need for pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed and documented; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays and other diagnostic tests are reviewed. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained and the physician must sign the consent. The physician verifies all endoscopic equipment is available and appropriate computer entries are made. The patient is positioned on the examination table. The endoscopic and moderate sedation monitoring equipment is positioned to provide access for the procedure. A time out is performed. A bite block is placed in the mouth. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible upper endoscope is inserted through the mouth into the oropharynx and advanced through the esophagus into the proximal stomach and, when indicated, retroflexed to allow examination of the cardia. The endoscope is withdrawn, allowing measurement of the squamocolumnar and gastro-esophageal junction from the incisors, assessment for presence of a hiatal hernia, and then examination of the esophageal mucosa. If indicated, brushings are obtained of suspicious abnormalities. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. The endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. Post procedure orders are completed. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to referral source and other appropriate parties. Data is entered into procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others. Necessary prescriptions, follow-up tests and appointments are provided to the patient.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	10/2012					
<b>Presenter(s):</b>	Joel V. Brill, MD (AGA), Nicholas Nickl, MD (ASGE), Edward S. Bentley, MD (ASGE), Wayne M. Koch, MD (AAO-HNS), John Lanza, MD (AAO-HNS), Michael Edye, MD (SAGES), Don J. Selzer, MD (SAGES)					
<b>Specialty(s):</b>	AGA, ASGE, AAO-HNS, SAGES					
<b>CPT Code:</b>	43200					
<b>Sample Size:</b>	5029	<b>Resp N:</b>	121	<b>Response:</b> 2.4 %		
<b>Description of Sample:</b>	The AGA and ASGE conducted a random sample of their member gastroenterologists using the Census Department office regions ( <a href="http://www.census.gov/regions/">http://www.census.gov/regions/</a> ). Between 150 and 200 gastroenterologists were randomly selected in each region for a total of 2,000 gastroenterologists. The AGA and ASGE enhanced the random sample by adding 514 members of the ASGE endoscopy Special Interest Groups, and 786 physicians who perform esophagoscopy EUS and stent, TNE and optical endomicroscopy and ablation provided by Industry. The AGA and ASGE also added 86 volunteers who responded to the educational article on the RUC survey process that was approved by the Research Subcommittee and was distributed to all AGA and ASGE members. The AGA and ASGE's total survey sample size was 3,386. AAO-HNS conducted a random sampling of 704 physicians. SAGES sent a total of 1,000 emails (939 successfully delivered) using a random selection of 250 members from each of the four CMS DME Regions A-D (ie, geographically distributed). The total survey sample size for AAO-HNS, SAGES, AGA and ASGE was 5,029.					
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>		0.00	10.00	75.00	300.00	1500.00
<b>Survey RVW:</b>		0.48	1.80	2.78	3.39	6.52
<b>Pre-Service Evaluation Time:</b>				25.00		
<b>Pre-Service Positioning Time:</b>				5.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				5.00		
<b>Intra-Service Time:</b>		3.00	10.00	15.00	20.00	45.00
<b>Immediate Post Service-Time:</b>	<b>10.00</b>					
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>				
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00	15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00	
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00		

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1b-FAC Straightforw Pat Procedure(w sedate/anes)

<b>CPT Code:</b>	43200	<b>Recommended Physician Work RVU: 1.59</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		19.00	19.00	0.00
<b>Pre-Service Positioning Time:</b>		3.00	1.00	2.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00

Intra-Service Time:		15.00
Immediate Post Service-Time:	10.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00
Discharge Day Mgmt:	0.00	99238x 0.0 99239x 0.0 99217x 0.00
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
49421	000	4.21	RUC Time

CPT Descriptor Insertion of tunneled intraperitoneal catheter for dialysis, open**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
31575	000	1.10	RUC Time	599,944

CPT Descriptor 1 Laryngoscopy, flexible fiberoptic; diagnostic

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
57410	000	1.75	RUC Time	3,277

CPT Descriptor 2 Pelvic examination under anesthesia (other than local)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31622	000	2.78	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 25      % of respondents: 20.6 %

**TIME ESTIMATES (Median)**

	CPT Code:	Key Reference CPT Code:	Source of Time
	43200	49421	Harvard Time
Median Pre-Service Time	27.00	46.00	

Median Intra-Service Time	15.00	45.00
Median Immediate Post-service Time	10.00	20.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>52.00</b>	<b>111.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.52	3.41
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.31	3.33
Urgency of medical decision making	3.38	3.26

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.66	3.43
Physical effort required	3.21	3.02

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.23	3.02
Outcome depends on the skill and judgment of physician	3.57	3.45
Estimated risk of malpractice suit with poor outcome	3.69	3.46

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.89	2.82
Intra-Service intensity/complexity	3.50	3.42
Post-Service intensity/complexity	2.77	2.73

## Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

43200 *Esophagoscopy, flexible; transoral diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* RVW, 1.59, physician time, (27/15/13) was initially Harvard valued in 1993 and reviewed by the RUC in the 1<sup>st</sup> five-year review in 1995. This code is being reviewed in response to comments by CMS in the Proposed Rule and Final Rule for CY 2012, requesting review of a number of gastrointestinal endoscopic services as being potentially misvalued.

Although this code was not specifically identified by CMS in the Final Rule, the societies that committed to a comprehensive review of gastrointestinal endoscopic services – the AGA, ACG, ASGE and SAGES – identified that code 43200 was primarily performed by otolaryngologists, while the remaining codes in the 43200-43232 family were primarily performed by gastroenterologists and endoscopic surgeons. In view of such, a coding change proposal was brought to the February 2012 CPT Editorial Panel in conjunction with the AAO-HNS and the Triological Society, requesting the development of new codes for trans-nasal esophagoscopy (primarily performed in the non-facility setting without moderate sedation) and rigid esophagoscopy (primarily performed in the OR setting with anesthesia administered by an anesthesia professional). While the code number, 43200, remains the same, this code is now specific for a flexible, transoral, esophagoscopy procedure.

In May 2012 the AGA, ASGE and SAGES requested that the Research Subcommittee consider a mini-survey methodology for this and the other codes in the 43200-43232 family, which was approved. The Research Subcommittee required that a standard survey be conducted of the new base code for flexible trans-oral esophagoscopy, 43200 *Esophagoscopy, flexible; transoral diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*, specifically including the elements of pre- and post-service physician work. For the remaining codes that were surveyed in the 43201-43232 family, the mini-survey instrument only asked the physician to address the intra-service work component for the procedure. Accordingly, the societies submitting these recommendations are using the same pre- and post- service times for all of the codes in 43201-43232 as for the revised base code for flexible trans-oral esophagoscopy, 43200.

A survey of practicing physicians representing urban, suburban and rural community and academic settings was performed with 121 respondents of 5029 queried (2.4 %). Of the responses received, 86% were from Gastroenterologists, 11% were from Otolaryngologists, and 3% were from Endoscopic Surgeons. 96% found the vignette to be typical. The median service performance rate was 75. 85% typically used moderate sedation in the facility (hospital outpatient, ambulatory surgery center) setting. In the base code survey of pre-service and post-service times, as described above, the respondents reported median pre-service evaluation, positioning, and scrub/dress/wait times of 25, 5, and 5 minutes respectively, and post service time of 10 minutes. The respondents reported a median intra-service time of 15 minutes and post-service time of 10 minutes. 25 (21%) of the respondents chose key reference service 49421 (Insertion of tunneled intraperitoneal catheter for dialysis, open 46/45/20 RVW 4.21) and considered 43200 to be of slightly greater intensity in 10 of 11 measures and almost equal intensity in 1 of 11 measures. The median survey RVW was 2.78. We note that as all of the gastrointestinal endoscopy codes are being surveyed over the next two years, the reference service list (RSL) does not contain any endoscopic procedures that would be familiar to the physicians completing the surveys.

The specialty societies convened an expert panel to review the survey results and make recommendations. The panel noted that the median service performance rate (75) was substantially higher than would be expected for a typical gastroenterologist in solo or small group practice and that those who responded most likely overrepresented high volume referral centers comprising more experienced and efficient practitioners. The

expert panel felt this supported the concept that the survey respondents were more experienced than the typical practitioner, and that this should be considered in the development of work recommendations.

The panel noted there has been a change in the practice pattern for this service since it was initially valued by Harvard in 1993. In the 1980s and 1990s when code 43200 was first valued, flexible esophagoscopy was performed with fiberoptic instruments; today's standard of practice is the use of high-definition video endoscopes and high definition video monitors. In the early 1990s, conscious sedation used rapid intravenous administration of meperidine and diazepam without routine monitoring of pulse oximetry; in 2012, moderate sedation using benzodiazepines and opiates is administered in a controlled, titrated manner with automated monitoring of pulse oximetry, electrocardiogram and, in some settings, capnography. In the 1990s and early 2000s when this code was previously valued, there were no regulations and/or requirements for a complete History and Physical of the patient within 30 days of the procedure, documentation of a comprehensive examination updated on the day of procedure, a pre-sedation assessment including ASA physical status, airway and cardiac risk completed prior to the procedure, a mandatory timeout before beginning the procedure, or photodocumentation of the findings – all of which are now required to meet various local, state, payor and Medicare accreditation, quality standards, and/or patient safety requirements. In the early 1990s eosinophilic esophagitis had not been described, endoscopic management of Barrett's esophagus, endoscopic mucosal resection of tumors and stenting of esophageal cancer was in development, and endoscopic ultrasound was yet to be commercially available. The panel also noted that "open access" endoscopy, where the patient is not seen by the endoscopist until the day of the procedure, has gained increasing acceptance in a number of settings – community, academic, teaching, military, VA and public; urban, suburban and rural; single and multi-specialty group; independent and employed - during the past decade.

Medicare claims for diagnostic esophagoscopy, code 43200 – which includes flexible trans-oral, rigid trans-oral, and flexible trans-nasal esophagoscopy – have declined over a seven year period from 18,000 in 2005 to 14,834 in 2011. A review of a 5% Medicare claims file from 2011 (total 2011 claims 14,834) reveals that code 43200 was reported 70.74% percent of the time by otolaryngologists, 15.33% by gastroenterologists, and 4.42% by general surgeons. For Medicare, the procedure was performed 47.58% in the outpatient hospital, 22.71% in the inpatient hospital, 18.67% in the physician office, and 10.53% in the ambulatory surgery center setting. In comparison, the remaining codes in 43201-43232 are reported primarily by gastroenterologists. As otolaryngologists and surgeons perform both rigid and flexible esophagoscopy, one can make only an estimate assumption that a percentage of the services performed by those specialties in facility settings represent rigid esophagoscopy procedures performed under general anesthesia. Similarly, one can make only an estimate assumption as to the percentage of services performed in the office setting represent flexible trans-oral vs. trans-nasal esophagoscopy.

The expert, multi-society panel notes that a change has occurred in the way that the work of moderate sedation is calculated for the purposes of the RUC's recommendations to CMS. Prior to 2012, the RUC and CMS affirmed that physician work of administering moderate sedation was part of the intra-service time, as in endoscopic procedures 43235 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* and 45378 *Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)* which were surveyed in the 2005 Third Five-Year review, and 43262 *Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy* which was surveyed in the 2010 Fourth Five-Year review. In fact, an overwhelming majority (89%) of codes in Appendix G in which moderate sedation is intrinsic to the service, where moderate sedation is specifically identified in the RUC work descriptors, describe moderate sedation as occurring during the intra-service period. The decision by the RUC's Research Subcommittee to change how the physician work of administering moderate sedation is accounted for as pre-service, not intra-service work, may constitute recognition that there has been a change in the physician work of performing endoscopic procedures over the past 20 years. In view of such, the RUC's introduction of the standardized pre-service packages in 2008 which specify a difference in pre-service evaluation minutes depending on whether a procedure involves sedation / anesthesia care, and the Research Subcommittee's 2012 clarification that the administration of moderate sedation constitutes work as occurring

during the pre-service period, represents an important change in the way that physician work for procedures involving moderate sedation is valued, and constitutes compelling evidence for re-valuation of the gastrointestinal endoscopy codes.

The expert panel felt that in view of the change in how the procedure was performed, new diagnoses, and new requirements to ensure patient safety, the predominance of otolaryngologists performing code 43200 vs. gastroenterologists performing the predominance of other procedures in the 43201-43232 family, and the inability to distinguish the percentage of previous services that represent rigid trans-oral, flexible trans-oral, and flexible trans-nasal procedures, the flexible, trans-oral esophagoscopy procedure has changed since the initial valuation by Harvard, providing compelling evidence for re-valuation.

After assessing the pre-service work that is performed, the expert panel determined that the assumption that all endoscopic procedures would have identical pre- and post-service time may have been incorrect. We note that the survey instrument approved by the Research Subcommittee did not allow the expert panel to draw any conclusions about the role of moderate sedation in the valuation of the pre-service work. The expert panel attempted to address this by reviewing similar services, based on whether the typical patient and typical procedure was straightforward or complex. For this procedure, we are recommending pre-service package 1b with changes of times to 19/3/5 for a total of 27 minutes of pre-service time when the procedure is performed in the facility setting, as follows:

**Evaluation:** 19 minutes, which is the package time, but less than the survey median.

**Positioning:** Addition of 2 minutes (3 min total) to account for positioning the patient, anesthesia lines, and video/scope equipment to allow access for the procedure and moderate sedation monitoring.

**Scrub/Dress/Wait:** 5 minutes, which is equal to the survey median and package time.

The panel felt that the median post-service time of 10 minutes underestimated the elements of post service work. The panel reviewed other scope procedures that had recently been reviewed by the RUC and recommended adjusting the post service time work to 15 minutes which is equivalent to code 31622, *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* reviewed by the RUC in April 2009. The panel determined that the post-service time should be less than the 20 minutes of post-service work for code 52005, *Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;* reviewed by the RUC in October 2010 at the 4<sup>th</sup> Five-Year review.

The panel noted the survey median intra-service time was 15 minutes and felt that, even though the survey group represented a more experienced referral center practitioner group, this time was acceptable as it represented approximately 1/3 of the intra-service time for the key reference service 49421, *Insertion of tunneled intraperitoneal catheter for dialysis, open*, which was reviewed by the RUC in April 2010, and approximately twice the intra-service time of code 31575, *Laryngoscopy, flexible fiberoptic; diagnostic*, which was reviewed by the RUC in the 2005 five-year review. Of note is that laryngoscopy is a service which does not inspect the esophagus. The panel noted that the respondent 25<sup>th</sup> percentile and median RVW recommendation were respectively 1.80 and 2.78, which along with the changes in the practice patterns and new diagnoses represented compelling evidence to recommend a revaluation in the physician work of this procedure. The expert panel then reviewed the rank order of code 43200 along with the intra-service times for the other codes surveyed in the 43200-43232 family. Based on the comprehensive review of the family of codes surveyed, the expert panel determined that despite the 25<sup>th</sup> percentile RVW recommendation of 1.80 and the presence of compelling evidence which would otherwise merit a work value increase, the panel could not justify recommending an increase in the current valuation of code 43200 from 1.59.

As the physicians who completed the surveys were significantly limited in their choice of key reference codes within the endoscopic family, the panel felt that code 49421 represented an appropriate key reference code even though the total and intraservice times for code 43200 were greater. Adjusting for the differences in times, the panel concluded that the current RVW of 1.59 and revised IWPOT (0.0480) for code 43200 is



consistent with MPC code 31575 *Laryngoscopy, flexible fiberoptic; diagnostic (000 global, 15/8/5 RVW 1.10, IWPUT 0.0904)* which is considered to be a more intense service, and less than code 49421 *Insertion of tunneled intraperitoneal catheter for dialysis, open (000 global, 49/45/20, RVW 4.21, IWPUT 0.0639)* which is considered to be a more intense service. The panel considered MPC code 57410 *Pelvic examination under anesthesia (other than local) (000 global, 30/15/25 RVW 1.75, IWPUT 0.0345)* to be a reasonable comparable code of lesser complexity. In addition code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure) (000 global 25/30/15 RVW 2.78, IWPUT 0.0688)* compares favorably with 43200 adjusting for the difference in intra service times.

While there was compelling evidence to recommend an increase in the wRVU times for code 43200, based on the survey times adjusted for pre-service package 1b in the facility setting, the expert panel recommends that the existing wRVU value of 1.59 should be retained with physician times 27/15/15 (compared to the previous Harvard valuation of 27/15/13).

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43200

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology                      How often? Rarely

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 10167

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. ~Medicare 2011 volume 14,834 x (15.33% (GI cases) + {[70.74% (ENT) + 4.42% (Surgery)] x 10%}. 70.74%+4.42%= 75.16% x 10% = 7.516% x 14834 = 1115 ; 14834 x 15.33% = 2274; (1115 + 2274)\*3 = 10,167

Specialty Gastroenterology	Frequency 6822	Percentage 67.09 %
----------------------------	----------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 7,402

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Leftover utilization not going to codes 4319X1,X7 and 4321X1

Specialty Gastroenterology	Frequency 4966	Percentage 67.08 %
----------------------------	----------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? No

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43200

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43201	Tracking Number	Original Specialty Recommended RVU: <b>2.09</b>
		Presented Recommended RVU: <b>2.09</b>
Global Period: 000		RUC Recommended RVU: <b>1.90</b>

CPT Descriptor: Esophagoscopy, flexible, transoral; with directed submucosal injection(s), any substance

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 68 year-old patient with achalasia undergoes therapeutic esophagoscopy with injection of botulinum toxin

Percentage of Survey Respondents who found Vignette to be Typical: 97%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 87%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 83%

Description of Pre-Service Work: Review with the patient any symptoms and ascertain characteristics of the dysphagia problem when it is clear there is dysphagia. The patient's history is reviewed to assess for the need for pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed and documented; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays and other diagnostic tests are reviewed. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained and the physician must sign the consent. The physician verifies all endoscopic equipment is available and appropriate computer entries are made. The patient is positioned on the examination table. The endoscopic and moderate sedation monitoring equipment is positioned to provide access for the procedure. A time out is performed. A bite block is placed in the mouth. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible upper endoscope is inserted through the mouth into the oropharynx and advanced through the esophagus into the proximal stomach and, when indicated, retroflexed to allow examination of the cardia. The endoscope is withdrawn, allowing measurement of the squamocolumnar and gastro-esophageal junction from the incisors, assessment for presence of a hiatal hernia, and then examination of the esophageal mucosa. The lower esophageal sphincter is identified. The endoscope is withdrawn to 38cm and Botulinum toxin A solution is injected submucosally at four quadrants under endoscopic direction. Photodocumentation of the exam findings including measurements of the lesion, labeling of the identified structures and magnified images of the abnormality are obtained and sent to a hard copy device. After observation to confirm the absence

of bleeding, the endoscope is then withdrawn. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. The endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. Post procedure orders are completed. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to referral source and other appropriate parties. Data is entered into procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others. Necessary prescriptions, follow-up tests and appointments are provided to the patient.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	10/2012				
<b>Presenter(s):</b>	Joel V. Brill, MD (AGA), Nicholas Nickl, MD (ASGE), Edward S. Bentley, MD (ASGE), Michael Edye, MD (SAGES), Don J. Selzer, MD (SAGES)				
<b>Specialty(s):</b>	AGA, ASGE, SAGES				
<b>CPT Code:</b>	43201				
<b>Sample Size:</b>	4325	<b>Resp N:</b>	121	<b>Response:</b> 2.7 %	
<b>Description of Sample:</b>	The AGA and ASGE conducted a random sample of their member gastroenterologists using the Census Department office regions ( <a href="http://www.census.gov/regions/">http://www.census.gov/regions/</a> ). Between 150 and 200 gastroenterologists were randomly selected in each region for a total of 2,000 gastroenterologists. The AGA and ASGE enhanced the random sample by adding 514 members of the ASGE Special Interest Groups and 786 physicians who perform esophagoscopy EUS and stent, TNE and optical endomicroscopy and ablation provided by Industry. The AGA and ASGE also added 86 volunteers who responded to the educational article on the RUC survey process that was approved by the Research Subcommittee and was distributed to all AGA and ASGE members. The AGA and ASGE's total survey sample size was 3,386. SAGES sent a total of 1,000 emails (939 successfully delivered) using a random selection of 250 members from each of the four CMS DME Regions A-D (ie, geographically distributed). The total survey sample size for SAGES, AGA and ASGE was 4,325.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	5.00	10.00	20.00	500.00
<b>Survey RVW:</b>	0.55	2.10	3.00	3.90	9.27
<b>Pre-Service Evaluation Time:</b>			25.00		
<b>Pre-Service Positioning Time:</b>			5.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			5.00		
<b>Intra-Service Time:</b>	0.00	10.00	15.00	20.00	45.00
<b>Immediate Post Service-Time:</b>	<u>10.00</u>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1b-FAC Straightforw Pat Procedure(w sedate/anes)

<b>CPT Code:</b>	43201	<b>Recommended Physician Work RVU: 1.90</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		19.00	19.00	0.00
<b>Pre-Service Positioning Time:</b>		3.00	1.00	2.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00
<b>Intra-Service Time:</b>		15.00		
<b>Immediate Post Service-Time:</b>	<u>10.00</u>			

<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b><u>0.00</u></b>	99291x <b>0.00</b>	99292x <b>0.00</b>		
<b>Other Hospital time/visit(s):</b>	<b><u>0.00</u></b>	99231x <b>0.00</b>	99232x <b>0.00</b>	99233x <b>0.00</b>	
<b>Discharge Day Mgmt:</b>	<b><u>0.00</u></b>	99238x <b>0.0</b>	99239x <b>0.0</b>	99217x <b>0.00</b>	
<b>Office time/visit(s):</b>	<b><u>0.00</u></b>	99211x <b>0.00</b>	12x <b>0.00</b>	13x <b>0.00</b>	14x <b>0.00</b> 15x <b>0.00</b>
<b>Prolonged Services:</b>	<b><u>0.00</u></b>	99354x <b>0.00</b>	55x <b>0.00</b>	56x <b>0.00</b>	57x <b>0.00</b>
<b>Sub Obs Care:</b>	<b><u>0.00</u></b>	99224x <b>0.00</b>	99225x <b>0.00</b>	99226x <b>0.00</b>	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
49421	000	4.21	RUC Time

CPT Descriptor Insertion of tunneled intraperitoneal catheter for dialysis, open**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
31575	000	1.10	RUC Time	599,944
<u>CPT Descriptor 1</u> Laryngoscopy, flexible fiberoptic; diagnostic				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
57410	000	1.75	RUC Time	3,277

CPT Descriptor 2 Pelvic examination under anesthesia (other than local)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31622	000	2.78	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 23      % of respondents: 19.0 %

**TIME ESTIMATES (Median)**

	<b>CPT Code:</b> <b>43201</b>	<b>Key Reference CPT Code:</b> <b>49421</b>	<b>Source of Time</b> <b>RUC Time</b>
Median Pre-Service Time	27.00	46.00	
Median Intra-Service Time	15.00	45.00	

Median Immediate Post-service Time	10.00	20.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>52.00</b>	<b>111.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered		
--	--	--

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed		
--	--	--

Urgency of medical decision making		
------------------------------------	--	--

**Technical Skill/Physical Effort (Mean)**

Technical skill required		
--------------------------	--	--

Physical effort required		
--------------------------	--	--

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality		
---	--	--

Outcome depends on the skill and judgment of physician		
--	--	--

Estimated risk of malpractice suit with poor outcome		
--	--	--

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity		
----------------------------------	--	--

Intra-Service intensity/complexity	4.15	3.42
------------------------------------	------	------

Post-Service intensity/complexity		
-----------------------------------	--	--

## Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

43201 *Esophagoscopy, flexible; transoral diagnostic, with directed submucosal injection(s), any substance* RVW, 2.09, physician time, (12/25/27.5) was initially reviewed by the RUC in April 2002. This code is being reviewed in response to comments by CMS in the Proposed Rule and Final Rule for CY 2012, requesting review of a number of gastrointestinal endoscopic services as being potentially misvalued.

Although this code was not specifically identified by CMS in the Final Rule, the societies that committed to a comprehensive review of gastrointestinal endoscopic services – the AGA, ACG, ASGE and SAGES – identified that code 43200 was primarily performed by otolaryngologists, while the remaining codes in the 43200-43232 family were primarily performed by gastroenterologists and endoscopic surgeons. In view of such, a coding change proposal was brought to the February 2012 CPT Editorial Panel in conjunction with the AAO-HNS and the Triological Society, requesting the development of new codes for trans-nasal esophagoscopy (primarily performed in the non-facility setting without moderate sedation) and rigid esophagoscopy (primarily performed in the OR setting with anesthesia administered by an anesthesia professional). While the code number, 43201, remains the same, this code is now specific for a flexible, transoral, esophagoscopy procedure.

In May 2012 the AGA, ASGE and SAGES requested that the Research Subcommittee consider a mini-survey methodology for this and the other codes in the 43200-43232 family, which was approved. The Research Subcommittee required that a standard survey be conducted of the new base code for flexible trans-oral esophagoscopy, 43200 *Esophagoscopy, flexible; transoral diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*, specifically including the elements of pre- and post-service physician work. For the remaining codes that were surveyed in the 43201-43232 family, the mini-survey instrument only asked the physician to address the intra-service work component for the procedure. Accordingly, the societies submitting these recommendations are using the same pre- and post- service times for all of the codes in 43201-43232 as for the revised base code for flexible trans-oral esophagoscopy, 43200.

A survey of practicing physicians representing urban, suburban and rural community and academic settings was performed with 121 respondents of 4325 queried (2.7 %). Of the responses received, 98% were from Gastroenterologists and 2% were from Endoscopic Surgeons. Of those who participated in the survey, 73 (60%) responded to a subsequent email asking whether the vignette was typical. Of the 73 who responded, 97% found the vignette to be typical. The median service performance rate was 10. 87% typically used moderate sedation in the facility (hospital outpatient, ambulatory surgery center) setting. In the base code survey of pre-service and post-service times, as described above, the respondents reported median pre-service evaluation, positioning, and scrub/dress/wait times of 25, 5, and 5 minutes respectively, and post service time of 10 minutes. The respondents reported a median intra-service time of 15 minutes and post-service time of 10 minutes. 23 (19%) of the respondents chose key reference service 49421 *Insertion of tunneled intraperitoneal catheter for dialysis, open* (wRVW 4.21 46/45/20). The survey intra-service intensity of 43201 was 4.15, compared to the comparison code intra-service intensity of 3.42. We note that as all of the gastrointestinal endoscopy codes are being surveyed over the next two years, the reference service list (RSL) does not contain any endoscopic procedures that would be familiar to the physicians completing the surveys.

The specialty societies convened an expert panel to review the survey results and make recommendations. The panel noted that the median service performance rate (10) was what would be expected for a typical gastroenterologist in solo or small group practice.

When 43201 is performed in the facility setting, the panel recommended pre-service package **1b**, Facility Straightforward Patient / Straightforward Procedure (With sedation / anesthesia care), which would be used for this non-incisional trans-oral endoscopic procedure. The expert panel felt the survey respondents underestimated the time necessary to complete all of the elements included in the facility pre-service package



that are typically performed with 43201 and failed to consider all of the elements in their time estimation (indications and contraindications for sedation, history of relevant cardiovascular, pulmonary, and neurological conditions, focused physical examination including modified Mallampati score to predict ease of intubation, ASA physical status classification, and summative determination of sedation requirement) and therefore recommended an adjustment of times to reflect the pre-service package and work.

Medicare claims for diagnostic esophagoscopy, with directed submucosal injection(s), any substance code 43201 – which includes flexible trans-oral, rigid trans-oral, and flexible trans-nasal esophagoscopy – have increased slightly over a seven year period from 409 in 2005 to 506 in 2011. A review of a 5% Medicare claims file from 2011 (total 2011 claims 506) reveals that code 43201 was reported 35.98% percent of the time by otolaryngologists, 55.13% by gastroenterologists, 2.94 % by thoracic surgeons and 2.75% by general surgeons. For Medicare, the procedure was performed 73.25% in the outpatient hospital, 16.64% in the inpatient hospital, 2.33% in the physician office, and 7.79% in the ambulatory surgery center setting. As otolaryngologists and surgeons perform both rigid and flexible esophagoscopy, one can make only an estimate assumption that a percentage of the services performed by those specialties in facility settings represent rigid esophagoscopy procedures performed under general anesthesia. Similarly, one can make only an estimate assumption as to the percentage of services performed in the office setting represent flexible trans-oral vs. trans-nasal esophagoscopy.

The expert, multi-society panel notes that a change has occurred in the way that the work of moderate sedation is calculated for the purposes of the RUC's recommendations to CMS. Prior to 2012, the RUC and CMS affirmed that physician work of administering moderate sedation was part of the intra-service time, as in endoscopic procedures 43235 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* and 45378 *Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)* which were surveyed in the 2005 Third Five-Year review, and 43262 *Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy* which was surveyed in the 2010 Fourth Five-Year review. In fact, an overwhelming majority (89%) of codes in Appendix G in which moderate sedation is intrinsic to the service, where moderate sedation is specifically identified in the RUC work descriptors, describe moderate sedation as occurring during the intra-service period. The decision by the RUC's Research Subcommittee to change how the physician work of administering moderate sedation is accounted for as pre-service, not intra-service work, may constitute recognition that there has been a change in the physician work of performing endoscopic procedures over the past 20 years. In view of such, the RUC's introduction of the standardized pre-service packages in 2008 which specify a difference in pre-service evaluation minutes depending on whether a procedure involves sedation / anesthesia care, and the Research Subcommittee's 2012 clarification that the administration of moderate sedation constitutes work as occurring during the pre-service period, represents an important change in the way that physician work for procedures involving moderate sedation is valued, and constitutes compelling evidence for re-valuation of the gastrointestinal endoscopy codes.

After assessing the pre-service work that is performed, the expert panel determined that the assumption that all endoscopic procedures would have identical pre- and post-service time may have been incorrect. We note that the survey instrument approved by the Research Subcommittee did not allow the expert panel to draw any conclusions about the role of moderate sedation in the valuation of the pre-service work. The expert panel attempted to address this by reviewing similar services, based on whether the typical patient and typical procedure was straightforward or complex. For this procedure, we are recommending pre-service package 1b with changes of times to 19/3/5 for a total of 27 minutes of pre-service time when the procedure is performed in the facility setting, as follows:

**Evaluation:** 19 minutes which is the package time, but less than the survey median.

**Positioning:** Addition of 2 minutes (3 min total) to account for positioning the patient, anesthesia lines, and video/scope equipment to allow access for the procedure and moderate sedation monitoring.

**Scrub/Dress/Wait:** 5 minutes which is equal to the survey median and package time.

The panel felt that the median post-service time of 10 minutes underestimated the elements of post service work. The panel reviewed other scope procedures that had recently been reviewed by the RUC and recommended adjusting the post service time work to 15 minutes which is equivalent to code 31622, *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* reviewed by the RUC in April 2009. The panel determined that the post-service time should be less than the 20 minutes of post-service work for code 52005, *Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;* reviewed by the RUC in October 2010 at the 4<sup>th</sup> Five-Year review.

The panel noted the survey median intra-service time was 15 minutes and considered it an underestimate as it was the same intraservice time as the base code and a reduction of 10 minutes since it was last reviewed. Nevertheless, the panel felt that this time was acceptable as it represented approximately 1/3 of the intra-service time for the key reference service 49421, *Insertion of tunneled intraperitoneal catheter for dialysis, open*, which was reviewed by the RUC in April 2010, and approximately twice the intra-service time of code 31575, *Laryngoscopy, flexible fiberoptic; diagnostic*, which was reviewed by the RUC in the 2005 five-year review. Of note is that laryngoscopy is a service which does not inspect the esophagus. The panel felt that although the intraservice time was approximately two thirds of the previous valuation, the intensity of the service (i.e. the necessity to successfully perform the service without complication in a shorter period of time) had substantially increased. The panel noted that the respondent 25<sup>th</sup> percentile and median RVW recommendation were respectively 2.10 and 3.00 which was consistent with the increase in intensity. The expert panel then reviewed the rank order of code 43200 along with the intra-service times for the other codes surveyed in the 43200-43232 family. Based on the comprehensive review of the family of codes surveyed, the expert panel determined that despite the 25<sup>th</sup> percentile RVW recommendation of 2.10, the lack of compelling evidence which would otherwise merit a work value increase could not justify recommending an increase in the current valuation of code 43201 from 2.09.

As the physicians who completed the surveys were significantly limited in their choice of key reference codes within the endoscopic family, the panel felt that code 49421 represented an appropriate key reference code even though the total and intraservice times for code 49421 were greater. Adjusting for the differences in times, the panel concluded that the current RVW of 2.09 and revised IWPUT (0.081) for code 43201 is consistent with MPC code 31575 *Laryngoscopy, flexible fiberoptic; diagnostic* (000 global, 15/8/5 RVW 1.10, IWPUT 0.0904) which is considered to be a more intense service, and less than code 49421 *Insertion of tunneled intraperitoneal catheter for dialysis, open* (wRVW 4.21, IWPUT 0.0639) which is considered to be a slightly more intense service. The panel considered MPC code 57410 *Pelvic examination under anesthesia (other than local)* (000 global, 30/15/25 RVW 1.75, IWPUT 0.0345) to be a reasonable comparable code of lesser complexity. In addition code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (000 global 25/30/15 RVW 2.78, IWPUT 0.0688) compares favorably with 43201 adjusting for the difference in intra service times.

Since there was no compelling evidence to recommend an increase in the wRVU times for code 43201, based on the survey times adjusted for pre-service package 1b in the facility setting, the expert panel recommends that the existing wRVU value of 2.09 should be retained with physician times 27/15/15 (compared to the previous RUC valuation of 12/25/27.5).

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43201

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology                      How often? Rarely

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1500

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare data 2011 = 506.  $(506 \times 3) = \sim 1,500$ . We believe that 90% of the previously reported procedures will now be reported using the codes specific for flexible, transoral esophagoscopy procedures.

Specialty Gastroenterology                      Frequency 1350                      Percentage 90.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 378

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare data 2011 = 506. leftover utilization not going to 4319X2

Specialty Gastroenterology                      Frequency 341                      Percentage 90.21 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? No

## Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43201

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

**CPT Long Descriptor:**

- 77280 Therapeutic radiology simulation-aided field setting; simple
  - 77285 Therapeutic radiology simulation-aided field setting; intermediate
  - 77290 Therapeutic radiology simulation-aided field setting; complex
  - 77293 Respiratory motion management simulation  
(List separately in addition to code for primary procedure)  
(Use +77293 in conjunction with 77295, 77301)
  - 77295 3-dimensional radiotherapy plan, including dose volume histograms
- 

**Global Period:** 77280, 77285, 77290 & 77295 XXX and 77293 ZZZ

**Meeting Date:** January 2013

**Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:**

ASTRO convened a panel that included a number of experts familiar with these services to evaluate the direct practice expense inputs for these procedures.

**You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison. You must provide an explanation for the selection of reference codes. Reference Code Rationale:**

For the four existing codes, ASTRO included the current direct practice expense inputs as well as the recommended inputs for the procedures. We also included the direct practice expense inputs for CPT codes that are sometimes billed with the procedures as a point of reference to ensure there is no double counting. ASTRO included recommendations for the new code. One of the existing codes 77014 can serve as a reference code for this new procedure.

**If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:**

N/A

**Please describe in detail the clinical activities of your staff:**

**Pre Service Clinical Activities**

N/A

**Intra-Service Clinical Labor Activities**

*CPT codes 77280*

The radiation therapist will first prepare the CT room. This will include positioning the CT table at its lowest position, placing any pads on the table and setting the moveable patient positioning lasers at their zero position. The Radiation Therapist will gather and ready any necessary supplies for patient marking.

The radiation therapist will then greet the patient and give them a brief explanation of the simulation procedure and its expected duration. The patient will be led to the changing area and instructed to change into the appropriate exam gown.

After gowning, the radiation therapist will bring the patient into the CT room and verify the patient's identity according to department policy. The therapist will explain the CT procedure in detail, ask if they have any questions or concerns and provide any additional information as necessary. The therapist will then take a face photo of the patient. The therapist will assist the patient onto the CT table and place them into the appropriate position. The patient's arms and legs will then be positioned according to scan protocol and/or patient comfort considerations. Knee wedges, arm straps and other pads may be added as needed to ensure patient comfort and stability. The patient positioning lasers are used to verify patient alignment. Markers are placed on the patient's skin as directed by the radiation oncologist.

After verifying with the radiation oncologist the extent of the area to be scanned, the therapist manually moves the patient into the CT unit bore checking for sufficient clearance between the patient, table and the CT unit. The table is then positioned using the internal CT lasers to the start position for the scanning sequence. The radiation therapist chooses the appropriate scanning parameters at the CT console and takes AP and lateral scout images.

The scout images are shown to the radiation oncologist and reviewed. Adjustments are made to patient position as necessary to improve patient alignment and/or comfort. Scout images are then repeated and the final patient positioning verified. At this point the field of view for the scan, including the superior/inferior scan extent, is set by the therapist. The patient is then scanned and the images are reconstructed.

The scan images are then reviewed by the radiation therapist and radiation oncologist. It is verified that the patient position is acceptable, that the scan extends sufficiently in the superior/inferior directions, and that no part of the patient's skin contour is cut off. The image quality of the scan is also noted, in particular any artifacts that might arise from contrast agents or metallic implants.

The scan images are then sent to the virtual simulation workstation where the radiation oncologist places the treatment fields and sets isocenter. The radiation therapist then generates digitally reconstructed radiographs (DRR's) from the virtual treatment fields.

The therapist then exports the isocenter coordinates to the laser system which projects the isocenter position onto the patient. The therapist tattoos the patient with the projected isocenter position as well as any other ancillary leveling and positioning marks that will be used for patient set up on the treatment unit. The therapist documents these tattoos with photos. The therapist then assists the patient off of the CT table and takes them back to the changing area.

Back in the CT room, the therapist exports the scan images and DRR's to the PACS system and the radiation therapy planning computer and uploads the patient face and tattoo photos into the record and verify system. The therapist then completes the simulation documentation and prepares the patient set up instructions for use at the treatment unit. The pads and other positioning devices are then removed from the CT table. The table and other equipment is then cleaned and disinfected and unused supplies are put away.

#### CPT Code 77285

The radiation therapist will first prepare the CT room. This will include positioning the CT table at its lowest position, installing any immobilization devices or pads on the table and setting the moveable patient positioning lasers at their zero position. The Radiation Therapist will gather and ready any necessary supplies for patient marking.

The radiation therapist will then greet the patient and give them a brief explanation of the simulation procedure and its expected duration. The patient will be led to the changing area and instructed to change into the appropriate exam gown.

After gowning, the radiation therapist will bring the patient into the CT room and verify the patient's identity according to department policy. The therapist will explain the CT procedure in detail, ask if they have any questions or concerns and provide any additional information as necessary. The therapist will then take a face photo of the patient. The therapist will assist the patient onto the CT table and place them into the appropriate position. This may involve placing the patient into immobilization devices such as a mold or mask or other supporting devices as appropriate. The patient's arms and legs will then be positioned according to scan protocol and/or patient comfort considerations. Knee wedges, arm straps and other pads may be added as needed to ensure patient comfort and stability. The patient positioning lasers are used to verify patient alignment. Markers for the first treatment area are placed on the patient's skin as directed by the radiation oncologist.

After verifying with the radiation oncologist the extent of the area to be scanned, the therapist manually moves the patient into the CT unit bore checking for sufficient clearance between the patient, table and immobilization devices and the CT unit. The table is then positioned using the internal CT lasers to the start position for the scanning sequence. The radiation therapist chooses the appropriate scanning parameters at the CT console and takes AP and lateral scout images.

The scout images are shown to the radiation oncologist and reviewed. Adjustments are made to patient position as necessary to improve patient alignment and/or comfort. The scout images may indicate that an alternative patient position would be advantageous in which case the patient

positioning sequence would be repeated. Scout images are then repeated and the final patient positioning verified. At this point the field of view for the scan, including the superior/inferior scan extent, is set by the therapist. The patient is then scanned and the images are reconstructed.

The scan images are then reviewed by the radiation therapist and radiation oncologist. It is verified that the patient position is acceptable, that the scan extends sufficiently in the superior/inferior directions, and that no part of the patient's skin contour is cut off. The image quality of the scan is also noted, in particular any artifacts that might arise from contrast agents or metallic implants.

The patient is then repositioned, as necessary, for scanning of the second treatment area. New markers are placed on the patient's skin, clearances are checked and AP and lateral scout images are obtained as described above. They are reviewed, patient position is adjusted as necessary and scouts are repeated. After approval by the radiation oncologist, the second treatment area of the patient is scanned.

Both sets of scan images are then sent to the virtual simulation workstation where the radiation oncologist places the treatment fields and sets isocenters for both treatment areas. The radiation therapist then generates digitally reconstructed radiographs (DRR's) for both sites from the virtual treatment fields.

The therapist then exports the isocenter coordinates for the first treatment site to the laser system which projects the isocenter position onto the patient. The therapist tattoos the patient with the projected isocenter position as well as any other ancillary leveling and positioning marks that will be used for patient set up on the treatment unit. This process is then repeated for the second treatment area. The therapist documents the tattoos for both sites with photos. The therapist then assists the patient off of the CT table and takes them back to the changing area.

Back in the CT room, the therapist exports the scans and DRR's to the PACS system and the radiation therapy planning computer and uploads the patient face and tattoo photos into the record and verify system. The therapist then completes the simulation documentation and prepares the patient set up instructions for use at the treatment unit. The immobilization equipment and other devices are then removed from the CT table. The table and other equipment is then cleaned and disinfected and unused supplies are put away.

#### CPT Code 77290

The radiation therapist will first prepare the CT room. This will include positioning the CT table at its lowest position, installing the customized immobilization device that was fabricated for the patient and setting the moveable patient positioning lasers at their zero position. The Radiation Therapist will gather and ready any necessary supplies for patient marking.

The radiation therapist will then greet the patient and give them a brief explanation of the simulation procedure and its expected duration. The patient will be led to the changing area and instructed to change into the appropriate exam gown.

After gowning, the radiation therapist will bring the patient into the CT room and verify the patient's identity according to department policy. The therapist will explain the CT procedure in detail, ask if they have any questions or concerns and provide any additional information as



necessary. The therapist will then take a face photo of the patient. The therapist will assist the patient onto the CT table and place them into the immobilization device. This consists of an angled support structure which holds the patient's torso and arms in positions which permit optimum treatment geometry. The support structure incorporates a customized mold for the patient to ensure reproducibility of the patient's position. Treatment of the breast and supraclavicular area require complicated treatment beam geometry and it is vital that the patient be positioned correctly and reproducibly. Extra time is required for such positioning. Knee wedges, straps and other pads may be added as needed to ensure patient comfort and stability. The patient positioning lasers are used to verify patient alignment. Markers are placed on the patient's skin as directed by the radiation oncologist.

After verifying with the radiation oncologist the extent of the area to be scanned, the therapist manually moves the patient into the CT unit bore checking for sufficient clearance between the patient, table and immobilization devices and the CT unit. This must be checked very carefully due to the size of the immobilization device and the position of the patient's arm over her head. The table is then positioned using the internal CT lasers to the start position for the scanning sequence. The radiation therapist chooses the appropriate scanning parameters at the CT console and takes AP and lateral scout images.

The scout images are shown to the radiation oncologist and reviewed. Adjustments are made to patient position as necessary to improve patient alignment and/or comfort. The scout images may indicate that an alternative arm position or angle of the patient's torso would be advantageous in which case the immobilization device would be modified and the patient positioning sequence would be repeated. Scout images are then repeated and the final patient positioning verified. At this point the field of view for the scan, including the superior/inferior scan extent, is set by the therapist. The patient is then scanned and the images are reconstructed.

The scan images are then reviewed by the radiation therapist and radiation oncologist. It is verified that the patient position is acceptable, that the scan extends sufficiently in the superior/inferior directions, and that no part of the patient's skin contour is cut off. The image quality of the scan is also noted, in particular any artifacts that might arise from contrast agents or metallic implants.

The scan images are then sent to the virtual simulation workstation where the radiation oncologist places the treatment fields for both the breast and the nodal areas and sets one or more isocenters for those beams. The radiation therapist then generates digitally reconstructed radiographs (DRR's) from the virtual treatment fields.

The therapist then exports the isocenter coordinates to the laser system which projects the isocenter position onto the patient. The therapist tattoos the patient with the projected isocenter position as well as any other ancillary leveling and positioning marks that will be used for patient set up on the treatment unit. If multiple isocenters will be utilized, each will be exported, projected onto the patient and tattooed. The therapist documents all of the tattoos with photos. The therapist then assists the patient off of the CT table and takes them back to the changing area.

Back in the CT room, the therapist exports the scans and DRR's to the PACS system and the radiation therapy planning computer and uploads the patient face and tattoo photos into the

record and verify system. The therapist then completes the simulation documentation and prepares the patient set up instructions for use at the treatment unit. The immobilization equipment and other devices are then removed from the CT table. The table and other equipment is then cleaned and disinfected and unused supplies are put away.

CPT code 77293 -- ZZZ

The Radiation Therapist (RT) positions the respiratory transducers (infrared reflective device, respiratory sensing belt, active breathing control, etc.) on the patient and verifies connectivity with the 4D CT scanning system and/or respiratory signal processing computer.

The physicist then assists the physician in coaching the patient to achieve an optimal yet natural breathing cycle consistent with minimizing respiratory excursion. The resultant transducer signal is tracked over a length of time similar to what will be necessary to acquire the 4D data set. The respiratory cycle duration is measured. The coaching and tracking process is repeated to assure that the measured respiratory cycle characteristics are reproducible and will be typical of the cycle that will occur when the patient is treated.

In consultation with the physician and physicist, a decision is made as to triggering on phase or amplitude, the computer system is programmed to reflect that choice and a sample trigger data set is run to assure that the respiratory cycle will be properly segmented by the trigger signal. If the segmentation is sub-optimal, the transducer placement – coaching- tracking and triggering analysis is repeated.

Based upon the analysis of the respiratory cycle, appropriate cine and/or pitch parameters are calculated. A set of orthogonal scout images is acquired and the desired scan positions are set. The slice thickness, slice number, pitch/cine time and x-ray output parameters are optimized based on tube heating/cooling characteristics and maximum slice number constraints. The RT then adjusts the scan position parameters to be congruent with the initial CT simulation image data set and acquires the 4D data set. The physicist and physician observe both the progression of the scan acquisition and the integrity of the triggering signal overlaid on the respiratory cycle curve. If significant anomalies in the respiratory cycle curve occur the coaching/positioning/ respiratory cycle confirmation/ scan acquisition process is repeated.

At the conclusion of the raw data acquisition, the physicist adjusts the recorded respiratory trigger signal to account for minor deviations in the respiratory cycle. A 4D reconstruction is then implemented, generally creating a segmented series of 10 image data sets, each imaging 10% of the respiratory cycle. The physicist then reviews the resultant 4D data set in both static and Cine modes with the physician, and if acceptable, creates a Maximum Intensity Projection data Set (MIP) and an average or ungated data set. The RT then transmits the entire series (10 respiratory segments, MIP and Average) to a processing station for the physician to create an ITV or series of GTV's.

CPT Code 77295

The dosimetrist reviews the patient chart and prescription and receives guidance from the physician as to the particular issues related to the development of the 3-D isodose plan. The dosimetrist then enters the patient demographics into the Radiation Therapy Planning (RTP) computer, verifying that the patient name and medical record number are identical across the RTP system, the Record and Verify (RV) system and the CT simulation system.

The dosimetrist then imports the CT simulation image data sets into the RTP system and reviews each data set for completeness and appropriate planning characteristics. The dosimetrist contours the basic 3D organs at risk structures (i.e. skin) and then reviews the contours with the physician, making modifications as directed. As the physician draws the 3-D GTV, CTV and PTV structures, and critical structures, the dosimetrist assists as necessary, and then modifies adjacent or overlapping OAR structures using Boolean operators to avoid over-determined constraints during the development of the 3D isodose plan.

Based upon the contour sets designed/approved by the physician, the dosimetrist positions the isocenter to allow the optimal linac beam configuration, assigns beam energies, initial field sizes, gantry and table angles and beam weights in consultation with the physicist. The collimation of the beams is reviewed with the physician and adjusted as necessary with the aid of beams-eye views overlaid on digitally reconstructed radiographs (DRRs). A 3-D plan is then generated using the beam-modeling algorithm recommended by the physicist. Dose volume histograms are generated from the 3-D dose matrix of the plan, and beam parameters (beam energies, initial field sizes, gantry and table angles and beam weights) are adjusted as necessary. Additional trials (typically 3-4) with modified beam parameters are created and the dose volume histograms and isodose curve displays are compared to assist in plan optimization. The resultant 3-D information is reviewed with the physicist and physician and additional modifications are made as directed.

Once the physician has made a final decision on the 3-D isodose plan, the dosimetrist generates final treatment beam DRR's and orthogonal set-up DRR's, locks and archives the plan, exports it to the RV system, creates and reviews treatment field definitions in the RV system based upon the data imported from the RTP system and creates the treatment delivery notes for the Radiation Therapist to use during the patient treatment.

Lastly, the dosimetrist verifies that the beam delivery parameters transmitted from the RV system are correctly implemented on the linear accelerator delivery computer console.

**Post-Service Clinical Labor Activities:**

N/A

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43204	Tracking Number	Original Specialty Recommended RVU: <b>3.76</b>
		Presented Recommended RVU: <b>2.89</b>
Global Period: 000		RUC Recommended RVU: <b>2.89</b>

CPT Descriptor: Esophagoscopy, flexible, transoral: with injection sclerosis of esophageal varices

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 53 year old patient with cirrhosis and esophageal varices undergoes therapeutic esophagoscopy with injection sclerosis for control of active variceal hemorrhage.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 86%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 82%

Description of Pre-Service Work: Review with the patient any symptoms and ascertain characteristics of the dysphagia problem when it is clear there is dysphagia. The patient's history is reviewed to assess for the need for pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed and documented; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays and other diagnostic tests are reviewed. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained and the physician must sign the consent. The physician verifies all endoscopic equipment is available and appropriate computer entries are made. The patient is positioned on the examination table. The endoscopic and moderate sedation monitoring equipment is positioned to provide access for the procedure. A time out is performed. A bite block is placed in the mouth. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible upper endoscope is inserted through the mouth into the oropharynx and advanced through the esophagus into the proximal stomach and, when indicated, retroflexed to allow examination of the cardia. The endoscope is withdrawn, allowing measurement of the squamocolumnar and gastro-esophageal junction from the incisors, assessment for presence of a hiatal hernia, and then examination of the esophageal mucosa. Actively bleeding 3-4+ esophageal varices are identified. The area is washed. After obtaining adequate visibility of the most likely bleeding site, a sclerotherapy needle is inserted into the bleeding varix. Injections of sclerosing agent are performed to the primary bleeding varix. The level of sedation of the patient is reassessed and additional medication is administered as needed. The sclerotherapy needle is withdrawn, inserted at a second site in the varix, and injections of sclerosing agent are performed. Subsequent insertion of the sclerotherapy

needle and injections of sclerosing agent are performed for all other prominent varices identified as active or potential bleeding sources. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. The endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. Post procedure orders are completed. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to referral source and other appropriate parties. Data is entered into procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others. Necessary prescriptions, follow-up tests and appointments are provided to the patient.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	10/2012				
<b>Presenter(s):</b>	Joel V. Brill, MD (AGA), Nicholas Nickl, MD (ASGE), Edward S. Bentley, MD (ASGE), Michael Edye, MD (SAGES), Don J. Selzer, MD (SAGES)				
<b>Specialty(s):</b>	AGA, ASGE, SAGES				
<b>CPT Code:</b>	43204				
<b>Sample Size:</b>	4325	<b>Resp N:</b>	95	<b>Response:</b> 2.1 %	
<b>Description of Sample:</b>	The AGA and ASGE conducted a random sample of their member gastroenterologists using the Census Department office regions ( <a href="http://www.census.gov/regions/">http://www.census.gov/regions/</a> ). Between 150 and 200 gastroenterologists were randomly selected in each region for a total of 2,000 gastroenterologists. The AGA and ASGE enhanced the random sample by adding 514 members of the ASGE Special Interest Groups and 786 physicians who perform esophagoscopy EUS and stent, TNE and optical endomicroscopy and ablation provided by Industry. The AGA and ASGE also added 86 volunteers who responded to the educational article on the RUC survey process that was approved by the Research Subcommittee and was distributed to all AGA and ASGE members. The AGA and ASGE's total survey sample size was 3,386. SAGES sent a total of 1,000 emails (939 successfully delivered) using a random selection of 250 members from each of the four CMS DME Regions A-D (ie, geographically distributed). The total survey sample size for SAGES, AGA and ASGE was 4,325.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	0.00	2.00	5.00	150.00
<b>Survey RVW:</b>	0.00	2.89	3.76	4.79	12.00
<b>Pre-Service Evaluation Time:</b>			25.00		
<b>Pre-Service Positioning Time:</b>			5.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			5.00		
<b>Intra-Service Time:</b>	5.00	15.00	20.00	30.00	60.00
<b>Immediate Post Service-Time:</b>	<u>10.00</u>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	43204	<b>Recommended Physician Work RVU: 2.89</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		25.00	33.00	-8.00
<b>Pre-Service Positioning Time:</b>		3.00	1.00	2.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00
<b>Intra-Service Time:</b>		20.00		
<b>Immediate Post Service-Time:</b>	<u>10.00</u>			

Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

Key CPT Code	Global	Work RVU	Time Source
49421	000	4.21	RUC Time

CPT Descriptor Insertion of tunneled intraperitoneal catheter for dialysis, open**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
31575	000	1.10	RUC Time	599,944
<u>CPT Descriptor 1</u> Laryngoscopy, flexible fiberoptic; diagnostic				

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
57410	000	1.75	RUC Time	3,277
<u>CPT Descriptor 2</u> Pelvic examination under anesthesia (other than local)				

Other Reference CPT Code	Global	Work RVU	Time Source
31622	000	2.78	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 21      % of respondents: 22.1 %

**TIME ESTIMATES (Median)**

	CPT Code: 43204	Key Reference CPT Code: 49421	Source of Time RUC Time
Median Pre-Service Time	33.00	46.00	
Median Intra-Service Time	20.00	45.00	

Median Immediate Post-service Time	10.00	20.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>63.00</b>	<b>111.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)**(of those that selected Key  
Reference code)**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered		
--	--	--

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed		
--	--	--

Urgency of medical decision making		
------------------------------------	--	--

**Technical Skill/Physical Effort (Mean)**

Technical skill required		
--------------------------	--	--

Physical effort required		
--------------------------	--	--

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality		
---	--	--

Outcome depends on the skill and judgment of physician		
--	--	--

Estimated risk of malpractice suit with poor outcome		
--	--	--

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity		
----------------------------------	--	--

Intra-Service intensity/complexity	4.93	3.42
------------------------------------	------	------

Post-Service intensity/complexity		
-----------------------------------	--	--



## Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

### **Rationale and comments for 43204**

43204 *Esophagoscopy, flexible; transoral diagnostic, with injection sclerosis of esophageal varices* RVW, 3.76, physician time, (42/43/20) was last reviewed by the RUC in April 1993. This code is being reviewed in response to the CMS comments in the Proposed Rule and Final Rule for CY 2012, requesting review of gastrointestinal endoscopic services as potentially misvalued.

Although this code was not specifically identified by CMS in the Final Rule, the societies that committed to a comprehensive review of gastrointestinal endoscopic services – the AGA, ACG, ASGE and SAGES – identified that code 43200 was primarily performed by otolaryngologists, while the remaining codes in the 43200-43232 family were primarily performed by gastroenterologists and endoscopic surgeons. In view of such, a coding change proposal was brought to the February 2012 CPT Editorial Panel in conjunction with the AAO-HNS and the Trilogical Society, requesting the development of new codes for trans-nasal esophagoscopy (primarily performed in the non-facility setting without moderate sedation) and rigid esophagoscopy (primarily performed in the OR setting with anesthesia administered by an anesthesia professional). While the code number, 43204, remains the same, this code is now specific for a flexible, transoral, esophagoscopy procedure.

In May 2012 the AGA, ASGE and SAGES requested that the Research Subcommittee consider a mini-survey methodology for this and the other codes in the 43200-43232 family, which was approved. The Research Subcommittee required that a standard survey be conducted of the new base code for flexible trans-oral esophagoscopy, 43200 *Esophagoscopy, flexible; transoral diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*, specifically including the elements of pre- and post-service physician work. For the remaining codes that were surveyed in the 43201-43232 family, including code 43204, the mini-survey instrument only asked the physician to address the intra-service work component for the procedure. Accordingly, the societies submitting these recommendations are using for 43204 the same pre- and post- service times as for the revised base code for flexible trans-oral esophagoscopy, 43200.

A survey of practicing physicians representing urban, suburban and rural community and academic settings was performed with 95 respondents of 4325 queried (2.1 %). Of the responses received, 97% were from Gastroenterologists and 3% were from Endoscopic Surgeons. 96% found the vignette to be typical. The median service performance rate was 2. 86% typically used moderate sedation in the facility (hospital outpatient, ambulatory surgery center) setting. In the base code survey of pre-service and post-service times, as described above, the respondents reported median pre-service evaluation, positioning, and scrub/dress/wait times of 25, 5, and 5 minutes respectively, and post service time of 10 minutes. The respondents reported a median intra-service time of 20 minutes. 23 (23.2%) of the respondents chose key reference service 49421, *Insertion of tunneled intraperitoneal catheter for dialysis, open* (wRVW 4.21 45/45/20). The survey intra-service intensity of 43204 was 4.93, compared to the comparison code intra-service intensity of 3.42. As the mini-survey methodology only captured intra-service intensity / complexity, we are unable to provide an assessment regarding the relative intensity of the surveyed code to the comparison code on other measures. The median survey RVW was 3.76. We note that as all of the gastrointestinal endoscopy codes are being surveyed over the next two years, the reference service list (RSL) does not contain any endoscopic procedures that would be familiar to the physicians completing the surveys.

The specialty societies convened an expert panel to review the survey results and make recommendations. The panel noted that the median service performance rate (2) was what would be expected for a typical gastroenterologist in solo or small group practice. This reflects the change in practice patterns since this code was valued in 1993, with band ligation as the primary elective treatment of esophageal varices and variceal

sclerotherapy being reserved for cases which are more emergent or urgent, severe, and/or refractory to band ligation.

When 43204 is performed, the panel recommended pre-service package **2b**, Facility Difficult Patient / Straightforward Procedure (With sedation / anesthesia care), which would be used for this incisional trans-oral endoscopic procedure. Patients undergoing sclerotherapy of esophageal varices are considered difficult because of the underlying co-morbidities from cirrhosis, cancer, encephalopathy, and/or coagulopathy that are often seen in these patients. Patients with active bleeding from esophageal varices carries a greater risk of aspiration, uncontrollable bleeding, pain and perforation associated with the procedure. The expert panel felt the survey respondents underestimated the time necessary to complete all of the elements included in the facility pre-service package that are typically performed with 43204 and failed to consider all of the elements in their time estimation (indications and contraindications for sedation, history of relevant cardiovascular, pulmonary, and neurological conditions, focused physical examination including modified Mallampati score to predict ease of intubation, ASA physical status classification, and summative determination of sedation requirement) and therefore recommended an adjustment of times to reflect the pre-service package and work.

The panel noted there has been a change in the practice pattern for this service since it was most recently valued by the RUC in 1993. In the 1980s and 1990s when this code was first valued, flexible esophagoscopy was performed with fiberoptic instruments; today's standard of practice is the use of high-definition video endoscopes and high definition video monitors. In the early 1990s, conscious sedation used rapid intravenous administration of meperidine and diazepam without routine monitoring of pulse oximetry; in 2012, moderate sedation using benzodiazepines and opiates is administered in a controlled, titrated manner with automated monitoring of pulse oximetry, electrocardiogram and, in some settings, capnography. In the 1990s when this code was valued, there were no regulations and/or requirements for a complete History and Physical of the patient within 30 days of the procedure, documentation of a comprehensive examination updated on the day of procedure, a pre-sedation assessment including ASA physical status, airway and cardiac risk completed prior to the procedure, a mandatory timeout before beginning the procedure, or photodocumentation of the findings – all of which are now required to meet various local, state, payor and Medicare accreditation, quality standards, and/or patient safety requirements. In the early 1990s eosinophilic esophagitis had not been described, endoscopic management of Barrett's esophagus, endoscopic mucosal resection of tumors and stenting of esophageal cancer was in development, and endoscopic ultrasound was yet to be commercially available. The panel also noted that "open access" endoscopy, where the patient is not seen by the endoscopist until the day of the procedure, has gained increasing acceptance in a number of settings – community, academic, teaching, military, VA and public; urban, suburban and rural; single and multi-specialty group; independent and employed - during the past decade. Finally, the panel noted that treatment of esophageal varices today is almost entirely by band ligation, which was not yet commercially available in 1993, and sclerotherapy is almost exclusively performed on those most severe cases which fail band ligation therapy.

Medicare claims for Esophagoscopy, rigid or flexible; with injection sclerosis of esophageal varices (code 43204) have declined over a seven year period from 216 in 2005 to 91 in 2011. A review of a 5% Medicare claims file from 2011 (total 2011 claims 91) reveals that code 43204 was reported 3.53% percent of the time by otolaryngologists, 50.55% by gastroenterologists, 24.72% by internal medicine specialists, and 21.19% by general surgeons. For Medicare, the procedure was performed 50.55 % in the outpatient hospital, 41.17% in the inpatient hospital, 7.06% in the physician office, and 1.21% in the ambulatory surgery center setting. As otolaryngologists and surgeons perform both rigid and flexible esophagoscopy, one can make only an estimate assumption that a percentage of the services performed by those specialties in facility settings represent rigid esophagoscopy procedures performed under general anesthesia.

The expert, multi-society panel notes that a change has occurred in the way that the work of moderate sedation is calculated for the purposes of the RUC's recommendations to CMS. Prior to 2012, the RUC and CMS affirmed that physician work of administering moderate sedation was part of the intra-service time, as in endoscopic procedures 43235 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* and 45378 *Colonoscopy, flexible, proximal to splenic flexure; diagnostic,*

with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure) which were surveyed in the 2005 Third Five-Year review, and 43262 *Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy* which was surveyed in the 2010 Fourth Five-Year review. In fact, an overwhelming majority (89%) of codes in Appendix G in which moderate sedation is intrinsic to the service, where moderate sedation is specifically identified in the RUC work descriptors, describe moderate sedation as occurring during the intra-service period. The decision by the RUC's Research Subcommittee to change how the physician work of administering moderate sedation is accounted for as pre-service, not intra-service work, may constitute recognition that there has been a change in the physician work of performing endoscopic procedures over the past 20 years. In view of such, the RUC's introduction of the standardized pre-service packages in 2008 which specify a difference in pre-service evaluation minutes depending on whether a procedure involves sedation / anesthesia care, and the Research Subcommittee's 2012 clarification that the administration of moderate sedation constitutes work as occurring during the pre-service period, represents an important change in the way that physician work for procedures involving moderate sedation is valued, and constitutes compelling evidence for re-valuation of the gastrointestinal endoscopy codes.

The expert panel felt that in view of the change in how the procedure was performed, new diagnoses, and new requirements to ensure patient safety, the predominance of otolaryngologists performing code 43200 vs. gastroenterologists performing the predominance of other procedures in the 43201-43232 family, and the inability to distinguish the percentage of previous services that represent rigid trans-oral, flexible trans-oral, and flexible trans-nasal procedures, the flexible, trans-oral esophagoscopy procedure has changed since the initial valuation by Harvard, providing compelling evidence for re-valuation.

After assessing the pre-service work that is performed, the expert panel determined that the assumption that all endoscopic procedures would have identical pre- and post-service time may have been incorrect. We note that the survey instrument approved by the Research Subcommittee did not allow the expert panel to draw any conclusions about the role of moderate sedation in the valuation of the pre-service work. The expert panel attempted to address this by reviewing similar services, based on whether the typical patient and typical procedure was straightforward or complex. For this procedure, we are recommending pre-service package 2b with changes of times to 25/3/5 for a total of 33 minutes of pre-service time, as follows:

**Evaluation:** 25 minutes which is the survey median time, but less than the package time.

**Positioning:** Addition of 2 minutes (3 min total) to account for positioning the patient, anesthesia lines, and video/scope equipment to allow access for the procedure and moderate sedation monitoring.

**Scrub/Dress/Wait:** 5 minutes which is equal to the survey median and package time.

The panel felt that the median post-service time of 10 minutes also underestimated the elements of post service work. The panel reviewed other scope procedures that had recently been reviewed by the RUC and recommended adjusting the post service time work to 15 minutes similar to code 31622, *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)*. The panel determined that the post-service time should be less than the 20 minutes of post-service work for code 52005, *Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service*; reviewed by the RUC in October 2010 at the 4<sup>th</sup> Five-Year review.

The panel noted the survey median intra-service time was 20 minutes and felt that this time was acceptable as it represented slightly less than half of the intra-service time for the key reference service 49421, *Insertion of tunneled intraperitoneal catheter for dialysis, open*, (000 global, 46/45/20, RVW 4.21) which was reviewed by the RUC in April 2010. The panel felt that although the intraservice time was approximately half of the previous valuation the intensity of the service (i.e. the necessity to successfully perform the service without complication in a shorter period of time) had substantially increased due to the change in practice caused by the introduction of band ligation resulting in use of this service in sicker patients. The panel also compared

the 20 minutes survey time to the intra-service time of 15 minutes for the base code, 43200, and felt that the 5 minutes of incremental time represents an appropriate incremental work time for the typical procedure. The panel noted that the respondent 25<sup>th</sup> percentile and median RVW recommendation were respectively 2.89 and 3.76 reflecting the increased intensity of service, which along with the changes in the practice patterns and new diagnoses represented compelling evidence to recommend a revaluation in the physician work of this procedure. The expert panel then reviewed the rank order of code 43204 along with the intra-service times for the other codes surveyed in the 43200-43232 family. Based on the comprehensive review of the family of codes surveyed, the expert panel determined that despite the presence of compelling evidence which would otherwise merit a work value increase, the panel could not justify recommending an increase in the current valuation of code 43216 from 3.76 which is the median RVW recommendation of the survey.

As the physicians who completed the surveys were significantly limited in their choice of key reference codes within the endoscopic family, the panel felt that code 49421 represented an appropriate key reference code even though the total and intraservice times for code 43204 were less. Adjusting for the differences in times, the panel concluded that the current RVW and revised IWPUT (0.138) for code 43204 is consistent with code MPC code 31575 *Laryngoscopy, flexible fiberoptic; diagnostic (000 global, 15/8/5 RVW 1.10, IWPUT 0.0904)* and proportional to code 49421 *Insertion of tunneled intraperitoneal catheter for dialysis, open (wRVW 4.21, IWPUT 0.0639)*. The panel also noted that MPC code 19103 *Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance (000 global, 20/30/15 RVW 3.69, IWPUT 0.0969)* compares appropriately with 43204 adjusting for the difference in service times and complexity. Code 57410 *Pelvic examination under anesthesia (other than local) (000 global, 30/15/25, RVW 1.75, IWPUT 0.0345)*, and code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure) (000 global 20/30/15, RVW 2.78, IWPUT 0.0688)*, were identified as comparable codes of lesser complexity.

While there was compelling evidence to recommend an increase in the wRVU times for code 43204 based on the survey times adjusted for pre-service package 2b, the expert panel recommends that the existing wRVU value of 3.76 should be retained with physician times 33/20/15 (compared to the previous RUC valuation of 42/43/20). The expert panel also recommends that code 43204 should be valued only in the facility setting.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43204

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology                      How often? Rarely

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 270

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. ~270 (Medicare data 2011 = 91\*3). We believe that 90% of the previously reported procedures will now be reported using the codes specific for flexible, transoral esophagoscopy procedures.

Specialty Gastroenterology                      Frequency 243                      Percentage 90.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 91 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. ~91 (Medicare data 2011 = 91).

Specialty Gastroenterology                      Frequency 82                      Percentage 90.10 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? No

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43204

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43205	Tracking Number	Original Specialty Recommended RVU: <b>3.78</b>
		Presented Recommended RVU: <b>3.00</b>
Global Period: 000		RUC Recommended RVU: <b>3.00</b>

CPT Descriptor: Esophagoscopy, flexible, transoral: with band ligation of esophageal varices

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 55 year old patient with cirrhosis and esophageal varices undergoes therapeutic esophagoscopy with band ligation for control of active variceal hemorrhage.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 84%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 74%

Description of Pre-Service Work: Review with the patient any symptoms and ascertain characteristics of the dysphagia problem when it is clear there is dysphagia. The patient's history is reviewed to assess for the need for pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed and documented; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays and other diagnostic tests are reviewed. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained and the physician must sign the consent. The physician verifies all endoscopic equipment is available and appropriate computer entries are made. The patient is positioned on the examination table. The endoscopic and moderate sedation monitoring equipment is positioned to provide access for the procedure. A time out is performed. A bite block is placed in the mouth. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible upper endoscope is inserted through the mouth into the oropharynx and advanced through the esophagus into the proximal stomach and, when indicated, retroflexed to allow examination of the cardia. The endoscope is withdrawn, allowing measurement of the squamocolumnar and gastro-esophageal junction from the incisors, assessment for presence of a hiatal hernia, and then examination of the esophageal mucosa and varices. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. The endoscope is withdrawn and the band ligator is attached to the end of the scope. The endoscope is reinserted, advanced into the stomach and then withdrawn to the largest varix just proximal to the gastroesophageal junction. The varix is banded and observed. The level of sedation of the patient is reassessed and additional medication is administered as needed. The endoscope is withdrawn to the next largest varix. The varix is

banded and observed. All remaining varices in the distal esophagus are banded. Photodocumentation of the exam findings including measurements of the varices and labeling of the identified structures are obtained and sent to a hard copy device. After observation to confirm the absence of bleeding, the endoscope is then withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. Post procedure orders are completed. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to referral source and other appropriate parties. Data is entered into procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others. Necessary prescriptions, follow-up tests and appointments are provided to the patient.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	10/2012				
<b>Presenter(s):</b>	Joel V. Brill, MD (AGA), Nicholas Nickl, MD (ASGE), Edward S. Bentley, MD (ASGE), Michael Edye, MD (SAGES), Don J. Selzer, MD (SAGES)				
<b>Specialty(s):</b>	AGA, ASGE, SAGES				
<b>CPT Code:</b>	43205				
<b>Sample Size:</b>	4325	<b>Resp N:</b>	108	<b>Response:</b> 2.4 %	
<b>Description of Sample:</b>	The AGA and ASGE conducted a random sample of their member gastroenterologists using the Census Department office regions ( <a href="http://www.census.gov/regions/">http://www.census.gov/regions/</a> ). Between 150 and 200 gastroenterologists were randomly selected in each region for a total of 2,000 gastroenterologists. The AGA and ASGE enhanced the random sample by adding 514 members of the ASGE Special Interest Groups and 786 physicians who perform esophagoscopy EUS and stent, TNE and optical endomicroscopy and ablation provided by Industry. The AGA and ASGE also added 86 volunteers who responded to the educational article on the RUC survey process that was approved by the Research Subcommittee and was distributed to all AGA and ASGE members. The AGA and ASGE's total survey sample size was 3,386. SAGES sent a total of 1,000 emails (939 successfully delivered) using a random selection of 250 members from each of the four CMS DME Regions A-D (ie, geographically distributed). The total survey sample size for SAGES, AGA and ASGE was 4,325.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	5.00	12.00	25.00	200.00
<b>Survey RVW:</b>	0.55	3.00	3.80	4.80	10.00
<b>Pre-Service Evaluation Time:</b>			25.00		
<b>Pre-Service Positioning Time:</b>			5.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			5.00		
<b>Intra-Service Time:</b>	5.00	15.00	20.00	30.00	60.00
<b>Immediate Post Service-Time:</b>	<u>10.00</u>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	43205	<b>Recommended Physician Work RVU: 3.00</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		25.00	33.00	-8.00
<b>Pre-Service Positioning Time:</b>		3.00	1.00	2.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00
<b>Intra-Service Time:</b>		20.00		
<b>Immediate Post Service-Time:</b>	<u>10.00</u>			



<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b><u>0.00</u></b>	99291x <b>0.00</b>	99292x <b>0.00</b>		
<b>Other Hospital time/visit(s):</b>	<b><u>0.00</u></b>	99231x <b>0.00</b>	99232x <b>0.00</b>	99233x <b>0.00</b>	
<b>Discharge Day Mgmt:</b>	<b><u>0.00</u></b>	99238x <b>0.0</b>	99239x <b>0.0</b>	99217x <b>0.00</b>	
<b>Office time/visit(s):</b>	<b><u>0.00</u></b>	99211x <b>0.00</b>	12x <b>0.00</b>	13x <b>0.00</b>	14x <b>0.00</b> 15x <b>0.00</b>
<b>Prolonged Services:</b>	<b><u>0.00</u></b>	99354x <b>0.00</b>	55x <b>0.00</b>	56x <b>0.00</b>	57x <b>0.00</b>
<b>Sub Obs Care:</b>	<b><u>0.00</u></b>	99224x <b>0.00</b>	99225x <b>0.00</b>	99226x <b>0.00</b>	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
49421	000	4.21	RUC Time

CPT Descriptor Insertion of tunneled intraperitoneal catheter for dialysis, open**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
31575	000	1.10	RUC Time	599,944
<u>CPT Descriptor 1</u> Laryngoscopy, flexible fiberoptic; diagnostic				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
57410	000	1.75	RUC Time	3,277

CPT Descriptor 2 Pelvic examination under anesthesia (other than local)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31622	000	2.78	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 24      % of respondents: 22.2 %

**TIME ESTIMATES (Median)**

	<b>CPT Code:</b> <b>43205</b>	<b>Key Reference CPT Code:</b> <b>49421</b>	<b>Source of Time</b> <b>RUC Time</b>
Median Pre-Service Time	33.00	46.00	
Median Intra-Service Time	20.00	45.00	

Median Immediate Post-service Time	10.00	20.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>63.00</b>	<b>111.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)**(of those that selected Key  
Reference code)**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered		
--	--	--

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed		
--	--	--

Urgency of medical decision making		
------------------------------------	--	--

**Technical Skill/Physical Effort (Mean)**

Technical skill required		
--------------------------	--	--

Physical effort required		
--------------------------	--	--

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality		
---	--	--

Outcome depends on the skill and judgment of physician		
--	--	--

Estimated risk of malpractice suit with poor outcome		
--	--	--

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity		
----------------------------------	--	--

Intra-Service intensity/complexity	4.87	3.42
------------------------------------	------	------

Post-Service intensity/complexity		
-----------------------------------	--	--

## Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

### **Rationale and comments for 43205**

43205 *Esophagoscopy, flexible, transoral; with band ligation of esophageal varices* RVW 3.78 physician time, 20/30/20 was previously valued by the RUC in April 1993. This code is being reviewed in response to the CMS comments in the Proposed Rule and Final Rule for CY 2012, requesting review of gastrointestinal endoscopic services as potentially misvalued.

Although this code was not specifically identified by CMS in the Final Rule, the societies that committed to a comprehensive review of gastrointestinal endoscopic services – the AGA, ACG, ASGE and SAGES – identified that code 43200 was primarily performed by otolaryngologists, while the remaining codes in the 43200-43232 family were primarily performed by gastroenterologists and endoscopic surgeons. In view of such, a coding change proposal was brought to the February 2012 CPT Editorial Panel in conjunction with the AAO-HNS and the Trilogical Society, requesting the development of new codes for trans-nasal esophagoscopy (primarily performed in the non-facility setting without moderate sedation) and rigid esophagoscopy (primarily performed in the OR setting with anesthesia administered by an anesthesia professional). While the code number, 43205, remains the same, this code is now specific for a flexible, transoral, esophagoscopy procedure.

In May 2012 the AGA, ASGE and SAGES requested that the Research Subcommittee consider a mini-survey methodology for this and the other codes in the 43200-43232 family, which was approved. The Research Subcommittee required that a standard survey be conducted of the new base code for flexible trans-oral esophagoscopy, 43200 *Esophagoscopy, flexible; transoral diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*, specifically including the elements of pre- and post-service physician work. For the remaining codes that were surveyed in the 43201-43232 family, including code 43205, the mini-survey instrument only asked the physician to address the intra-service work component for the procedure. Accordingly, the societies submitting these recommendations are using for 43204 the same pre- and post- service times as for the revised base code for flexible trans-oral esophagoscopy, 43200.

A survey of practicing physicians representing urban, suburban and rural community and academic settings was performed with 108 respondents of 4325 queried (2.4 %). Of the responses received 97% were from Gastroenterologists and 3% were from Endoscopic Surgeons. 95% found the vignette to be typical. The median service performance rate was 12. 84% typically used moderate sedation in the facility (hospital outpatient, ambulatory surgery center) setting. In the base code survey of pre-service and post-service times, as described above, the respondents reported median pre-service evaluation, positioning, and scrub/dress/wait times of 25, 5, and 5 minutes respectively, and post service time of 10 minutes. The respondents reported a median intra-service time of 20 minutes. 24 (22.2%) of the respondents chose key reference service 49421, *Insertion of tunneled intraperitoneal catheter for dialysis, open*, (wRVW 4.21 45/45/20). The survey intra-service intensity of 43205 was 4.87, compared to the comparison code intra-service intensity of 3.42. As the mini-survey methodology only captured intra-service intensity / complexity, we are unable to provide an assessment regarding the relative intensity of the surveyed code to the comparison code on other measures. The median survey RVW was 3.80. We note that as all of the gastrointestinal endoscopy codes are being surveyed over the next two years, the reference service list (RSL) does not contain any endoscopic procedures that would be familiar to the physicians completing the surveys.

The specialty societies convened an expert panel to review the survey results and make recommendations. The panel noted that the median service performance rate (12) was what would be expected for a typical gastroenterologist in solo or small group practice.

The panel noted there has been a change in the practice pattern for this service since it was most recently valued by the RUC in 1993. In the 1980s and 1990s when this code was first valued, flexible esophagoscopy was performed with fiberoptic instruments; today's standard of practice is the use of high-definition video endoscopes and high definition video monitors. In the early 1990s, conscious sedation used rapid intravenous administration of meperidine and diazepam without routine monitoring of pulse oximetry; in 2012, moderate sedation using benzodiazepines and opiates is administered in a controlled, titrated manner with automated monitoring of pulse oximetry, electrocardiogram and, in some settings, capnography. In the 1990s when this code was valued, there were no regulations and/or requirements for a complete History and Physical of the patient within 30 days of the procedure, documentation of a comprehensive examination updated on the day of procedure, a pre-sedation assessment including ASA physical status, airway and cardiac risk completed prior to the procedure, a mandatory timeout before beginning the procedure, or photodocumentation of the findings – all of which are now required to meet various local, state, payor and Medicare accreditation, quality standards, and/or patient safety requirements. In the early 1990s eosinophilic esophagitis had not been described, endoscopic management of Barrett's esophagus, endoscopic mucosal resection of tumors and stenting of esophageal cancer was in development, and endoscopic ultrasound was yet to be commercially available. The panel also noted that "open access" endoscopy, where the patient is not seen by the endoscopist until the day of the procedure, has gained increasing acceptance in a number of settings – community, academic, teaching, military, VA and public; urban, suburban and rural; single and multi-specialty group; independent and employed - during the past decade.

Medicare claims for Esophagoscopy, rigid or flexible; with band ligation of esophageal varices (code 43205) have declined over a seven year period from 479 in 2005 to 265 in 2011. A review of a 5% Medicare claims file from 2011 (total 2011 claims 265) reveals that code 43205 was reported 0.41% percent of the time by otolaryngologists, 88.35% by gastroenterologists, 8.03% by internal medicine specialists, and 3.21% by general surgeons. For Medicare, the procedure was performed 56.60% in the outpatient hospital, 36.16% in the inpatient hospital, 0.41% in the physician office, and 4.41% in the ambulatory surgery center setting. As otolaryngologists and surgeons perform both rigid and flexible esophagoscopy, one can make only an estimate assumption that a percentage of the services performed by those specialties in facility settings represent rigid esophagoscopy procedures performed under general anesthesia.

The expert, multi-society panel notes that a change has occurred in the way that the work of moderate sedation is calculated for the purposes of the RUC's recommendations to CMS. Prior to 2012, the RUC and CMS affirmed that physician work of administering moderate sedation was part of the intra-service time, as in endoscopic procedures 43235 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* and 45378 *Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)* which were surveyed in the 2005 Third Five-Year review, and 43262 *Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy* which was surveyed in the 2010 Fourth Five-Year review. In fact, an overwhelming majority (89%) of codes in Appendix G in which moderate sedation is intrinsic to the service, where moderate sedation is specifically identified in the RUC work descriptors, describe moderate sedation as occurring during the intra-service period. The decision by the RUC's Research Subcommittee to change how the physician work of administering moderate sedation is accounted for as pre-service, not intra-service work, may constitute recognition that there has been a change in the physician work of performing endoscopic procedures over the past 20 years. In view of such, the RUC's introduction of the standardized pre-service packages in 2008 which specify a difference in pre-service evaluation minutes depending on whether a procedure involves sedation / anesthesia care, and the Research Subcommittee's 2012 clarification that the administration of moderate sedation constitutes work as occurring during the pre-service period, represents an important change in the way that physician work for procedures involving moderate sedation is valued, and constitutes compelling evidence for re-valuation of the gastrointestinal endoscopy codes.

The expert panel felt that in view of the change in how the procedure was performed, new diagnoses, and new requirements to ensure patient safety, the predominance of otolaryngologists performing code 43200 vs.

gastroenterologists performing the predominance of other procedures in the 43201-43232 family, and the inability to distinguish the percentage of previous services that represent rigid trans-oral, flexible trans-oral, and flexible trans-nasal procedures, the flexible, trans-oral esophagoscopy procedure has changed since the initial valuation by Harvard, providing compelling evidence for re-valuation.

After assessing the pre-service work that is performed, the expert panel determined that the assumption that all endoscopic procedures would have identical pre- and post-service time may have been incorrect. We note that the survey instrument approved by the Research Subcommittee did not allow the expert panel to draw any conclusions about the role of moderate sedation in the valuation of the pre-service work. The expert panel attempted to address this by reviewing similar services, based on whether the typical patient and typical procedure was straightforward or complex. For this procedure, we are recommending pre-service package 2b with changes of times to 25/3/5 for a total of 33 minutes of pre-service time, as follows:

**Evaluation:** 25 minutes which is the survey median time, but less than the package time.

**Positioning:** Addition of 2 minutes (3 min total) to account for positioning the patient, anesthesia lines, and video/scope equipment to allow access for the procedure and moderate sedation monitoring.

**Scrub/Dress/Wait:** 5 minutes which is equal to the survey median and package time.

The panel felt that the median post-service time of 10 minutes also underestimated the elements of post service work. The panel reviewed other scope procedures that had recently been reviewed by the RUC and recommended adjusting the post service time work to 15 minutes similar to code 31622, *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)*. The panel determined that the post-service time should be less than the 20 minutes of post-service work for code 52005, *Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service*; reviewed by the RUC in October 2010 at the 4<sup>th</sup> Five-Year review.

The panel noted the survey median intra-service time was 20 minutes and felt that this time was acceptable as it represented slightly less than half of the intra-service time for the key reference service 49421, *Insertion of tunneled intraperitoneal catheter for dialysis, open*, (000 global, 46/45/20, RVW 4.21) which was reviewed by the RUC in April 2010. The panel felt that although the intraservice time was approximately two thirds of the previous valuation, the intensity of the service (i.e. the necessity to successfully perform the service without complication in a shorter period of time) had substantially increased. The panel also compared the 20 minutes survey time to the intra-service time of 15 minutes for the base code, 43200, and felt that the 5 minutes of incremental time represents an appropriate incremental work time for the typical procedure. The panel noted that the respondent 25<sup>th</sup> percentile and median RVW recommendation were respectively 3.00 and 3.80 reflecting the increased intensity of service, which along with the changes in the practice patterns and new diagnoses represented compelling evidence to recommend a revaluation in the physician work of this procedure. The expert panel then reviewed the rank order of code 43205 along with the intra-service times for the other codes surveyed in the 43200-43232 family. Based on the comprehensive review of the family of codes surveyed, the expert panel determined that despite the median RVW recommendation of 3.80 and the presence of compelling evidence which would otherwise merit a work value increase, the panel could not justify recommending an increase in the current valuation of code 43205 from 3.78.

As the physicians who completed the surveys were significantly limited in their choice of key reference codes within the endoscopic family, the panel felt that code 49421 represented an appropriate key reference code even though the total and intraservice times for code 43205 were less. Adjusting for the differences in times, the panel concluded that the current RVW (3.78) and revised IWPUT (0.139) for code 43205 is consistent with code MPC code 31575 *Laryngoscopy, flexible fiberoptic; diagnostic* (000 global, 15/8/5 RVW 1.10, IWPUT 0.0904) and proportional to code 49421 *Insertion of tunneled intraperitoneal catheter for dialysis, open* (wRVW 4.21, IWPUT 0.0639). The panel also noted that MPC code 19103 *Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance* (000 global,

20/30/15 RVW 3.69, IWPUT 0.0969) compares appropriately with 43205 adjusting for the difference in service times and complexity. Code 57410 *Pelvic examination under anesthesia (other than local) (000 global, 30/15/25, RVW 1.75, IWPUT 0.0345)*, and code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure) (000 global 20/30/15, RVW 2.78, IWPUT 0.0688)*, were identified as comparable codes of lesser complexity.

While there was compelling evidence to recommend an increase in the wRVU times for code 43205 based on the survey times adjusted for pre-service package 2b in the facility setting, the expert panel recommends that the existing wRVU value of 3.78 should be retained with physician times 33/22/15 (compared to the previous RUC valuation of 20/30/20). The expert panel also recommends that code 43205 be valued in only the facility setting.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43205

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology                      How often? Rarely

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 800

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. ~800 (Medicare data 2011 = 265\*3) We believe that 90% of the previously reported procedures will now be reported using the codes specific for flexible, transoral esophagoscopy procedures.

Specialty Gastroenterology                      Frequency 700                      Percentage 87.50 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 265  
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. ~265 (Medicare data 2011 = 265)

Specialty Gastroenterology	Frequency 233	Percentage 87.92 %
----------------------------	---------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? No

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43205

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43206	Tracking Number	Original Specialty Recommended RVU: <b>3.00</b>
		Presented Recommended RVU: <b>2.39</b>
Global Period: 000		RUC Recommended RVU: <b>2.39</b>

CPT Descriptor: Esophagoscopy, flexible, transoral; with optical endomicroscopy

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: Typical Patient: A 59 year old patient with reflux symptoms and Barrett's epithelium with mucosal irregularity undergoes diagnostic esophagoscopy with optical endomicroscopy for examination.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 79%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 64%

Description of Pre-Service Work: Review with the patient any symptoms and ascertain characteristics of the dysphagia problem when it is clear there is dysphagia. The patient's history is reviewed to assess for the need for pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed and documented; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays and other diagnostic tests are reviewed. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained and the physician must sign the consent. The physician verifies all endoscopic equipment is available and appropriate computer entries are made. The patient is positioned on the examination table. The endoscopic and moderate sedation monitoring equipment is positioned to provide access for the procedure. A time out is performed. A bite block is placed in the mouth. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard upper endoscope is inserted into the mouth into the oropharynx and advanced through the esophagus into the proximal stomach and, when indicated, retroflexed to allow examination of the cardia. The endoscope is withdrawn, allowing measurement of the squamocolumnar and gastro-esophageal junction from the incisors, assessment for presence of a hiatal hernia, and then examination of the esophageal mucosa. Abnormal tissue in the distal esophagus at 33-37cm from the incisors suspicious for Barrett's esophagus is identified. An optical endomicroscopy probe is passed through the endoscope to examine the abnormal tissue. Real-time images are reviewed by the endoscopist, identifying areas that are suspicious for pre-malignant and/or malignant tissue, facilitating performance of biopsy (separate procedure). Photodocumentation of appropriate normal landmarks and abnormalities is obtained. The endoscope is withdrawn.



Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. Post procedure orders are completed. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to referral source and other appropriate parties. Data is entered into procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others. Necessary prescriptions, follow-up tests and appointments are provided to the patient.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	10/2012				
<b>Presenter(s):</b>	Joel V. Brill, MD (AGA), Nicholas Nickl, MD (ASGE), Edward S. Bentley, MD (ASGE), Wayne M. Koch, MD (AAO-HNS), John Lanza, MD (AAO-HNS), Michael Edye, MD (SAGES), Don J. Selzer, MD (SAGES)				
<b>Specialty(s):</b>	AGA, ASGE, SAGES				
<b>CPT Code:</b>	43206				
<b>Sample Size:</b>	4325	<b>Resp N:</b>	109	<b>Response:</b> 2.5 %	
<b>Description of Sample:</b>	The AGA and ASGE conducted a random sample of their member gastroenterologists using the Census Department office regions ( <a href="http://www.census.gov/regions/">http://www.census.gov/regions/</a> ). Between 150 and 200 gastroenterologists were randomly selected in each region for a total of 2,000 gastroenterologists. The AGA and ASGE enhanced the random sample by adding 514 members of the ASGE Special Interest Groups and 786 physicians who perform esophagoscopy EUS and stent, TNE and optical endomicroscopy and ablation provided by Industry. The AGA and ASGE also added 86 volunteers who responded to the educational article on the RUC survey process that was approved by the Research Subcommittee and was distributed to all AGA and ASGE members. The AGA and ASGE's total survey sample size was 3,386. SAGES sent a total of 1,000 emails (939 successfully delivered) using a random selection of 250 members from each of the four CMS DME Regions A-D (ie, geographically distributed). The total survey sample size for SAGES, AGA and ASGE was 4,325.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	6.00	13.00	20.00	100.00
<b>Survey RVW:</b>	0.55	3.00	4.00	4.61	10.00
<b>Pre-Service Evaluation Time:</b>			25.00		
<b>Pre-Service Positioning Time:</b>			5.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			5.00		
<b>Intra-Service Time:</b>	0.00	20.00	30.00	35.00	60.00
<b>Immediate Post Service-Time:</b>	<b>10.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1b-FAC Straightforw Pat Procedure(w sedate/anes)

<b>CPT Code:</b>	43206	<b>Recommended Physician Work RVU: 2.39</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		19.00	19.00	0.00
<b>Pre-Service Positioning Time:</b>		3.00	1.00	2.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00
<b>Intra-Service Time:</b>		30.00		

Immediate Post Service-Time:	<u>10.00</u>	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0 99239x 0.0 99217x 0.00
Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? Yes

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
49421	000	4.21	RUC Time

CPT Descriptor Insertion of tunneled intraperitoneal catheter for dialysis, open**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
31575	000	1.10	RUC Time	599,944
<u>CPT Descriptor 1</u> Laryngoscopy, flexible fiberoptic; diagnostic				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
57410	000	1.75	RUC Time	3,277

CPT Descriptor 2 Pelvic examination under anesthesia (other than local)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31622	000	2.78	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 24 % of respondents: 22.0 %

**TIME ESTIMATES (Median)**

	<u>CPT Code:</u> 43206	<u>Key Reference CPT Code:</u> 49421	<u>Source of Time</u> RUC Time
Median Pre-Service Time	27.00	46.00	

Median Intra-Service Time	30.00	45.00
Median Immediate Post-service Time	10.00	20.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>67.00</b>	<b>111.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered		
--	--	--

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed		
--	--	--

Urgency of medical decision making		
------------------------------------	--	--

**Technical Skill/Physical Effort (Mean)**

Technical skill required		
--------------------------	--	--

Physical effort required		
--------------------------	--	--

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality		
---	--	--

Outcome depends on the skill and judgment of physician		
--	--	--

Estimated risk of malpractice suit with poor outcome		
--	--	--

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity		
----------------------------------	--	--

Intra-Service intensity/complexity	4.89	3.42
------------------------------------	------	------

Post-Service intensity/complexity		
-----------------------------------	--	--

## Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

### 43206 *Esophagoscopy, flexible; transoral diagnostic, with optical endomicroscopy*

At the February 2012 CPT Editorial Panel the GI Societies, as part of a multi-specialty comprehensive review of esophagoscopy codes, brought forth coding proposals for two endoscopic procedures for optical endomicroscopy: 43206 *Esophagoscopy, flexible, transoral; with optical endomicroscopy* and 43252. At the April 2012 RUC meeting, the GI societies requested that these codes be carrier priced for 2013 so that the societies could include the surveys for these new services along with the surveys of the esophagoscopy (43200) and upper endoscopy (43235) families. Code 43206 (43206) is now being surveyed with the 43200-43232 family. Code 43252 will be reviewed along with the other codes in the esophagogastrroduodenoscopy (43235-43259) family at the January 2013 RUC meeting.

Although this code family was not specifically identified by CMS in the Final Rule, the societies that committed to a comprehensive review of gastrointestinal endoscopic services – the AGA, ACG, ASGE and SAGES – identified that code 43200 was primarily performed by otolaryngologists, while the remaining codes in the 43200-43232 family were primarily performed by gastroenterologists and endoscopic surgeons. In view of such, a coding change proposal was brought to the February 2012 CPT Editorial Panel in conjunction with the AAO-HNS and the Triological Society, requesting the development of new codes for trans-nasal esophagoscopy (primarily performed in the non-facility setting without moderate sedation) and rigid esophagoscopy (primarily performed in the OR setting with anesthesia administered by an anesthesia professional). While the code number for the base procedure, 43200, remains the same, this code is now specific for a flexible, transoral, esophagoscopy procedure.

In May 2012 the AGA, ASGE and SAGES requested that the Research Subcommittee consider a mini-survey methodology for this and the other codes in the 43200-43232 family, which was approved. The Research Subcommittee required that a standard survey be conducted of the new base code for flexible trans-oral esophagoscopy, 43200 *Esophagoscopy, flexible; transoral diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*, specifically including the elements of pre- and post-service physician work. For the remaining codes that were surveyed in the 43201-43232 family, the mini-survey instrument only asked the physician to address the intra-service work component for the procedure. Accordingly, the societies submitting these recommendations are using the same pre- and post- service times for all of the codes in 43201-43232 as for the revised base code for flexible trans-oral esophagoscopy, 43200.

A survey of practicing physicians representing urban, suburban and rural community and academic settings was performed with 109 respondents of 4325 queried (2.5 %). Of the responses received, 98% were from Gastroenterologists and 2% were from Endoscopic Surgeons. Of those who participated in the survey, 55 (50%) responded to a subsequent email asking whether the vignette was typical. Of the 55 who responded, 98% found the vignette to be typical. The median service performance rate was 13. 79% typically used moderate sedation in the facility (hospital outpatient, ambulatory surgery center) setting. In the base code survey of pre-service and post-service times, as described above, the respondents reported median pre-service evaluation, positioning, and scrub/dress/wait times of 25, 5, and 5 minutes respectively, and post service time of 10 minutes. The respondents reported a median intra-service time of 30 minutes and post-service time of 10 minutes. 24 (22%) of the respondents chose key reference service 49421, *Insertion of tunneled intraperitoneal catheter for dialysis, open* (46/45/20 RVW 4.21). The survey intra-service intensity of 43206 was 4.89, compared to the comparison code intra-service intensity of 3.42. The median survey RVW was 4.00. We note that as all of the gastrointestinal endoscopy codes are being surveyed over the next two years, the reference

service list (RSL) does not contain any endoscopic procedures that would be familiar to the physicians completing the surveys.

The specialty societies convened an expert panel to review the survey results and make recommendations. The panel noted that the median service performance rate (13) was substantially higher than would be expected for a typical gastroenterologist in solo or small group practice and that those who responded most likely overrepresented high volume referral centers comprising more experienced and efficient practitioners. The expert panel felt this supported the concept that the survey respondents were more experienced than the typical practitioner, and that this should be considered in the development of work recommendations.

When 43206 is performed in the facility setting, the panel recommended pre-service package **1b**, Facility Straightforward Patient / Straightforward Procedure (With sedation / anesthesia care), which would be used for this non-incisional trans-oral endoscopic procedure. The expert panel felt the survey respondents underestimated the time necessary to complete all of the elements included in the facility pre-service package that are typically performed with 43206 and failed to consider all of the elements in their time estimation (indications and contraindications for sedation, history of relevant cardiovascular, pulmonary, and neurological conditions, focused physical examination including modified Mallampati score to predict ease of intubation, ASA physical status classification, and summative determination of sedation requirement) and therefore recommended an adjustment of times to reflect the pre-service package and work.

The panel noted there has been a change in the practice pattern for the base code of this family of services since it was initially valued by Harvard in 1993. In the 1980s and 1990s when code 43200 was first valued, flexible esophagoscopy was performed with fiberoptic instruments; today's standard of practice is the use of high-definition video endoscopes and high definition video monitors. In the early 1990s, conscious sedation used rapid intravenous administration of meperidine and diazepam without routine monitoring of pulse oximetry; in 2012, moderate sedation using benzodiazepines and opiates is administered in a controlled, titrated manner with automated monitoring of pulse oximetry, electrocardiogram and, in some settings, capnography. In the 1990s and early 2000s when this code was previously valued, there were no regulations and/or requirements for a complete History and Physical of the patient within 30 days of the procedure, documentation of a comprehensive examination updated on the day of procedure, a pre-sedation assessment including ASA physical status, airway and cardiac risk completed prior to the procedure, a mandatory timeout before beginning the procedure, or photodocumentation of the findings – all of which are now required to meet various local, state, payor and Medicare accreditation, quality standards, and/or patient safety requirements. In the early 1990s eosinophilic esophagitis had not been described, endoscopic management of Barrett's esophagus, endoscopic mucosal resection of tumors and stenting of esophageal cancer was in development, and endoscopic ultrasound was yet to be commercially available. The panel also noted that "open access" endoscopy, where the patient is not seen by the endoscopist until the day of the procedure, has gained increasing acceptance in a number of settings – community, academic, teaching, military, VA and public; urban, suburban and rural; single and multi-specialty group; independent and employed - during the past decade.

The expert, multi-society panel notes that a change has occurred in the way that the work of moderate sedation is calculated for the purposes of the RUC's recommendations to CMS. Prior to 2012, the RUC and CMS affirmed that physician work of administering moderate sedation was part of the intra-service time, as in endoscopic procedures 43235 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* and 45378 *Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)* which were surveyed in the 2005 Third Five-Year review, and 43262 *Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy* which was surveyed in the 2010 Fourth Five-Year review. In fact, an overwhelming majority (89%) of codes in Appendix G in which moderate sedation is intrinsic to the service, where moderate sedation is specifically identified in the RUC work descriptors, describe moderate sedation as occurring during the intra-service period. The decision by the RUC's Research Subcommittee to change how the physician work of administering moderate sedation is

accounted for as pre-service, not intra-service work, may constitute recognition that there has been a change in the physician work of performing endoscopic procedures over the past 20 years. In view of such, the RUC's introduction of the standardized pre-service packages in 2008 which specify a difference in pre-service evaluation minutes depending on whether a procedure involves sedation / anesthesia care, and the Research Subcommittee's 2012 clarification that the administration of moderate sedation constitutes work as occurring during the pre-service period, represents an important change in the way that physician work for procedures involving moderate sedation is valued, and constitutes compelling evidence for re-valuation of the gastrointestinal endoscopy codes.

The expert panel felt that in view of the change in how the procedure was performed, new diagnoses, and new requirements to ensure patient safety, the predominance of otolaryngologists performing code 43200 vs. gastroenterologists performing the predominance of other procedures in the 43201-43232 family, and the inability to distinguish the percentage of previous services that represent rigid trans-oral, flexible trans-oral, and flexible trans-nasal procedures, the flexible, trans-oral esophagoscopy procedure has changed since the initial valuation by Harvard, providing compelling evidence for re-valuation.

After assessing the pre-service work that is performed, the expert panel determined that the assumption that all endoscopic procedures would have identical pre- and post-service time may have been incorrect. We note that the survey instrument approved by the Research Subcommittee did not allow the expert panel to draw any conclusions about the role of moderate sedation in the valuation of the pre-service work. The expert panel attempted to address this by reviewing similar services, based on whether the typical patient and typical procedure was straightforward or complex. For this procedure, we are recommending pre-service package 1b with changes of times to 19/3/5 for a total of 27 minutes of pre-service time when the procedure is performed in the facility setting, as follows:

**Evaluation:** 19 minutes which is the package time, but less than the survey median.

**Positioning:** Addition of 2 minutes (3 min total) to account for positioning the patient, anesthesia lines, and video/scope equipment to allow access for the procedure and moderate sedation monitoring.

**Scrub/Dress/Wait:** 5 minutes which is equal to the survey median and package time.

The panel identified several crosswalks that would be equivalent in terms of physician pre-service time to this procedure. Code 31626, *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple*, (wRVW 4.16, 25/45/15), preservice package 1b, with 25 minutes of preservice time (eval 19, positioning 1, scrub/dress/wait 5) and 15 minutes of postservice time, was reviewed by the RUC in April 2009. Code 32553, *Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple*, (wRVW 3.80, 25/45/20), preservice package 1b, with 25 minutes of preservice time (eval 19, positioning 1, scrub/dress/wait 5) and 20 minutes of postservice time, was reviewed by the RUC in April 2009. Code 55876, *Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple* (wRVW 1.73, 29/20/10), with 19 minutes of evaluation and 10 minutes of positioning time, was reviewed by the RUC in April 2010. Code 64446, *Injection, anesthetic agent; sciatic nerve, continuous infusion by catheter (including catheter placement)*, (wRVW 1.81, 29/20/15), preservice package 1b, with 29 minutes of preservice time (eval 19, positioning 5, scrub/dress/wait 5), was reviewed by the RUC in April 2008. The panel noted that in October 2010 at the 4<sup>th</sup> five-year review, the societies recommended and the RUC accepted 3 minutes positioning for 45331, *Sigmoidoscopy, flexible; with biopsy, single or multiple*. The panel believes that positioning time for 43200 is similar to that for 45331 and, while noting that CMS revised the positioning time for 45331 to 5 minutes, recommends that 3 minutes is the correct time for this element of work.

The panel felt that the median post-service time of 10 minutes underestimated the elements of post service work. The panel reviewed other scope procedures that had recently been reviewed by the RUC and recommended adjusting the post service time work to 15 minutes which is equivalent to code 31622, *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* reviewed by the RUC in April 2009. The panel determined

that the post-service time should be less than the 20 minutes of post-service work for code 52005, *Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service*; reviewed by the RUC in October 2010 at the 4<sup>th</sup> Five-Year review.

The panel noted the survey median intra-service time was 30 minutes and considered it an accurate estimation, even though the survey group represented a more experienced referral center practitioner group. The panel considered the time acceptable as it represented two-thirds the intra-service time for the key reference service 49421, *Insertion of tunneled intraperitoneal catheter for dialysis, open*, which was reviewed by the RUC in April 2010, and approximately three times the intra-service time of code 31575, *Laryngoscopy, flexible fiberoptic; diagnostic*, which was reviewed by the RUC in the 2005 five-year review. Of note is that laryngoscopy is a service which does not inspect the esophagus. The panel noted that the respondent 25<sup>th</sup> percentile and median RVW recommendation were respectively 3.00 and 4.00. The expert panel then reviewed the rank order of code 43206 along with the intra-service times for the other codes surveyed in the 43200-43232 family. Based on the comprehensive review of the family of codes surveyed, the expert panel determined that the 25<sup>th</sup> percentile RVW recommendation of 3.00 provided the best estimate.

As the physicians who completed the surveys were significantly limited in their choice of key reference codes within the endoscopic family, the panel felt that code 49421 represented an appropriate key reference code even though the total and intraservice times for code 49421 were greater. Adjusting for the differences in times, the panel concluded that the RVW of 3.0 for code 43206 is consistent with code 49421 which is considered to be a similar to slightly less intense service (IWPUT 0.071 for 43206 compared with 0.0639 for 49421) and less than the IWPUT for code 31575 (IWPUT 0.0904). The panel considered MPC codes 31575 *Laryngoscopy, flexible fiberoptic; diagnostic* (000 global, 15/8/5 RVW 1.10) and 57410 *Pelvic examination under anesthesia (other than local)* (000 global, 30/15/25 RVW 1.75) to be reasonable comparable codes of lesser complexity. In addition code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (000 global 20/30/15 RVW 2.78) compares favorably with 43206 adjusting for the difference in intra service times.

Based on the survey times adjusted for pre-service package 1b in the facility setting the expert panel recommends that the survey 25th percentile wRVU value of 3.0 with physician times 27/30/15.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.



**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43200 + 43499 unlisted procedure, esophagus

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology                      How often? Rarely

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 190

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare data 2011 for 43499 = 634. ( $634 \times 3 = \sim 1900$ ) We estimate that 43206 accounted for approximately 10% of the volume of 43499 ( $\sim 1900 \times 10\% = 190$ ). We believe that 90% of these procedures will now be reported by GI using 43206.

Specialty Gastroenterology                      Frequency 170                      Percentage 89.47 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 60 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare data 2011 for 43499 = 634. We estimate that 43206 accounted for approximately 10% of the volume of 43499 ( $634 \times 10\% = \sim 60$ ). We believe that 90% of these procedures will now be reported by GI using 43206.

Specialty Gastroenterology                      Frequency 55                      Percentage 91.66 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? No

**Professional Liability Insurance Information (PLI)**

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 43200

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43215	Tracking Number	Original Specialty Recommended RVU: <b>2.60</b>
		Presented Recommended RVU: <b>2.60</b>
Global Period: 000		RUC Recommended RVU: <b>2.60</b>

CPT Descriptor: Esophagoscopy, flexible, transoral; with removal of foreign body

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 74 year old patient with acute dysphagia undergoes therapeutic esophagoscopy for removal of an obstructing impaction.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 79%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 73%

Description of Pre-Service Work: Review with the patient any symptoms and ascertain characteristics of the dysphagia problem when it is clear there is dysphagia. The patient's history is reviewed to assess for the need for pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed and documented; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays and other diagnostic tests are reviewed. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained and the physician must sign the consent. The physician verifies all endoscopic equipment is available and appropriate computer entries are made. The patient is positioned on the examination table. The endoscopic and moderate sedation monitoring equipment is positioned to provide access for the procedure. A time out is performed. A bite block is placed in the mouth. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible upper endoscope is inserted through the mouth into the oropharynx and advanced through the esophagus into the proximal stomach and, when indicated, retroflexed to allow examination of the cardia. Several solid meat boluses are identified, lodged at 34cm from the incisors. Suctioning through the endoscope is performed, clearing retained secretions above the obstruction. The endoscope is advanced cautiously until the distal most impacted portion is identified at 39cm from the incisors. The endoscope is withdrawn through the mouth, and a retrieval hood is affixed to the tip of the endoscope. The endoscope is then inserted through the mouth into the oropharynx and advanced through the esophagus to the area of the foreign body. Using a tripod grasper biopsy forceps, the meat bolus is picked apart, loosened, grasped, and pulled to the tip of the endoscope. The endoscope and foreign body are withdrawn through the mouth. The meat bolus is removed and the

endoscope is reinserted through the mouth into the oropharynx and advanced through the esophagus. Retained secretions and materials are suctioned. The process is repeated as necessary until the food bolus is removed and residual materials are cleared from the esophagus. The level of sedation of the patient is reassessed during the procedure and additional medication is administered as needed. The endoscope is inserted into the proximal stomach and, when indicated, retroflexed to allow examination of the cardia. The endoscope is withdrawn, allowing measurement of the squamocolumnar and gastro-esophageal junction from the incisors. The esophagus is assessed for the presence of a hiatal hernia and for the cause of the obstruction. The remainder of the distal, mid, and proximal esophageal mucosa is examined. Photodocumentation of the exam findings including measurements of the lesion, labeling of the identified structures and magnified images of the abnormality responsible for the foreign body obstruction are obtained and sent to a hard copy device. The endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. Post procedure orders are completed. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to referral source and other appropriate parties. Data is entered into procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others. Necessary prescriptions, follow-up tests and appointments are provided to the patient.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	10/2012				
<b>Presenter(s):</b>	Joel V. Brill, MD (AGA), Nicholas Nickl, MD (ASGE), Edward S. Bentley, MD (ASGE), Wayne M. Koch, MD (AAO-HNS), John Lanza, MD (AAO-HNS), Michael Edye, MD (SAGES), Don J. Selzer, MD (SAGES)				
<b>Specialty(s):</b>	AGA, ASGE, AAO-HNS, SAGES				
<b>CPT Code:</b>	43215				
<b>Sample Size:</b>	5030	<b>Resp N:</b>	102	<b>Response:</b> 2.0 %	
<b>Description of Sample:</b>	The AGA and ASGE conducted a random sample of their member gastroenterologists using the Census Department office regions ( <a href="http://www.census.gov/regions/">http://www.census.gov/regions/</a> ). Between 150 and 200 gastroenterologists were randomly selected in each region for a total of 2,000 gastroenterologists. The AGA and ASGE enhanced the random sample by adding 514 members of the ASGE Special Interest Groups and 786 physicians who perform esophagoscopy EUS and stent, TNE and optical endomicroscopy and ablation provided by Industry. The AGA and ASGE also added 86 volunteers who responded to the educational article on the RUC survey process that was approved by the Research Subcommittee and was distributed to all AGA and ASGE members. The AGA and ASGE's total survey sample size was 3,386. AAO-HNS conducted a random sampling of 705 physicians. SAGES sent a total of 1,000 emails (939 successfully delivered) using a random selection of 250 members from each of the four CMS DME Regions A-D (ie, geographically distributed). The total survey sample size for AAO-HNS, SAGES, AGA and ASGE was 5,030.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	0.00	3.00	6.00	50.00
<b>Survey RVW:</b>	0.50	2.80	3.50	4.45	28.00
<b>Pre-Service Evaluation Time:</b>			25.00		
<b>Pre-Service Positioning Time:</b>			5.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			5.00		
<b>Intra-Service Time:</b>	2.00	15.00	20.00	30.00	60.00
<b>Immediate Post Service-Time:</b>	<u>10.00</u>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	43215	<b>Recommended Physician Work RVU: 2.60</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		25.00	33.00	-8.00
<b>Pre-Service Positioning Time:</b>		3.00	1.00	2.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00

Intra-Service Time:		20.00
Immediate Post Service-Time:	10.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00
Discharge Day Mgmt:	0.00	99238x 0.0 99239x 0.0 99217x 0.00
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

Key CPT Code	Global	Work RVU	Time Source
49421	000	4.21	RUC Time

CPT Descriptor Insertion of tunneled intraperitoneal catheter for dialysis, open**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
31575	000	1.10	RUC Time	599,944

CPT Descriptor 1 Laryngoscopy, flexible fiberoptic; diagnostic

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
57410	000	1.75	RUC Time	3,277

CPT Descriptor 2 Pelvic examination under anesthesia (other than local)

Other Reference CPT Code	Global	Work RVU	Time Source
31622	000	2.78	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 23      % of respondents: 22.5 %

**TIME ESTIMATES (Median)**

	CPT Code: 43215	Key Reference CPT Code: 49421	Source of Time RUC Time
Median Pre-Service Time	33.00	46.00	

Median Intra-Service Time	20.00	45.00
Median Immediate Post-service Time	10.00	0.00
Median Critical Care Time	0.0	20.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>63.00</b>	<b>111.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered		
--	--	--

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed		
--	--	--

Urgency of medical decision making		
------------------------------------	--	--

**Technical Skill/Physical Effort (Mean)**

Technical skill required		
--------------------------	--	--

Physical effort required		
--------------------------	--	--

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality		
---	--	--

Outcome depends on the skill and judgment of physician		
--	--	--

Estimated risk of malpractice suit with poor outcome		
--	--	--

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity		
----------------------------------	--	--

Intra-Service intensity/complexity	4.40	3.42
------------------------------------	------	------

Post-Service intensity/complexity		
-----------------------------------	--	--

## Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

### Rationale and comments for 43215

43215 *Esophagoscopy, flexible, transoral; with removal of foreign body* RVW 2.60 physician time, 29/39/15 was previously valued by Harvard and reviewed by the RUC in July 1993. This code is being reviewed in response to the CMS comments in the Proposed Rule and Final Rule for CY 2012, requesting review of gastrointestinal endoscopic services as potentially misvalued.

Although this code was not specifically identified by CMS in the Final Rule, the societies that committed to a comprehensive review of gastrointestinal endoscopic services – the AGA, ACG, ASGE and SAGES – identified that code 43200 was primarily performed by otolaryngologists, while the remaining codes in the 43200-43232 family were primarily performed by gastroenterologists and endoscopic surgeons. In view of such, a coding change proposal was brought to the February 2012 CPT Editorial Panel in conjunction with the AAO-HNS and the Trilogical Society, requesting the development of new codes for trans-nasal esophagoscopy (primarily performed in the non-facility setting without moderate sedation) and rigid esophagoscopy (primarily performed in the OR setting with anesthesia administered by an anesthesia professional). While the code number, 43215, remains the same, this code is now specific for a flexible, transoral, esophagoscopy procedure.

In May 2012 the AGA, ASGE and SAGES requested that the Research Subcommittee consider a mini-survey methodology for this and the other codes in the 43200-43232 family, which was approved. The Research Subcommittee required that a standard survey be conducted of the new base code for flexible trans-oral esophagoscopy, 43200 *Esophagoscopy, flexible; transoral diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*, specifically including the elements of pre- and post-service physician work. For the remaining codes that were surveyed in the 43201-43232 family, including code 43215, the mini-survey instrument only asked the physician to address the intra-service work component for the procedure. Accordingly, the societies submitting these recommendations are using for 43215 the same pre- and post- service times as for the revised base code for flexible trans-oral esophagoscopy, 43200.

A survey of practicing physicians representing urban, suburban and rural community and academic settings was performed with 102 respondents of 5030 queried (2.0 %). Of the responses received, 90% were from Gastroenterologists, 7% were from Endoscopic Surgeons, and 3% were from Otolaryngologists. 96% found the vignette to be typical. The median service performance rate was 3. 79% typically used moderate sedation in the facility (hospital outpatient, ambulatory surgery center) setting. In the base code survey of pre-service and post-service times, as described above, the respondents reported median pre-service evaluation, positioning, and scrub/dress/wait times of 25, 5, and 5 minutes respectively, and post service time of 10 minutes. The respondents reported a median intra-service time of 20 minutes. 23 (22.5%) of the respondents chose key reference service 49421, *Insertion of tunneled intraperitoneal catheter for dialysis, open*, 4.21 45/45/20 the intra-service intensity of 43215 to be 4.40, compared to the comparison code intra-service intensity of 3.42. As the mini-survey methodology only captured intra-service intensity / complexity, we are unable to provide an assessment regarding the relative intensity of the surveyed code to the comparison code on other measures. The median survey RVW was 3.50. We note that as all of the gastrointestinal endoscopy codes are being surveyed over the next two years, the reference service list (RSL) does not contain any endoscopic procedures that would be familiar to the physicians completing the surveys.

The specialty societies convened an expert panel to review the survey results and make recommendations. The panel noted that the median service performance rate (3) was what would be expected for a typical gastroenterologist in solo or small group practice.

The panel noted there has been a change in the practice pattern for this service since it was most recently valued by the RUC in 1993. In the 1980s and 1990s when this code was first valued, flexible esophagoscopy with insertion of guide wire followed by dilation over guide wire (code 43226) was performed with fiberoptic instruments; today's standard of practice is the use of high-definition video endoscopes and high definition video monitors. In the early 1990s, conscious sedation used rapid intravenous administration of meperidine and diazepam without routine monitoring of pulse oximetry; in 2012, moderate sedation using benzodiazepines and opiates is administered in a controlled, titrated manner with automated monitoring of pulse oximetry, electrocardiogram and, in some settings, capnography. In the 1990s when this code was valued, there were no regulations and/or requirements for a complete History and Physical of the patient within 30 days of the procedure, documentation of a comprehensive examination updated on the day of procedure, a pre-sedation assessment including ASA physical status, airway and cardiac risk completed prior to the procedure, a mandatory timeout before beginning the procedure, or photodocumentation of the findings – all of which are now required to meet various local, state, payor and Medicare accreditation, quality standards, and/or patient safety requirements. In the early 1990s eosinophilic esophagitis had not been described, endoscopic management of Barrett's esophagus, endoscopic mucosal resection of tumors and stenting of esophageal cancer was in development, and endoscopic ultrasound was yet to be commercially available. The panel also noted that "open access" endoscopy, where the patient is not seen by the endoscopist until the day of the procedure, has gained increasing acceptance in a number of settings – community, academic, teaching, military, VA and public; urban, suburban and rural; single and multi-specialty group; independent and employed - during the past decade.

Medicare claims for Esophagoscopy, rigid or flexible; with removal of foreign body (code 43215) have declined over a seven year period from 2210 in 2005 to 1632 in 2011. A review of a 5% Medicare claims file from 2011 (total 2011 claims 1632) reveals that code 43215 was reported 17.56% percent of the time by otolaryngologists, 48.23% by gastroenterologists, 8.68% by thoracic surgeons and 16.84% by general surgeons. For Medicare, the procedure was performed 46.48% in the outpatient hospital, 37% in the inpatient hospital, 2.1% in the physician office, and 2.68% in the ambulatory surgery center setting. As otolaryngologists and surgeons perform both rigid and flexible esophagoscopy, one can make only an estimate assumption that a percentage of the services performed by those specialties in facility settings represent rigid esophagoscopy procedures performed under general anesthesia.

The expert, multi-society panel notes that a change has occurred in the way that the work of moderate sedation is calculated for the purposes of the RUC's recommendations to CMS. Prior to 2012, the RUC and CMS affirmed that physician work of administering moderate sedation was part of the intra-service time, as in endoscopic procedures 43235 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* and 45378 *Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)* which were surveyed in the 2005 Third Five-Year review, and 43262 *Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy* which was surveyed in the 2010 Fourth Five-Year review. In fact, an overwhelming majority (89%) of codes in Appendix G in which moderate sedation is intrinsic to the service, where moderate sedation is specifically identified in the RUC work descriptors, describe moderate sedation as occurring during the intra-service period. The decision by the RUC's Research Subcommittee to change how the physician work of administering moderate sedation is accounted for as pre-service, not intra-service work, may constitute recognition that there has been a change in the physician work of performing endoscopic procedures over the past 20 years. In view of such, the RUC's introduction of the standardized pre-service packages in 2008 which specify a difference in pre-service evaluation minutes depending on whether a procedure involves sedation / anesthesia care, and the Research Subcommittee's 2012 clarification that the administration of moderate sedation constitutes work as occurring during the pre-service period, represents an important change in the way that physician work for procedures involving moderate sedation is valued, and constitutes compelling evidence for re-valuation of the gastrointestinal endoscopy codes.



The expert panel felt that in view of the change in how the procedure was performed, new diagnoses, and new requirements to ensure patient safety, the predominance of otolaryngologists performing code 43200 vs. gastroenterologists performing the predominance of other procedures in the 43201-43232 family, and the inability to distinguish the percentage of previous services that represent rigid trans-oral, flexible trans-oral, and flexible trans-nasal procedures, the flexible, trans-oral esophagoscopy procedure has changed since the initial valuation by Harvard, providing compelling evidence for re-valuation.

After assessing the pre-service work that is performed, the expert panel determined that the assumption that all endoscopic procedures would have identical pre- and post-service time may have been incorrect. We note that the survey instrument approved by the Research Subcommittee did not allow the expert panel to draw any conclusions about the role of moderate sedation in the valuation of the pre-service work. The expert panel attempted to address this by reviewing similar services, based on whether the typical patient and typical procedure was straightforward or complex. For this procedure, we are recommending pre-service package 2b with changes of times to 25/3/5 for a total of 33 minutes of pre-service time, as follows:

**Evaluation:** 25 minutes which is the survey median time, but less than the package time.

**Positioning:** Addition of 2 minutes (3 min total) to account for positioning the patient, anesthesia lines, and video/scope equipment to allow access for the procedure and moderate sedation monitoring.

**Scrub/Dress/Wait:** 5 minutes which is equal to the survey median and package time.

The panel felt that the median post-service time of 10 minutes also underestimated the elements of post service work. The panel reviewed other scope procedures that had recently been reviewed by the RUC and recommended adjusting the post service time work to 15 minutes which is equivalent to code 31622, *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* reviewed by the RUC in April 2009. The panel determined that the post-service time should be less than the 20 minutes of post-service work for code 52005, *Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;* reviewed by the RUC in October 2010 at the 4<sup>th</sup> Five-Year review.

The panel noted the survey median intra-service time was 20 minutes and felt that this time was acceptable as it represented approximately half of the intra-service time for the key reference service 49421, *Insertion of tunneled intraperitoneal catheter for dialysis, open*, (000 global, 46/45/20, RVW 4.21) which was reviewed by the RUC in April 2010. The panel felt that although the intraservice time was approximately half of the Harvard valuation the intensity of the service (i.e. the necessity to successfully perform the service without complication in a shorter period of time) had substantially increased. The panel also compared the 20 minutes survey time to the intra-service time of 15 minutes for the base code, 43200, and felt that the 5 minutes of incremental time represents an appropriate incremental work time for the typical procedure. The panel noted that the respondent 25<sup>th</sup> percentile and median RVW recommendation were respectively 2.80 and 3.50 reflecting the increased intensity of service, which along with the changes in the practice patterns and new diagnoses represented compelling evidence to recommend a revaluation in the physician work of this procedure. The expert panel then reviewed the rank order of code 43215 along with the intra-service times for the other codes surveyed in the 43200-43232 family. Based on the comprehensive review of the family of codes surveyed, the expert panel determined that despite the 25<sup>th</sup> percentile RVW recommendation of 3.25 and the presence of compelling evidence which would otherwise merit a work value increase, the panel could not justify recommending an increase in the current valuation of code 43215 from 2.60.

As the physicians who completed the surveys were significantly limited in their choice of key reference codes within the endoscopic family, the panel felt that code 49421 represented an appropriate key reference code even though the total and intraservice times for code 43215 were less. Adjusting for the differences in times, the panel concluded that the current RVW of 2.60 and revised IWPUT (0.0798) for code 43215 is consistent with code MPC code 31575 *Laryngoscopy, flexible fiberoptic; diagnostic* (000 global, 15/8/5 RVW 1.10,

IWPUT 0.0904) and proportional to code 49421 *Insertion of tunneled intraperitoneal catheter for dialysis, open (wRVW 4.21, IWPUT 0.0639)*. The panel also noted that MPC code 19103 *Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance (000 global, 20/30/15 RVW 3.69, IWPUT 0.0969)* compares appropriately with 43215 adjusting for the difference in service times and complexity. Code 57410 *Pelvic examination under anesthesia (other than local) (000 global, 30/15/25, RVW 1.75, IWPUT 0.0345)*, and code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure) (000 global 20/30/15, RVW 2.78, IWPUT 0.0688)*, were identified as comparable codes of lesser complexity.

While there was compelling evidence to recommend an increase in the wRVU times for code 43215 based on the survey times adjusted for pre-service package 2b, the expert panel recommends that the existing wRVU value of 2.60 should be retained with physician times 33/20/15 (compared to the previous RUC valuation of 29/39/15). The expert panel also recommends that code 43215 be valued in both the facility and non-facility setting.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43215

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology                      How often? Rarely

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. ~4,900 (Medicare data 2011 = 1,632\*3) In the future gastroenterologists will perform 90 percent of these procedures.

Specialty Gastroenterology	Frequency 4500	Percentage 0.00 %
----------------------------	----------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,426

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. (Medicare data 2011 = 1,632) Left over utilization not going to new code 4319X4.

Specialty Gastroenterology	Frequency 900	Percentage 0.00 %
----------------------------	---------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? No

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43215

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

## AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 43216	Tracking Number	Original Specialty Recommended RVU: <b>2.40</b>
		Presented Recommended RVU: <b>2.40</b>
Global Period: 000		RUC Recommended RVU: <b>2.40</b>

CPT Descriptor: Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery

### CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 64 year old patient with dysphagia and a partially obstructing polyp on barium swallow undergoes therapeutic esophagoscopy for removal of the lesion.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

### Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

### Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 83%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 79%

Description of Pre-Service Work: Review with the patient any symptoms and ascertain characteristics of the dysphagia problem when it is clear there is dysphagia. The patient's history is reviewed to assess for the need for pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed and documented; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays and other diagnostic tests are reviewed. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained and the physician must sign the consent. The physician verifies all endoscopic equipment is available and appropriate computer entries are made. The patient is positioned on the examination table. The endoscopic and moderate sedation monitoring equipment is positioned to provide access for the procedure. A time out is performed. A bite block is placed in the mouth. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible upper endoscope is inserted through the mouth into the oropharynx and advanced through the esophagus into the proximal stomach and, when indicated, retroflexed to allow examination of the cardia. The endoscope is withdrawn, allowing measurement of the squamocolumnar and gastro-esophageal junction from the incisors, assessment for presence of a hiatal hernia, and then examination of the esophageal mucosa. A 3mm lesion is identified at 27cm from the incisors. The identified lesion is removed with hot biopsy forceps until there is no residual. The level of sedation of the patient is reassessed and additional medication is administered as needed. The area is observed for bleeding. Photodocumentation of

the exam findings including measurements of the lesion, labeling of the identified structures and magnified images of the abnormality are obtained and sent to a hard copy device. The endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. Post procedure orders are completed. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to referral source and other appropriate parties. Data is entered into procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others. Necessary prescriptions, follow-up tests and appointments are provided to the patient.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	10/2012				
<b>Presenter(s):</b>	Joel V. Brill, MD (AGA), Nicholas Nickl, MD (ASGE), Edward S. Bentley, MD (ASGE), Michael Edye, MD (SAGES), Don J. Selzer, MD (SAGES)				
<b>Specialty(s):</b>	AGA, ASGE, SAGES				
<b>CPT Code:</b>	43216				
<b>Sample Size:</b>	4325	<b>Resp N:</b>	99	<b>Response:</b> 2.2 %	
<b>Description of Sample:</b>	The AGA and ASGE conducted a random sample of their member gastroenterologists using the Census Department office regions ( <a href="http://www.census.gov/regions/">http://www.census.gov/regions/</a> ). Between 150 and 200 gastroenterologists were randomly selected in each region for a total of 2,000 gastroenterologists. The AGA and ASGE enhanced the random sample by adding 514 members of the ASGE Special Interest Groups and 786 physicians who perform esophagoscopy EUS and stent, TNE and optical endomicroscopy and ablation provided by Industry. The AGA and ASGE also added 86 volunteers who responded to the educational article on the RUC survey process that was approved by the Research Subcommittee and was distributed to all AGA and ASGE members. The AGA and ASGE's total survey sample size was 3,386. SAGES sent a total of 1,000 emails (939 successfully delivered) using a random selection of 250 members from each of the four CMS DME Regions A-D (ie, geographically distributed). The total survey sample size for SAGES, AGA and ASGE was 4,325.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	2.00	5.00	10.00	75.00
<b>Survey RVW:</b>	0.50	2.99	3.88	4.65	11.47
<b>Pre-Service Evaluation Time:</b>			25.00		
<b>Pre-Service Positioning Time:</b>			5.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			5.00		
<b>Intra-Service Time:</b>	2.00	15.00	22.00	30.00	75.00
<b>Immediate Post Service-Time:</b>	<u>10.00</u>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	43216	<b>Recommended Physician Work RVU: 2.40</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		25.00	33.00	-8.00
<b>Pre-Service Positioning Time:</b>		3.00	1.00	2.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00
<b>Intra-Service Time:</b>		22.00		
<b>Immediate Post Service-Time:</b>	<u>10.00</u>			

<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b><u>0.00</u></b>	99291x <b>0.00</b>	99292x <b>0.00</b>		
<b>Other Hospital time/visit(s):</b>	<b><u>0.00</u></b>	99231x <b>0.00</b>	99232x <b>0.00</b>	99233x <b>0.00</b>	
<b>Discharge Day Mgmt:</b>	<b><u>0.00</u></b>	99238x <b>0.0</b>	99239x <b>0.0</b>	99217x <b>0.00</b>	
<b>Office time/visit(s):</b>	<b><u>0.00</u></b>	99211x <b>0.00</b>	12x <b>0.00</b>	13x <b>0.00</b>	14x <b>0.00</b> 15x <b>0.00</b>
<b>Prolonged Services:</b>	<b><u>0.00</u></b>	99354x <b>0.00</b>	55x <b>0.00</b>	56x <b>0.00</b>	57x <b>0.00</b>
<b>Sub Obs Care:</b>	<b><u>0.00</u></b>	99224x <b>0.00</b>	99225x <b>0.00</b>	99226x <b>0.00</b>	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
49421	000	4.21	RUC Time

CPT Descriptor Insertion of tunneled intraperitoneal catheter for dialysis, open**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
31575	000	1.10	RUC Time	599,944

CPT Descriptor 1 Laryngoscopy, flexible fiberoptic; diagnostic

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
57410	000	1.75	RUC Time	3,277

CPT Descriptor 2 Pelvic examination under anesthesia (other than local)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31622	000	2.78	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 23      % of respondents: 23.2 %

**TIME ESTIMATES (Median)**

	<b>CPT Code:</b> 43216	<b>Key Reference CPT Code:</b> 49421	<b>Source of Time</b> RUC Time
Median Pre-Service Time	33.00	46.00	
Median Intra-Service Time	22.00	45.00	

Median Immediate Post-service Time	10.00	20.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>65.00</b>	<b>111.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)**(of those that selected Key  
Reference code)**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed

Urgency of medical decision making

**Technical Skill/Physical Effort (Mean)**

Technical skill required

Physical effort required

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality

Outcome depends on the skill and judgment of physician

Estimated risk of malpractice suit with poor outcome

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity

Intra-Service intensity/complexity

Post-Service intensity/complexity



## Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

### **Rationale and comments for 43216**

43216 *Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery* RVW 2.40 physician time, 12/33/20 was previously valued by the RUC in April 1993. This code is being reviewed in response to the CMS comments in the Proposed Rule and Final Rule for CY 2012, requesting review of gastrointestinal endoscopic services as potentially misvalued.

Although this code was not specifically identified by CMS in the Final Rule, the societies that committed to a comprehensive review of gastrointestinal endoscopic services – the AGA, ACG, ASGE and SAGES – identified that code 43200 was primarily performed by otolaryngologists, while the remaining codes in the 43200-43232 family were primarily performed by gastroenterologists and endoscopic surgeons. In view of such, a coding change proposal was brought to the February 2012 CPT Editorial Panel in conjunction with the AAO-HNS and the Trilogical Society, requesting the development of new codes for trans-nasal esophagoscopy (primarily performed in the non-facility setting without moderate sedation) and rigid esophagoscopy (primarily performed in the OR setting with anesthesia administered by an anesthesia professional). While the code number, 43216, remains the same, this code is now specific for a flexible, transoral, esophagoscopy procedure.

In May 2012 the AGA, ASGE and SAGES requested that the Research Subcommittee consider a mini-survey methodology for this and the other codes in the 43200-43232 family, which was approved. The Research Subcommittee required that a standard survey be conducted of the new base code for flexible trans-oral esophagoscopy, 43200 *Esophagoscopy, flexible; transoral diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*, specifically including the elements of pre- and post-service physician work. For the remaining codes that were surveyed in the 43201-43232 family, including code 43216, the mini-survey instrument only asked the physician to address the intra-service work component for the procedure. Accordingly, the societies submitting these recommendations are using for 43216 the same pre- and post- service times as for the revised base code for flexible trans-oral esophagoscopy, 43200.

A survey of practicing physicians representing urban, suburban and rural community and academic settings was performed with 99 respondents of 4,325 queried (2.2 %). Of the responses received 97% were from Gastroenterologists and 3% were from Endoscopic Surgeons. 92% found the vignette to be typical. The median service performance rate was 5. 83% typically used moderate sedation in the facility (hospital outpatient, ambulatory surgery center) setting. In the base code survey of pre-service and post-service times, as described above, the respondents reported median pre-service evaluation, positioning, and scrub/dress/wait times of 25, 5, and 5 minutes respectively, and post service time of 10 minutes. The respondents reported a median intra-service time of 20 minutes. 23 (23.2%) of the respondents chose key reference service 49421, *Insertion of tunneled intraperitoneal catheter for dialysis, open*, (wRVW 4.21 45/45/20). The survey intra-service intensity of 43216 was 4.77, compared to the comparison code intra-service intensity of 3.42. As the mini-survey methodology only captured intra-service intensity / complexity, we are unable to provide an assessment regarding the relative intensity of the surveyed code to the comparison code on other measures. The median survey RVW was 3.88. We note that as all of the gastrointestinal endoscopy codes are being surveyed over the next two years, the reference service list (RSL) does not contain any endoscopic procedures that would be familiar to the physicians completing the surveys.

The specialty societies convened an expert panel to review the survey results and make recommendations. The panel noted that the median service performance rate (5) was what would be expected for a typical gastroenterologist in solo or small group practice.

The panel noted there has been a change in the practice pattern for this service since it was most recently valued by the RUC in 1993. In the 1980s and 1990s when this code was first valued, flexible esophagoscopy with insertion of guide wire followed by dilation over guide wire (code 43216) was performed with fiberoptic instruments; today's standard of practice is the use of high-definition video endoscopes and high definition video monitors. In the early 1990s, conscious sedation used rapid intravenous administration of meperidine and diazepam without routine monitoring of pulse oximetry; in 2012, moderate sedation using benzodiazepines and opiates is administered in a controlled, titrated manner with automated monitoring of pulse oximetry, electrocardiogram and, in some settings, capnography. In the 1990s when this code was valued, there were no regulations and/or requirements for a complete History and Physical of the patient within 30 days of the procedure, documentation of a comprehensive examination updated on the day of procedure, a pre-sedation assessment including ASA physical status, airway and cardiac risk completed prior to the procedure, a mandatory timeout before beginning the procedure, or photodocumentation of the findings – all of which are now required to meet various local, state, payor and Medicare accreditation, quality standards, and/or patient safety requirements. In the early 1990s eosinophilic esophagitis had not been described, endoscopic management of Barrett's esophagus, endoscopic mucosal resection of tumors and stenting of esophageal cancer was in development, and endoscopic ultrasound was yet to be commercially available. The panel also noted that "open access" endoscopy, where the patient is not seen by the endoscopist until the day of the procedure, has gained increasing acceptance in a number of settings – community, academic, teaching, military, VA and public; urban, suburban and rural; single and multi-specialty group; independent and employed - during the past decade.

Medicare claims for Esophagoscopy, rigid or flexible; with removal of foreign body (code 43216) have declined over a seven year period from 150 in 2005 to 75 in 2011. A review of a 5% Medicare claims file from 2011 (total 2011 claims 75) reveals that code 43216 was reported 8.70% percent of the time by otolaryngologists, 38.42% by gastroenterologists, and 34.27% by general surgeons. For Medicare, the procedure was performed 68.54% in the outpatient hospital, 17.14% in the inpatient hospital, 4.28% in the physician office, and 10.04 % in the ambulatory surgery center setting. As otolaryngologists and surgeons perform both rigid and flexible esophagoscopy, one can make only an estimate assumption that a percentage of the services performed by those specialties in facility settings represent rigid esophagoscopy procedures performed under general anesthesia.

The expert, multi-society panel notes that a change has occurred in the way that the work of moderate sedation is calculated for the purposes of the RUC's recommendations to CMS. Prior to 2012, the RUC and CMS affirmed that physician work of administering moderate sedation was part of the intra-service time, as in endoscopic procedures 43235 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* and 45378 *Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)* which were surveyed in the 2005 Third Five-Year review, and 43262 *Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy* which was surveyed in the 2010 Fourth Five-Year review. In fact, an overwhelming majority (89%) of codes in Appendix G in which moderate sedation is intrinsic to the service, where moderate sedation is specifically identified in the RUC work descriptors, describe moderate sedation as occurring during the intra-service period. The decision by the RUC's Research Subcommittee to change how the physician work of administering moderate sedation is accounted for as pre-service, not intra-service work, may constitute recognition that there has been a change in the physician work of performing endoscopic procedures over the past 20 years. In view of such, the RUC's introduction of the standardized pre-service packages in 2008 which specify a difference in pre-service evaluation minutes depending on whether a procedure involves sedation / anesthesia care, and the Research Subcommittee's 2012 clarification that the administration of moderate sedation constitutes work as occurring during the pre-service period, represents an important change in the way that physician work for procedures involving moderate sedation is valued, and constitutes compelling evidence for re-valuation of the gastrointestinal endoscopy codes.

The expert panel felt that in view of the change in how the procedure was performed, new diagnoses, and new requirements to ensure patient safety, the predominance of otolaryngologists performing code 43200 vs. gastroenterologists performing the predominance of other procedures in the 43201-43232 family, and the inability to distinguish the percentage of previous services that represent rigid trans-oral, flexible trans-oral, and flexible trans-nasal procedures, the flexible, trans-oral esophagoscopy procedure has changed since the initial valuation by Harvard, providing compelling evidence for re-valuation.

After assessing the pre-service work that is performed, the expert panel determined that the assumption that all endoscopic procedures would have identical pre- and post-service time may have been incorrect. We note that the survey instrument approved by the Research Subcommittee did not allow the expert panel to draw any conclusions about the role of moderate sedation in the valuation of the pre-service work. The expert panel attempted to address this by reviewing similar services, based on whether the typical patient and typical procedure was straightforward or complex. For this procedure, we are recommending pre-service package 2b with changes of times to 25/3/5 for a total of 33 minutes of pre-service time, as follows:

**Evaluation:** 25 minutes which is the survey median time, but less than the package time.

**Positioning:** Addition of 2 minutes (3 min total) to account for positioning the patient, anesthesia lines, and video/scope equipment to allow access for the procedure and moderate sedation monitoring.

**Scrub/Dress/Wait:** 5 minutes which is equal to the survey median and package time.

The panel felt that the median post-service time of 10 minutes also underestimated the elements of post service work. The panel reviewed other scope procedures that had recently been reviewed by the RUC and recommended adjusting the post service time work to 15 minutes similar to code 31622, *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)*. The panel determined that the post-service time should be less than the 20 minutes of post-service work for code 52005, *Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service*; reviewed by the RUC in October 2010 at the 4<sup>th</sup> Five-Year review.

The panel noted the survey median intra-service time was 22 minutes and felt that this time was acceptable as it represented approximately half of the intra-service time for the key reference service 49421, *Insertion of tunneled intraperitoneal catheter for dialysis, open*, (000 global, 46/45/20, RVW 4.21) which was reviewed by the RUC in April 2010. The panel felt that although the intraservice time was approximately two thirds of the previous valuation the intensity of the service (i.e. the necessity to successfully perform the service without complication in a shorter period of time) had substantially increased. The panel also compared the 22 minutes survey time to the intra-service time of 15 minutes for the base code, 43200, and felt that the 7 minutes of incremental time represents an appropriate incremental work time for the typical procedure. The panel noted that the respondent 25<sup>th</sup> percentile and median RVW recommendation were respectively 2.99 and 3.88 reflecting the increased intensity of service, which along with the changes in the practice patterns and new diagnoses represented compelling evidence to recommend a revaluation in the physician work of this procedure. The expert panel then reviewed the rank order of code 43216 along with the intra-service times for the other codes surveyed in the 43200-43232 family. Based on the comprehensive review of the family of codes surveyed, the expert panel determined that despite the 25<sup>th</sup> percentile RVW recommendation of 2.99 and the presence of compelling evidence which would otherwise merit a work value increase, the panel could not justify recommending an increase in the current valuation of code 43216 from 2.40.

As the physicians who completed the surveys were significantly limited in their choice of key reference codes within the endoscopic family, the panel felt that code 49421 represented an appropriate key reference code even though the total and intraservice times for code 43216 were less. Adjusting for the differences in times, the panel concluded that the current RVW of 2.40 and revised IWPUT (0.0635) for code 43216 is consistent with code MPC code 31575 *Laryngoscopy, flexible fiberoptic; diagnostic* (000 global, 15/8/5 RVW 1.10, IWPUT 0.0904) and proportional to code 49421 *Insertion of tunneled intraperitoneal catheter for dialysis*,

*open (wRVW 4.21, IWPUT 0.0639). The panel also noted that MPC code 19103 Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance (000 global, 20/30/15 RVW 3.69, IWPUT 0.0969) compares appropriately with 43216 adjusting for the difference in service times and complexity. Code 57410 Pelvic examination under anesthesia (other than local) (000 global, 30/15/25, RVW 1.75, IWPUT 0.0345), and code 31622 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure) (000 global 20/30/15, RVW 2.78, IWPUT 0.0688), were identified as comparable codes of lesser complexity.*

While there was compelling evidence to recommend an increase in the wRVU times for code 43216 based on the survey times adjusted for pre-service package 2b, the expert panel recommends that the existing wRVU value of 2.40 should be retained with physician times 33/22/15 (compared to the previous RUC valuation of 12/33/20). The expert panel also recommends that code 43216 be valued in both the facility and non-facility setting.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43216

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology                      How often? Rarely

Specialty                      How often? Rarely

Specialty                      How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 250

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. ~250 (Medicare data 2011 = 75\*3) In the future GI will perform 90 percent of these procedures.

Specialty Gastroenterology

Frequency 220

Percentage 88.00 %

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 75 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. ~75 (Medicare data 2011 = 75)

Specialty Gastroenterology	Frequency 70	Percentage 93.33 %
----------------------------	--------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? No

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43216

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43217	Tracking Number	Original Specialty Recommended RVU: <b>2.90</b>
		Presented Recommended RVU: <b>2.90</b>
Global Period: 000		RUC Recommended RVU: <b>2.90</b>

CPT Descriptor: Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 68 year old patient with dysphagia and a partially obstructing polyp on barium swallow undergoes therapeutic esophagoscopy for snare removal of the lesion.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 82%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 75%

**Description of Pre-Service Work:** Review with the patient any symptoms and ascertain characteristics of the dysphagia problem when it is clear there is dysphagia. The patient's history is reviewed to assess for the need for pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed and documented; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays and other diagnostic tests are reviewed. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained and the physician must sign the consent. The physician verifies all endoscopic equipment is available and appropriate computer entries are made. The patient is positioned on the examination table. The endoscopic and moderate sedation monitoring equipment is positioned to provide access for the procedure. A time out is performed. A bite block is placed in the mouth. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat.

**Description of Intra-Service Work:** The level of sedation is assessed prior to inserting the endoscope. A standard flexible upper endoscope is inserted through the mouth into the oropharynx and advanced through the esophagus into the proximal stomach and, when indicated, retroflexed to allow examination of the cardia. The endoscope is withdrawn, allowing measurement of the squamocolumnar and gastro-esophageal junction from the incisors, assessment for presence of a hiatal hernia, and then examination of the esophageal mucosa. A 8mm polypoid lesion is identified at 33cm from the incisors. A snare is passed through the endoscope and looped around the lesion. As the snare is tightened, electrocautery is applied in a controlled manner and the identified lesion is removed. The snare is withdrawn, and a retrieval device is inserted through the endoscope to capture the polyp. The retrieval device and polyp are withdrawn to the tip of the endoscope. The

endoscope with the device and polyp are withdrawn through the mouth. The lesion is placed in a biopsy container. The level of sedation of the patient is reassessed and additional medication is administered as needed. The endoscope is reinserted through the mouth to the area of the lesion. The base of the lesion is examined; if there is residual tissue the snare technique is repeated until there is no residual. The area is observed for bleeding. Photodocumentation of the exam findings including measurements of the lesion, labeling of the identified structures and magnified images of the abnormality are obtained and sent to a hard copy device. The endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. Post procedure orders are completed. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to referral source and other appropriate parties. Data is entered into procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others. Necessary prescriptions, follow-up tests and appointments are provided to the patient.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	10/2012				
<b>Presenter(s):</b>	Joel V. Brill, MD (AGA), Nicholas Nickl, MD (ASGE), Edward S. Bentley, MD (ASGE), Wayne M. Koch, MD (AAO-HNS), John Lanza, MD (AAO-HNS), Michael Edye, MD (SAGES), Don J. Selzer, MD (SAGES)				
<b>Specialty(s):</b>	AGA, ASGE, SAGES				
<b>CPT Code:</b>	43217				
<b>Sample Size:</b>	4325	<b>Resp N:</b>	90	<b>Response:</b> 2.0 %	
<b>Description of Sample:</b>	The AGA and ASGE conducted a random sample of their member gastroenterologists using the Census Department office regions ( <a href="http://www.census.gov/regions/">http://www.census.gov/regions/</a> ). Between 150 and 200 gastroenterologists were randomly selected in each region for a total of 2,000 gastroenterologists. The AGA and ASGE enhanced the random sample by adding 514 members of the ASGE Special Interest Groups and 786 physicians who perform esophagoscopy EUS and stent, TNE and optical endomicroscopy and ablation provided by Industry. The AGA and ASGE also added 86 volunteers who responded to the educational article on the RUC survey process that was approved by the Research Subcommittee and was distributed to all AGA and ASGE members. The AGA and ASGE's total survey sample size was 3,386. SAGES sent a total of 1,000 emails (939 successfully delivered) using a random selection of 250 members from each of the four CMS DME Regions A-D (ie, geographically distributed). The total survey sample size for SAGES, AGA and ASGE was 4,325.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	2.00	5.00	10.00	100.00
<b>Survey RVW:</b>	0.60	3.31	4.20	5.30	8.50
<b>Pre-Service Evaluation Time:</b>			25.00		
<b>Pre-Service Positioning Time:</b>			5.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			5.00		
<b>Intra-Service Time:</b>	5.00	25.00	30.00	45.00	60.00
<b>Immediate Post Service-Time:</b>	15.00				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	0.00	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	0.00	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	0.00	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	0.00	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	43217	<b>Recommended Physician Work RVU: 2.90</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		25.00	33.00	-8.00
<b>Pre-Service Positioning Time:</b>		3.00	1.00	2.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00
<b>Intra-Service Time:</b>		30.00		



Immediate Post Service-Time:	<u>10.00</u>	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0 99239x 0.0 99217x 0.00
Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
49421	000	4.21	RUC Time

CPT Descriptor Insertion of tunneled intraperitoneal catheter for dialysis, open**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
31575	000	1.10	RUC Time	599,944
<u>CPT Descriptor 1</u> Laryngoscopy, flexible fiberoptic; diagnostic				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
57410	000	1.75	RUC Time	3,277

CPT Descriptor 2 Pelvic examination under anesthesia (other than local)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31622	000	2.78	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 19 % of respondents: 21.1 %

**TIME ESTIMATES (Median)**

	<u>CPT Code:</u> 43217	<u>Key Reference CPT Code:</u> 49421	<u>Source of Time</u> RUC Time
Median Pre-Service Time	33.00	46.00	

Median Intra-Service Time	30.00	45.00
Median Immediate Post-service Time	10.00	20.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>73.00</b>	<b>111.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered		
--	--	--

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed		
--	--	--

Urgency of medical decision making		
------------------------------------	--	--

**Technical Skill/Physical Effort (Mean)**

Technical skill required		
--------------------------	--	--

Physical effort required		
--------------------------	--	--

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality		
---	--	--

Outcome depends on the skill and judgment of physician		
--	--	--

Estimated risk of malpractice suit with poor outcome		
--	--	--

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity		
----------------------------------	--	--

Intra-Service intensity/complexity	4.87	3.42
------------------------------------	------	------

Post-Service intensity/complexity		
-----------------------------------	--	--

## Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

### Rationale and comments for 43217

43217 *Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique* RVW 2.90 physician time, 30/29/18 was previously valued by Harvard and reviewed by the RUC in June 1993. This code is being reviewed in response to the CMS comments in the Proposed Rule and Final Rule for CY 2012, requesting review of gastrointestinal endoscopic services as potentially misvalued.

Although this code was not specifically identified by CMS in the Final Rule, the societies that committed to a comprehensive review of gastrointestinal endoscopic services – the AGA, ACG, ASGE and SAGES – identified that code 43200 was primarily performed by otolaryngologists, while the remaining codes in the 43200-43232 family were primarily performed by gastroenterologists and endoscopic surgeons. In view of such, a coding change proposal was brought to the February 2012 CPT Editorial Panel in conjunction with the AAO-HNS and the Trilogical Society, requesting the development of new codes for trans-nasal esophagoscopy (primarily performed in the non-facility setting without moderate sedation) and rigid esophagoscopy (primarily performed in the OR setting with anesthesia administered by an anesthesia professional). While the code number, 43217, remains the same, this code is now specific for a flexible, transoral, esophagoscopy procedure.

In May 2012 the AGA, ASGE and SAGES requested that the Research Subcommittee consider a mini-survey methodology for this and the other codes in the 43200-43232 family, which was approved. The Research Subcommittee required that a standard survey be conducted of the new base code for flexible trans-oral esophagoscopy, 43200 *Esophagoscopy, flexible; transoral diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*, specifically including the elements of pre- and post-service physician work. For the remaining codes that were surveyed in the 43201-43232 family, including code 43215, the mini-survey instrument only asked the physician to address the intra-service work component for the procedure. Accordingly, the societies submitting these recommendations are using for 43217 the same pre- and post- service times as for the revised base code for flexible trans-oral esophagoscopy, 43200.

A survey of practicing physicians representing urban, suburban and rural community and academic settings was performed with 90 respondents of 4325 queried (2.0 %). Of the responses received, 97% were from Gastroenterologists and 3% were from Endoscopic Surgeons. 98% found the vignette to be typical. The median service performance rate was 5. 82% typically used moderate sedation in the facility (hospital outpatient, ambulatory surgery center) setting. In the base code survey of pre-service and post-service times, as described above, the respondents reported median pre-service evaluation, positioning, and scrub/dress/wait times of 25, 5, and 5 minutes respectively, and post service time of 10 minutes. The respondents reported a median intra-service time of 30 minutes. 19 (21.1%) of the respondents chose key reference service 49421, *Insertion of tunneled intraperitoneal catheter for dialysis, open*, (wRVW 4.21 45/45/20). The survey intra-service intensity of 43217 was 4.87, compared to the comparison code intra-service intensity of 3.42. As the mini-survey methodology only captured intra-service intensity / complexity, we are unable to provide an assessment regarding the relative intensity of the surveyed code to the comparison code on other measures. The median survey RVW was 4.20. We note that as all of the gastrointestinal endoscopy codes are being surveyed over the next two years, the reference service list (RSL) does not contain any endoscopic procedures that would be familiar to the physicians completing the surveys.

The specialty societies convened an expert panel to review the survey results and make recommendations. The panel noted that the median service performance rate (5) was what would be expected for a typical gastroenterologist in solo or small group practice.

The panel noted there has been a change in the practice pattern for this service since it was most recently valued by the RUC in 1993. In the 1980s and 1990s when this code was first valued, flexible esophagoscopy with removal of tumor(s), polyp(s), or other lesion(s) by snare technique (code 43217) was performed with fiberoptic instruments; today's standard of practice is the use of high-definition video endoscopes and high definition video monitors. In the early 1990s, conscious sedation used rapid intravenous administration of meperidine and diazepam without routine monitoring of pulse oximetry; in 2012, moderate sedation using benzodiazepines and opiates is administered in a controlled, titrated manner with automated monitoring of pulse oximetry, electrocardiogram and, in some settings, capnography. In the 1990s when this code was valued, there were no regulations and/or requirements for a complete History and Physical of the patient within 30 days of the procedure, documentation of a comprehensive examination updated on the day of procedure, a pre-sedation assessment including ASA physical status, airway and cardiac risk completed prior to the procedure, a mandatory timeout before beginning the procedure, or photodocumentation of the findings – all of which are now required to meet various local, state, payor and Medicare accreditation, quality standards, and/or patient safety requirements. In the early 1990s eosinophilic esophagitis had not been described, endoscopic management of Barrett's esophagus, endoscopic mucosal resection of tumors and stenting of esophageal cancer was in development, and endoscopic ultrasound was yet to be commercially available. The panel also noted that "open access" endoscopy, where the patient is not seen by the endoscopist until the day of the procedure, has gained increasing acceptance in a number of settings – community, academic, teaching, military, VA and public; urban, suburban and rural; single and multi-specialty group; independent and employed - during the past decade.

Medicare claims for Esophagoscopy, rigid or flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique (code 43217) have not changed over a seven year period from 210 in 2005 to 220 in 2011. A review of a 5% Medicare claims file from 2011 (total 2011 claims 220) reveals that code 43217 was reported 4.37% percent of the time by otolaryngologists, 54.35% by gastroenterologists, and 27.15% by general surgeons. For Medicare, the procedure was performed 65.01% in the outpatient hospital, 14.58% in the inpatient hospital, 3.92% in the physician office, and 16.49% in the ambulatory surgery center setting. As otolaryngologists and surgeons perform both rigid and flexible esophagoscopy, one can make only an estimate assumption that a percentage of the services performed by those specialties in facility settings represent rigid esophagoscopy procedures performed under general anesthesia.

The expert, multi-society panel notes that a change has occurred in the way that the work of moderate sedation is calculated for the purposes of the RUC's recommendations to CMS. Prior to 2012, the RUC and CMS affirmed that physician work of administering moderate sedation was part of the intra-service time, as in endoscopic procedures 43235 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* and 45378 *Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)* which were surveyed in the 2005 Third Five-Year review, and 43262 *Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy* which was surveyed in the 2010 Fourth Five-Year review. In fact, an overwhelming majority (89%) of codes in Appendix G in which moderate sedation is intrinsic to the service, where moderate sedation is specifically identified in the RUC work descriptors, describe moderate sedation as occurring during the intra-service period. The decision by the RUC's Research Subcommittee to change how the physician work of administering moderate sedation is accounted for as pre-service, not intra-service work, may constitute recognition that there has been a change in the physician work of performing endoscopic procedures over the past 20 years. In view of such, the RUC's introduction of the standardized pre-service packages in 2008 which specify a difference in pre-service evaluation minutes depending on whether a procedure involves sedation / anesthesia care, and the Research Subcommittee's 2012 clarification that the administration of moderate sedation constitutes work as occurring during the pre-service period, represents an important change in the way that physician work for procedures involving moderate sedation is valued, and constitutes compelling evidence for re-valuation of the gastrointestinal endoscopy codes.

The expert panel felt that in view of the change in how the procedure was performed, new diagnoses, and new requirements to ensure patient safety, the predominance of otolaryngologists performing code 43200 vs. gastroenterologists performing the predominance of other procedures in the 43201-43232 family, and the inability to distinguish the percentage of previous services that represent rigid trans-oral, flexible trans-oral, and flexible trans-nasal procedures, the flexible, trans-oral esophagoscopy procedure has changed since the initial valuation by Harvard, providing compelling evidence for re-valuation.

After assessing the pre-service work that is performed, the expert panel determined that the assumption that all endoscopic procedures would have identical pre- and post-service time may have been incorrect. We note that the survey instrument approved by the Research Subcommittee did not allow the expert panel to draw any conclusions about the role of moderate sedation in the valuation of the pre-service work. The expert panel attempted to address this by reviewing similar services, based on whether the typical patient and typical procedure was straightforward or complex. For this procedure, we are recommending pre-service package 2b with changes of times to 25/3/5 for a total of 33 minutes of pre-service time, as follows:

**Evaluation:** 25 minutes which is the survey median time, but less than the package time.

**Positioning:** Addition of 2 minutes (3 min total) to account for positioning the patient, anesthesia lines, and video/scope equipment to allow access for the procedure and moderate sedation monitoring.

**Scrub/Dress/Wait:** 5 minutes which is equal to the survey median and package time.

The panel noted that in 2010 at the third five-year review, the societies recommended and the RUC accepted 3 minutes positioning for 45331, *Sigmoidoscopy, flexible; with biopsy, single or multiple*. The panel believes that positioning time for 43200 is similar to that for 45331 and, while noting that CMS revised the positioning time for 45331 to 5 minutes, continues to believe that 3 minutes is the correct time for this work element.

The panel felt that the median post-service time of 10 minutes also underestimated the elements of post service work. The panel reviewed other scope procedures that had recently been reviewed by the RUC and recommended adjusting the post service time work to 15 minutes similar to code 31622, *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)*. The panel determined that the post-service time should be less than the 20 minutes of post-service work for code 52005, *Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service*; reviewed by the RUC in October 2010 at the 4<sup>th</sup> Five-Year review.

The panel noted the survey median intra-service time was 30 minutes and felt that this time was acceptable as it represented approximately two thirds of the intra-service time for the key reference service 49421, *Insertion of tunneled intraperitoneal catheter for dialysis, open*, (000 global, 46/45/20, RVW 4.21) which was reviewed by the RUC in April 2010. The panel noted that the intraservice time was essentially the same as the intraservice time when valued by Harvard. The panel also compared the 30 minutes survey time to the intra-service time of 15 minutes for the base code, 43200, and felt that the 15 minutes of incremental time represents an appropriate incremental work time for the typical procedure. The panel noted that the respondent 25<sup>th</sup> percentile and median RVW recommendation were respectively 3.31 and 4.20 reflecting the increased intensity of service, which along with the changes in the practice patterns and new diagnoses represented compelling evidence to recommend a revaluation in the physician work of this procedure. The expert panel then reviewed the rank order of code 43217 along with the intra-service times for the other codes surveyed in the 43200-43232 family. Based on the comprehensive review of the family of codes surveyed, the expert panel determined that despite the 25<sup>th</sup> percentile RVW recommendation of 3.31 and the presence of compelling evidence which would otherwise merit a work value increase, the panel could not justify recommending an increase in the current valuation of code 43217 from 2.90.

As the physicians who completed the surveys were significantly limited in their choice of key reference codes within the endoscopic family, the panel felt that code 49421 represented an appropriate key reference code

even though the total and intraservice times for code 43217 were less. Adjusting for the differences in times, the panel concluded that the current RVW of 2.90 and revised IWPUT (0.0632) for code 43217 is consistent with code MPC code 31575 *Laryngoscopy, flexible fiberoptic; diagnostic (000 global, 15/8/5 RVW 1.10, IWPUT 0.0904)* and proportional to code 49421 *Insertion of tunneled intraperitoneal catheter for dialysis, open (wRVW 4.21, IWPUT 0.0639)*. The panel also noted that MPC code 19103 *Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance (000 global, 20/30/15 RVW 3.69, IWPUT 0.0969)* compares appropriately with 43217 adjusting for the difference in service times and complexity. Code 57410 *Pelvic examination under anesthesia (other than local) (000 global, 30/15/25, RVW 1.75, IWPUT 0.0345)*, and code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure) (000 global 20/30/15, RVW 2.78, IWPUT 0.0688)*, were identified as comparable codes of lesser complexity.

While there was compelling evidence to recommend an increase in the wRVU times for code 43217 based on the survey times adjusted for pre-service package 2b, the expert panel recommends that the existing wRVU value of 2.90 should be retained with physician times 33/30/15 (compared to the previous RUC valuation of 30/29/18). The expert panel also recommends that code 43217 be valued in both the facility and non-facility setting.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43217

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology How often? Rarely

Specialty How often? Rarely

Specialty How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 650

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. ~650 (Medicare data 2011 = 220\*3) We believe that 90% of the previously reported procedures will now be reported using the codes specific for flexible, transoral esophagoscopy procedures..

Specialty Gastroenterology	Frequency 600	Percentage 92.30 %
----------------------------	---------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 220

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. ~220 (Medicare data 2011 = 220)

Specialty Gastroenterology	Frequency 200	Percentage 90.90 %
----------------------------	---------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? No

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43217

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43211      Tracking Number   C25

Original Specialty Recommended RVU: **4.62**

Global Period: 000

Presented Recommended RVU: **4.58**RUC Recommended RVU: **4.58**

CPT Descriptor: Esophagoscopy, flexible, transoral; with endoscopic mucosal resection

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 62-year-old patient with heartburn unresponsive to pharmacological treatment is found to have dysplastic Barrett's esophagus. The patient is referred for therapeutic esophagoscopy with endoscopic mucosal resection of the lesion.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 58%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 45%

Description of Pre-Service Work: Review with the patient any symptoms and ascertain characteristics of the dysphagia problem when it is clear there is dysphagia. The patient's history is reviewed to assess for the need for pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed and documented; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays and other diagnostic tests are reviewed. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained and the physician must sign the consent. The physician verifies all endoscopic equipment is available and appropriate computer entries are made. The patient is positioned on the examination table. The endoscopic and moderate sedation monitoring equipment is positioned to provide access for the procedure. A time out is performed. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat. A bite block is placed in the mouth.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible upper endoscope is inserted through the mouth into the oropharynx and advanced through the esophagus into the proximal stomach and, when indicated, retroflexed to allow examination of the cardia. The endoscope is withdrawn, allowing measurement of the squamocolumnar and gastro-esophageal junction from the incisors, assessment for presence of a hiatal hernia, and then examination of the esophageal mucosa. The lesion to be resected is identified and assessed. The endoscope may be withdrawn and a cap placed on the endoscope tip for cap assisted resection or a band ligation device is fitted on the endoscope tip. Cautery marks are then applied to the borders of the lesion. Submucosal injection assisted EMR of saline with epinephrine and dilute methylene blue is performed circumferentially at the base of the lesion. The lesion is resected



with appropriate cutting devices inserted through the biopsy channel. If a cap assisted EMR technique is used, the lesion is suctioned into the cap and then resected using a cutting device inserted through the biopsy channel. If band ligation EMR technique is used, the target is suctioned into the cap and a band is deployed to capture the lesion. The lesion is then resected with appropriate cutting devices inserted through the biopsy channel. Hemostasis is accomplished with electrocautery, clips, or other devices as appropriate. Mucosal defects are closed with endoscopically placed clips. The lesion is retrieved with a retrieval device and placed in a specimen container. The endoscope is reinserted to the point of mucosal resection and the area is observed for bleeding and assessed for perforation. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. Supervision of the level of sedation and vital signs is performed during the procedure with additional measures taken to maintain an appropriate level of sedation, vital signs, airway and oxygenation as indicated. At the conclusion of the procedure, the endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. Post procedure orders are completed. Pathology forms are completed; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. Post procedure radiographs are ordered and reviewed. A procedure report is generated and forwarded to referral source and other appropriate parties. Data is entered into procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others. Necessary prescriptions, follow-up tests and appointments are provided to the patient.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	01/2013				
<b>Presenter(s):</b>	Joel V. Brill, MD (AGA), Nicholas Nickl, MD (ASGE), Edward S. Bentley, MD (ASGE)				
<b>Specialty(s):</b>	AGA, ASGE				
<b>CPT Code:</b>	43211				
<b>Sample Size:</b>	1454	<b>Resp N:</b>	62	<b>Response:</b> 4.2 %	
<b>Description of Sample:</b>	The AGA and ASGE received permission from the Research Subcommittee to administer surveys for the specialized and less frequently performed EGD and esophagoscopy procedures, including 4320X1 to an expert panel. The expert panel included physicians recommended from Industry and members of ASGE Special Interest Groups (SIG) who perform specific procedures (e.g. stent placement, ablation, etc.).				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	5.00	10.00	25.00	250.00
<b>Survey RVW:</b>	1.50	4.91	6.00	7.37	14.00
<b>Pre-Service Evaluation Time:</b>			35.00		
<b>Pre-Service Positioning Time:</b>			5.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10.00		
<b>Intra-Service Time:</b>	10.00	30.00	45.00	50.00	80.00
<b>Immediate Post Service-Time:</b>	<b>18.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	43211	<b>Recommended Physician Work RVU: 4.58</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		33.00	33.00	0.00
<b>Pre-Service Positioning Time:</b>		3.00	1.00	2.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00
<b>Intra-Service Time:</b>		45.00		
<b>Immediate Post Service-Time:</b>	<b>18.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		

<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service?

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31267	000	5.45	RUC Time

CPT Descriptor Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
31628	000	3.80	RUC Time	39,047

CPT Descriptor 1 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
52342	000	5.85	RUC Time

CPT Descriptor Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 14      % of respondents: 22.5 %

**TIME ESTIMATES (Median)**

	<b>CPT Code:</b> <b>43211</b>	<b>Key Reference CPT Code:</b> <b>31267</b>	<b>Source of Time</b> <b>RUC Time</b>
Median Pre-Service Time	41.00	30.00	
Median Intra-Service Time	45.00	50.00	
Median Immediate Post-service Time	18.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>104.00</b>	<b>110.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.07	3.71
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.79	3.43
--	------	------

Urgency of medical decision making	3.86	3.57
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.86	4.21
--------------------------	------	------

Physical effort required	4.07	3.71
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.79	4.21
---	------	------

Outcome depends on the skill and judgment of physician	4.86	4.21
--	------	------

Estimated risk of malpractice suit with poor outcome	4.57	4.00
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.50	3.29
----------------------------------	------	------

Intra-Service intensity/complexity	4.57	4.07
------------------------------------	------	------

Post-Service intensity/complexity	3.50	3.21
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**

In review of the family of esophagoscopy codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In October 2012, the CPT Editorial Panel approved further revised guidelines along with addition of codes within the esophagoscopy codeset.

### Compelling Evidence

For a detailed discussion of compelling evidence, please see the Attachment to the cover letter that was submitted with the SoRs for this family of esophagoscopy codes.

### Overview of Esophagoscopy Family RVW Recommendations

Similar to the review of new EGD codes, for new codes that bundle multiple codes and/or deleted codes, the RVW recommendation is based on endoscopy multiple procedure payment policy or surgical multiple procedure payment policy, as applicable.

Code 43211 *Esophagoscopy, flexible, transoral; with endoscopic mucosal resection* is a new code for 2014. The AGA and ASGE conducted a RUC survey and received 62 responses.

**We recommend an RVW of 4.62.** This value is less than the survey 25<sup>th</sup> percentile is based on: 1) payment policy for multiple endoscopy work; and 2) increments approved by the RUC for esophagoscopy codes at the October 2012 meeting.

Code 43211 includes the work of snaring, banding, and injection. This incremental work would be added to the base esophagoscopy code 43200. To develop the incremental work, we used the RVW increment approved for the esophagoscopy code pairs below (total RVW increment = 3.03) plus the RVW for 43200 (1.59). This equals 4.62.

		Rec RVW	Base 43200	RVW increment
43217	Snare	2.90	1.59	1.31
43205	Band	3.00	1.59	1.41
43201	Inject	1.89	1.59	0.30
				<b>3.02</b>

**Pre-time Package 2b** is appropriate for 43211, with an additional 2 minutes for positioning the patient, endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

### Comparison to Key Ref 31267

Many different codes were chosen by survey respondents for this new service. Code 31267 was chosen most often. The similarity in time and difference in anesthesia (ie, 31267 does not include moderate sedation), support the recommended RVW for 43211.

### Comparison To MPC Other RUC-Reviewed Codes with 40-45 Minutes Intra-Service Time

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2010	<b>12018</b>	Rpr f/e/n/l/m >30.0 cm	3.61	0.071	64	8	2	1	<b>45</b>	8
MPC 2003	<b>31628</b>	Bronchoscopy/lung bx each	3.80	0.071	90	10	10	10	<b>40</b>	20
2009	<b>49411</b>	Ins mark abd/pel for rt perq	3.82	0.072	85	19	1	5	<b>40</b>	20
2009	<b>31626</b>	Bronchoscopy w/markers	4.16	0.074	85	19	1	5	<b>45</b>	15
	<b>43211</b>	<b>Esoph, EMR</b>	<b>4.58</b>	<b>0.075</b>	<b>104</b>	<b>33</b>	<b>3</b>	<b>5</b>	<b>45</b>	<b>18</b>
1995	<b>93505</b>	Biopsy of heart lining	4.37	0.084	100	27		15	<b>38</b>	20
1997	<b>58558</b>	Hysteroscopy biopsy	4.74	0.091	90	30			<b>40</b>	20
2011	<b>52315</b>	Cystoscopy and treatment	5.20	0.093	94	19	5	5	<b>45</b>	20
2011	<b>36246</b>	Ins cath abd/l-ext art 2nd	5.27	0.088	106	33	3	5	<b>45</b>	20
2008	<b>52341</b>	Cysto w/ureter stricture tx	5.35	0.079	135	45	10	15	<b>45</b>	20

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43201

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 900

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. 750 procedures in Year 1 with a 10% increase each year for the first three years

Specialty Gastroenterology Frequency 900 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 15 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 43201 was performed 509 in 2011. 3% of that is performed by this code.

Specialty Gastroenterology Frequency 300 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

**Professional Liability Insurance Information (PLI)**

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 43201

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43212      Tracking Number   C26

Original Specialty Recommended RVU: **3.31**Presented Recommended RVU: **3.73**

Global Period: 000

RUC Recommended RVU: **3.73**

CPT Descriptor: Esophagoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 74 year old patient with progressive dysphagia and weight loss is found to have an obstructing, concentric mass lesion in the mid-esophagus that is not amenable to surgical resection. The patient is referred for therapeutic esophagoscopy and placement of an esophageal stent.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 60%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 50%

Description of Pre-Service Work: Review with the patient any symptoms and ascertain characteristics of the dysphagia problem when it is clear there is dysphagia. The patient's history is reviewed to assess for the need for pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed and documented; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays and other diagnostic tests are reviewed. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained and the physician must sign the consent. The physician verifies all endoscopic equipment is available and appropriate computer entries are made. The patient is positioned on the examination table. The endoscopic and moderate sedation monitoring equipment is positioned to provide access for the procedure. A time out is performed. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat. A bite block is placed in the mouth.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible upper endoscope is inserted through the mouth into the oropharynx and advanced through the esophagus into the proximal stomach and, when indicated, retroflexed to allow examination of the cardia. The obstructing, stricture is identified and, if appropriate, an alternative flexible endoscope of appropriate diameter to traverse the lesion is inserted through the mouth into the esophagus. When necessary, a dilating balloon is passed through the strictured area using endoscopic and fluoroscopic guidance and the stricture is dilated. Additional dilations are performed until the endoscope can be passed through the stricture, confirming the length of the stricture from the incisors. The endoscope is then passed into the



proximal stomach and, when indicated, retroflexed to allow examination of the cardia, confirming the absence of other abnormal tissue in the distal esophagus and proximal stomach. The endoscope is withdrawn, allowing measurement of the stricture and marking the distal and proximal margins for stent placement. The endoscope is reinserted to 2 cm past the distal end of the stricture and a guidewire is inserted through the endoscope. The endoscope is withdrawn through the mouth while visually confirming proper positioning of the guidewire. The level of sedation of the patient is reassessed and additional medication is administered as needed. Using fluoroscopic guidance, the expandable wire mesh stent and introducing device is advanced over the guidewire through the mouth into the esophagus and positioned across the stricture. If necessary, contrast is inserted under fluoroscopic guidance to confirm positioning of the stent. Fluoroscopic imaging is obtained and spot digital images are taken. The stent is slowly deployed across the stricture under fluoroscopic and/or endoscopic guidance, with repositioning if necessary. Once the stent is placed, the guidewire and introducing device are withdrawn through the mouth and the endoscope is reinserted through the mouth to confirm proper positioning of the stent and confirming that the endoscope can be passed through the stented area without difficulty. If necessary, contrast is injected through the endoscope to assess placement and patency with additional fluoroscopic imaging. The area is observed to confirm absence of active bleeding. Photodocumentation of the exam findings including measurements of the lesion, labeling of the identified structures and magnified images of the abnormality are obtained and sent to a hard copy device. The endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. Post procedure orders are completed. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to referral source and other appropriate parties. Data is entered into procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others. Necessary prescriptions, follow-up tests and appointments are provided to the patient.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	01/2013				
<b>Presenter(s):</b>	Joel V. Brill, MD (AGA), Nicholas Nickl, MD (ASGE), Edward S. Bentley, MD (ASGE)				
<b>Specialty(s):</b>	AGA, ASGE				
<b>CPT Code:</b>	43212				
<b>Sample Size:</b>	1457	<b>Resp N:</b>	53	<b>Response:</b> 3.6 %	
<b>Description of Sample:</b>	The AGA and ASGE received permission from the Research Subcommittee to administer surveys for the specialized and less frequently performed EGD and esophagoscopy procedures, including 4320X4 to an expert panel. The expert panel included physicians recommended from Industry and members of ASGE Special Interest Groups (SIG) who perform specific procedures (e.g. stent placement, ablation, etc.).				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	5.00	6.00	10.00	200.00
<b>Survey RVW:</b>	2.40	4.36	5.00	5.85	8.15
<b>Pre-Service Evaluation Time:</b>			45.00		
<b>Pre-Service Positioning Time:</b>			10.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10.00		
<b>Intra-Service Time:</b>	20.00	25.00	30.00	45.00	75.00
<b>Immediate Post Service-Time:</b>	<u>15.00</u>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	43212	<b>Recommended Physician Work RVU: 3.73</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		33.00	33.00	0.00
<b>Pre-Service Positioning Time:</b>		3.00	1.00	2.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00
<b>Intra-Service Time:</b>		30.00		
<b>Immediate Post Service-Time:</b>	<u>15.00</u>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		

<b>Prolonged Services:</b>	<u>0.00</u>	99354x <b>0.00</b>	55x <b>0.00</b>	56x <b>0.00</b>	57x <b>0.00</b>
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x <b>0.00</b>	99225x <b>0.00</b>	99226x <b>0.00</b>	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? Yes

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31631	000	4.36	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of tracheal stent(s) (includes tracheal/bronchial dilation as required)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31638	000	4.88	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required)

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 29      % of respondents: 54.7 %**

**TIME ESTIMATES (Median)**

	<b>CPT Code: 43212</b>	<b>Key Reference CPT Code: 31631</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	41.00	45.00	
Median Intra-Service Time	30.00	45.00	
Median Immediate Post-service Time	15.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>86.00</b>	<b>120.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.03	3.97
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.10	4.03
--	------	------

Urgency of medical decision making	3.97	3.97
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.62	4.41
--------------------------	------	------

Physical effort required	4.00	3.86
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.45	4.31
---	------	------

Outcome depends on the skill and judgment of physician	4.59	4.31
--	------	------

Estimated risk of malpractice suit with poor outcome	3.90	3.86
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.00	3.93
----------------------------------	------	------

Intra-Service intensity/complexity	4.34	4.28
------------------------------------	------	------

Post-Service intensity/complexity	3.79	3.52
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**

In review of the family of esophagoscopy codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In October 2012, the CPT Editorial Panel approved further revised guidelines along with addition of codes within the esophagoscopy codeset.

### Compelling Evidence

For a detailed discussion of compelling evidence, please see the Attachment to the cover letter that was submitted with the SoRs for this family of esophagoscopy codes.

### Overview of Esophagoscopy Family RVW Recommendations

Similar to the review of new EGD codes, for new codes that bundle multiple codes and/or deleted codes, the RVW recommendation is based on endoscopy multiple procedure payment policy or surgical multiple procedure payment policy, as applicable.

Code 43212 *Esophagoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)* is a new/revised code for 2014 that adds balloon dilation to the work of to-be-deleted code 43219 *Esophagoscopy, rigid or flexible; with insertion of plastic tube or stent*. The AGA and ASGE conducted a RUC survey and received 53 responses.

**We recommend an RVW of 3.31.** This is less than the 25<sup>th</sup> percentile and is based on: 1) multiple endoscopy payment policy; and 2) increments approved by the RUC for esophagoscopy codes at the October 2012 meeting.

Code 43212 includes the work of esophagoscopy stent (43219) plus the incremental work of balloon dilation (43220-43200) or 2.80 + (2.10-1.59).

**Pre-time Package 2b** is appropriate for 43212, with an additional 2 minutes for positioning the patient, endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

### Comparison to Key Ref 31631

Key Reference code 31631 was surveyed and presented to the RUC in 2004. The RUC agreed with the specialty presentation that the work had not changed and maintained the RVW and accepted the survey times. Code 31631 does not include the additional work/intensity of physician administered moderate sedation.

### Comparison To Other RUC-Reviewed Codes with 30 Minutes Intra-Service Time

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2011	<b>36200</b>	Place catheter in aorta	3.02	0.058	91	33	3	5	<b>30</b>	20
2012	<b>32557</b>	Insert cath pleura w/ image	3.12	0.079	67	13	3	6	<b>30</b>	15
2010	<b>31296</b>	Sinus endo w/balloon dil	3.29	0.071	88	30	3	10	<b>30</b>	15
	<b>43212</b>	<i>Esoph, stent w-p/p dilation</i>	<b>3.73</b>	<b>0.071</b>	<b>86</b>	<b>33</b>	<b>3</b>	<b>5</b>	<b>30</b>	<b>15</b>
2012	<b>52214</b>	Cystoscopy and treatment	3.50	0.082	79	19	5	5	<b>30</b>	20
2007	<b>20660</b>	Apply rem fixation device	4.00	0.093	90	20		10	<b>30</b>	30
2012	<b>52224</b>	Cystoscopy and treatment	4.05	0.101	79	19	5	5	<b>30</b>	20
2012	<b>52224</b>	Cystoscopy and treatment	4.05	0.101	79	19	5	5	<b>30</b>	20

## SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.

- ☐ Multiple codes are used to maintain consistency with similar codes.  
☐ Historical precedents.  
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43219

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology                      How often? Rarely

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 2000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2011 volume for 43219 (Esophagoscopy, rigid or flexible; with insertion of plastic tube or stent) multiplied by 3 ( $700 \times 3$ ) = ~2,000, which will be deleted from CPT and replaced by 43212.

Specialty Gastroenterology                      Frequency 950                      Percentage 47.50 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 693

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2011 volume for 43219 (Esophagoscopy, rigid or flexible; with insertion of plastic tube or stent) = 693, which will be deleted from CPT and replaced by 43212

Specialty Gastroenterology                      Frequency 325                      Percentage 46.42 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? No

## Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 43219



**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43220	Tracking Number	Original Specialty Recommended RVU: <b>2.10</b>
		Presented Recommended RVU: <b>2.10</b>
Global Period: 000		RUC Recommended RVU: <b>2.10</b>

CPT Descriptor: Esophagoscopy, flexible, transoral; with balloon dilation (less than 30 mm diameter)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 61 year old patient with dysphagia due to a previously identified stenosis of the distal esophagus undergoes therapeutic esophagoscopy for balloon dilation of the stenosis.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 85%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 80%

Description of Pre-Service Work: Review with the patient any symptoms and ascertain characteristics of the dysphagia problem when it is clear there is dysphagia. The patient's history is reviewed to assess for the need for pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed and documented; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays and other diagnostic tests are reviewed. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained and the physician must sign the consent. The physician verifies all endoscopic equipment is available and appropriate computer entries are made. The patient is positioned on the examination table. The endoscopic and moderate sedation monitoring equipment is positioned to provide access for the procedure. A time out is performed. A bite block is placed in the mouth. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible upper endoscope is inserted through the mouth into the oropharynx and advanced through the esophagus into the proximal stomach and, when indicated, retroflexed to allow examination of the cardia. The endoscope is withdrawn, allowing measurement of the squamocolumnar and gastro-esophageal junction from the incisors, assessment for presence of a hiatal hernia, and then examination of the esophageal mucosa. A stricture is identified at 35cm from the incisors. The endoscope is positioned. A through-the-scope fixed wire balloon catheter is advanced through the endoscope, positioned across the stricture, and inflated to a diameter of approximately 15 mm. The balloon catheter is deflated and the stricture is observed. The level of sedation of the patient is reassessed and additional medication is administered as needed. If necessary, the balloon dilator is removed and subsequent balloon catheters of larger diameter are inserted through the endoscope,



positioned across the stricture, and inflated. The balloon catheter is then deflated, and the stricture is observed to confirm adequate dilation of the stricture. When dilation is adequate, the balloon catheter is removed. Following dilation, the area is observed for bleeding. Photodocumentation of the exam findings including measurements of the lesion, labeling of the identified structures and magnified images of the abnormality are obtained and sent to a hard copy device. The endoscope is withdrawn. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. The endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. Post procedure orders are completed. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to referral source and other appropriate parties. Data is entered into procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others. Necessary prescriptions, follow-up tests and appointments are provided to the patient.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	10/2012				
<b>Presenter(s):</b>	Joel V. Brill, MD (AGA), Nicholas Nickl, MD (ASGE), Edward S. Bentley, MD (ASGE), Michael Edye, MD (SAGES), Don J. Selzer, MD (SAGES)				
<b>Specialty(s):</b>	AGA, ASGE, SAGES				
<b>CPT Code:</b>	43220				
<b>Sample Size:</b>	4325	<b>Resp N:</b>	109	<b>Response:</b> 2.5 %	
<b>Description of Sample:</b>	The AGA and ASGE conducted a random sample of their member gastroenterologists using the Census Department office regions ( <a href="http://www.census.gov/regions/">http://www.census.gov/regions/</a> ). Between 150 and 200 gastroenterologists were randomly selected in each region for a total of 2,000 gastroenterologists. The AGA and ASGE enhanced the random sample by adding 514 members of the ASGE Special Interest Groups and 786 physicians who perform esophagoscopy EUS and stent, TNE and optical endomicroscopy and ablation provided by Industry. The AGA and ASGE also added 86 volunteers who responded to the educational article on the RUC survey process that was approved by the Research Subcommittee and was distributed to all AGA and ASGE members. The AGA and ASGE's total survey sample size was 3,386. SAGES sent a total of 1,000 emails (939 successfully delivered) using a random selection of 250 members from each of the four CMS DME Regions A-D (ie, geographically distributed). The total survey sample size for SAGES, AGA and ASGE was 4,325.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	5.00	15.00	49.00	250.00
<b>Survey RVW:</b>	0.50	2.76	3.55	4.25	9.50
<b>Pre-Service Evaluation Time:</b>			25.00		
<b>Pre-Service Positioning Time:</b>			5.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			5.00		
<b>Intra-Service Time:</b>	3.00	15.00	20.00	30.00	50.00
<b>Immediate Post Service-Time:</b>	<u>10.00</u>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1b-FAC Straightforw Pat Procedure(w sedate/anes)

<b>CPT Code:</b>	43220	<b>Recommended Physician Work RVU: 2.10</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		19.00	19.00	0.00
<b>Pre-Service Positioning Time:</b>		3.00	1.00	2.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00
<b>Intra-Service Time:</b>		20.00		
<b>Immediate Post Service-Time:</b>	<u>10.00</u>			

<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b><u>0.00</u></b>	99291x <b>0.00</b>	99292x <b>0.00</b>		
<b>Other Hospital time/visit(s):</b>	<b><u>0.00</u></b>	99231x <b>0.00</b>	99232x <b>0.00</b>	99233x <b>0.00</b>	
<b>Discharge Day Mgmt:</b>	<b><u>0.00</u></b>	99238x <b>0.0</b>	99239x <b>0.0</b>	99217x <b>0.00</b>	
<b>Office time/visit(s):</b>	<b><u>0.00</u></b>	99211x <b>0.00</b>	12x <b>0.00</b>	13x <b>0.00</b>	14x <b>0.00</b> 15x <b>0.00</b>
<b>Prolonged Services:</b>	<b><u>0.00</u></b>	99354x <b>0.00</b>	55x <b>0.00</b>	56x <b>0.00</b>	57x <b>0.00</b>
<b>Sub Obs Care:</b>	<b><u>0.00</u></b>	99224x <b>0.00</b>	99225x <b>0.00</b>	99226x <b>0.00</b>	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
49421	000	4.21	RUC Time

CPT Descriptor Insertion of tunneled intraperitoneal catheter for dialysis, open**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
31575	000	1.10	RUC Time	599,944

CPT Descriptor 1 Laryngoscopy, flexible fiberoptic; diagnostic

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
57410	000	1.75	RUC Time	3,277

CPT Descriptor 2 Pelvic examination under anesthesia (other than local)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31622	000	2.78	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 24      % of respondents: 22.0 %

**TIME ESTIMATES (Median)**

	<b>CPT Code:</b> 43220	<b>Key Reference CPT Code:</b> 49421	<b>Source of Time</b> RUC Time
Median Pre-Service Time	27.00	46.00	
Median Intra-Service Time	20.00	45.00	

Median Immediate Post-service Time	10.00	20.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>57.00</b>	<b>111.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered		
--	--	--

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed		
--	--	--

Urgency of medical decision making		
------------------------------------	--	--

**Technical Skill/Physical Effort (Mean)**

Technical skill required		
--------------------------	--	--

Physical effort required		
--------------------------	--	--

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality		
---	--	--

Outcome depends on the skill and judgment of physician		
--	--	--

Estimated risk of malpractice suit with poor outcome		
--	--	--

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity		
----------------------------------	--	--

Intra-Service intensity/complexity	4.50	3.42
------------------------------------	------	------

Post-Service intensity/complexity		
-----------------------------------	--	--

## Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

43220 *Esophagoscopy, flexible, transoral; with balloon dilation (less than 30 mm diameter)* RVW 2.10 physician time, 15/22/15 was previously valued by the RUC in June 1993. This code is being reviewed in response to the CMS comments in the Proposed Rule and Final Rule for CY 2012, requesting review of gastrointestinal endoscopic services as potentially misvalued.

Although this code was not specifically identified by CMS in the Final Rule, the societies that committed to a comprehensive review of gastrointestinal endoscopic services – the AGA, ACG, ASGE and SAGES – identified that code 43200 was primarily performed by otolaryngologists, while the remaining codes in the 43200-43232 family were primarily performed by gastroenterologists and endoscopic surgeons. In view of such, a coding change proposal was brought to the February 2012 CPT Editorial Panel in conjunction with the AAO-HNS and the Trilogical Society, requesting the development of new codes for trans-nasal esophagoscopy (primarily performed in the non-facility setting without moderate sedation) and rigid esophagoscopy (primarily performed in the OR setting with anesthesia administered by an anesthesia professional). While the code number, 43220, remains the same, this code is now specific for a flexible, transoral, esophagoscopy procedure.

In May 2012 the AGA, ASGE and SAGES requested that the Research Subcommittee consider a mini-survey methodology for this and the other codes in the 43200-43232 family, which was approved. The Research Subcommittee required that a standard survey be conducted of the new base code for flexible trans-oral esophagoscopy, 43200 *Esophagoscopy, flexible; transoral diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*, specifically including the elements of pre- and post-service physician work. For the remaining codes that were surveyed in the 43201-43232 family, including code 43220, the mini-survey instrument only asked the physician to address the intra-service work component for the procedure. Accordingly, the societies submitting these recommendations are using for 43220 the same pre- and post- service times as for the revised base code for flexible trans-oral esophagoscopy, 43200.

A survey of practicing physicians representing urban, suburban and rural community and academic settings was performed with 109 respondents of 4325 queried (2.5 %). Of the responses received, 97% were from Gastroenterologists and 3% were from Endoscopic Surgeons. Of those who participated in the survey, 58 (53%) responded to a subsequent email asking whether the vignette was typical. Of the 58 who responded, 100% found the vignette to be typical. The median service performance rate was 15. 85% typically used moderate sedation in the facility (hospital outpatient, ambulatory surgery center) setting. In the base code survey of pre-service and post-service times, as described above, the respondents reported median pre-service evaluation, positioning, and scrub/dress/wait times of 25, 5, and 5 minutes respectively, and post service time of 10 minutes. The respondents reported a median intra-service time of 20 minutes. 24 (22%) of the respondents chose key reference service 49421, *Insertion of tunneled intraperitoneal catheter for dialysis, open* (wRVW 4.21 46/45/20). The survey intra-service intensity of 43220 was 4.50, compared to the comparison code intra-service intensity of 3.42. As the mini-survey methodology only captured intra-service intensity / complexity, we are unable to provide an assessment regarding the relative intensity of the surveyed code to the comparison code on other measures. The median survey RVW was 3.55. We note that as all of the gastrointestinal endoscopy codes are being surveyed over the next two years, the reference service list (RSL) does not contain any endoscopic procedures that would be familiar to the physicians completing the surveys.

The specialty societies convened an expert panel to review the survey results and make recommendations. The panel noted that the median service performance rate (15) was what would be expected for a typical gastroenterologist in solo or small group practice.

When 43220 is performed in the facility setting, the panel recommended pre-service package **1b**, Facility Straightforward Patient / Straightforward Procedure (With sedation / anesthesia care), which would be used

for this non-incisional trans-oral endoscopic procedure. The expert panel felt the survey respondents underestimated the time necessary to complete all of the elements included in the facility pre-service package that are typically performed with 43220 and failed to consider all of the elements in their time estimation (indications and contraindications for sedation, history of relevant cardiovascular, pulmonary, and neurological conditions, focused physical examination including modified Mallampati score to predict ease of intubation, ASA physical status classification, and summative determination of sedation requirement) and therefore recommended an adjustment of times to reflect the pre-service package and work.

The panel noted there has been a change in the practice pattern for this service since it was most recently valued by the RUC in 1993. In the 1980s and 1990s when this code was first valued, flexible esophagoscopy with insertion of guide wire followed by dilation over guide wire (code 43216) was performed with fiberoptic instruments; today's standard of practice is the use of high-definition video endoscopes and high definition video monitors. In the early 1990s, conscious sedation used rapid intravenous administration of meperidine and diazepam without routine monitoring of pulse oximetry; in 2012, moderate sedation using benzodiazepines and opiates is administered in a controlled, titrated manner with automated monitoring of pulse oximetry, electrocardiogram and, in some settings, capnography. In the 1990s when this code was valued, there were no regulations and/or requirements for a complete History and Physical of the patient within 30 days of the procedure, documentation of a comprehensive examination updated on the day of procedure, a pre-sedation assessment including ASA physical status, airway and cardiac risk completed prior to the procedure, a mandatory timeout before beginning the procedure, or photodocumentation of the findings – all of which are now required to meet various local, state, payor and Medicare accreditation, quality standards, and/or patient safety requirements. In the early 1990s eosinophilic esophagitis had not been described, endoscopic management of Barrett's esophagus, endoscopic mucosal resection of tumors and stenting of esophageal cancer was in development, and endoscopic ultrasound was yet to be commercially available. The panel also noted that "open access" endoscopy, where the patient is not seen by the endoscopist until the day of the procedure, has gained increasing acceptance in a number of settings – community, academic, teaching, military, VA and public; urban, suburban and rural; single and multi-specialty group; independent and employed - during the past decade.

Medicare claims for Esophagoscopy, rigid or flexible; with balloon dilation (less than 30 mm diameter) (code 43220) have declined over a seven year period from 4,595 in 2005 to 3,041 in 2011. A review of a 5% Medicare claims file from 2011 (total 2011 claims 3,041) reveals that code 43220 was reported 27.74% percent of the time by otolaryngologists, 49.28% by gastroenterologists, and 10.79% by general surgeons. For Medicare, the procedure was performed 70.81% in the outpatient hospital, 12.58% in the inpatient hospital, 1.47% in the physician office, and 14.88 % in the ambulatory surgery center setting. As otolaryngologists and surgeons perform both rigid and flexible esophagoscopy, one can make only an estimate assumption that a percentage of the services performed by those specialties in facility settings represent rigid esophagoscopy procedures performed under general anesthesia.

The expert, multi-society panel notes that a change has occurred in the way that the work of moderate sedation is calculated for the purposes of the RUC's recommendations to CMS. Prior to 2012, the RUC and CMS affirmed that physician work of administering moderate sedation was part of the intra-service time, as in endoscopic procedures 43235 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* and 45378 *Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)* which were surveyed in the 2005 Third Five-Year review, and 43262 *Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy* which was surveyed in the 2010 Fourth Five-Year review. In fact, an overwhelming majority (89%) of codes in Appendix G in which moderate sedation is intrinsic to the service, where moderate sedation is specifically identified in the RUC work descriptors, describe moderate sedation as occurring during the intra-service period. The decision by the RUC's Research Subcommittee to change how the physician work of administering moderate sedation is accounted for as pre-service, not intra-service work, may constitute recognition that there has been a change in the physician work of performing endoscopic procedures over the past 20 years. In view of such, the RUC's

introduction of the standardized pre-service packages in 2008 which specify a difference in pre-service evaluation minutes depending on whether a procedure involves sedation / anesthesia care, and the Research Subcommittee's 2012 clarification that the administration of moderate sedation constitutes work as occurring during the pre-service period, represents an important change in the way that physician work for procedures involving moderate sedation is valued, and constitutes compelling evidence for re-valuation of the gastrointestinal endoscopy codes.

The expert panel felt that in view of the change in how the procedure was performed, new diagnoses, and new requirements to ensure patient safety, the predominance of otolaryngologists performing code 43200 vs. gastroenterologists performing the predominance of other procedures in the 43201-43232 family, and the inability to distinguish the percentage of previous services that represent rigid trans-oral, flexible trans-oral, and flexible trans-nasal procedures, the flexible, trans-oral esophagoscopy procedure has changed since the initial valuation by Harvard, providing compelling evidence for re-valuation.

After assessing the pre-service work that is performed, the expert panel determined that the assumption that all endoscopic procedures would have identical pre- and post-service time may have been incorrect. We note that the survey instrument approved by the Research Subcommittee did not allow the expert panel to draw any conclusions about the role of moderate sedation in the valuation of the pre-service work. The expert panel attempted to address this by reviewing similar services, based on whether the typical patient and typical procedure was straightforward or complex. For this procedure, we are recommending pre-service package 1b with changes of times to 19/3/5 for a total of 27 minutes of pre-service time when the procedure is performed in the facility setting, as follows:

**Evaluation:** 19 minutes which is the package time, but less than the survey median.

**Positioning:** Addition of 2 minutes (3 min total) to account for positioning the patient, anesthesia lines, and video/scope equipment to allow access for the procedure and moderate sedation monitoring.

**Scrub/Dress/Wait:** 5 minutes which is equal to the survey median and package time.

The panel identified several crosswalks that would be equivalent in terms of physician pre-service time to this procedure. Code 31626, *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple*, (wRVW 4.16, 25/45/15), preservice package 1b, with 25 minutes of preservice time (eval 19, positioning 1, scrub/dress/wait 5) and 15 minutes of postservice time, was reviewed by the RUC in April 2009. Code 32553, *Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple*, (wRVW 3.80, 25/45/20), preservice package 1b, with 25 minutes of preservice time (eval 19, positioning 1, scrub/dress/wait 5) and 20 minutes of postservice time, was reviewed by the RUC in April 2009. Code 55876, *Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple* (wRVW 1.73, 29/20/10), with 19 minutes of evaluation and 10 minutes of positioning time, was reviewed by the RUC in April 2010. Code 64446, *Injection, anesthetic agent; sciatic nerve, continuous infusion by catheter (including catheter placement)*, (wRVW 1.81, 29/20/15), preservice package 1b, with 29 minutes of preservice time (eval 19, positioning 5, scrub/dress/wait 5), was reviewed by the RUC in April 2008. The panel noted that in October 2010 at the 4<sup>th</sup> five-year review, the societies recommended and the RUC accepted 3 minutes positioning for 45331, *Sigmoidoscopy, flexible; with biopsy, single or multiple*. The panel believes that positioning time for 43200 is similar to that for 45331 and, while noting that CMS revised the positioning time for 45331 to 5 minutes, recommends that 3 minutes is the correct time for this element of work.

The panel felt that the median post-service time of 10 minutes also underestimated the elements of post service work. The panel reviewed other scope procedures that had recently been reviewed by the RUC and recommended adjusting the post service time work to 15 minutes similar to code 31622, *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)*. The panel determined that the post-service time should be less than the 20 minutes of post-service work for code 52005, *Cystourethroscopy, with ureteral catheterization, with or without*

*irrigation, instillation, or ureteropyelography, exclusive of radiologic service;* reviewed by the RUC in October 2010 at the 4<sup>th</sup> Five-Year review.

The panel noted the survey median intra-service time was 20 minutes and felt that this time was acceptable as it represented approximately half of the intra-service time for the key reference service 49421, *Insertion of tunneled intraperitoneal catheter for dialysis, open*, (000 global, 46/45/20, RVW 4.21) which was reviewed by the RUC in April 2010. The panel noted that the intraservice time was approximately the same as the previous valuation. The panel also compared the 20 minutes survey time to the intra-service time of 15 minutes for the base code, 43200, and felt that the 5 minutes of incremental time represents an appropriate incremental work time for the typical procedure. The panel noted that the respondent 25<sup>th</sup> percentile and median RVW recommendation were respectively 2.76 and 3.55 reflecting the increased intensity of service, which along with the changes in the practice patterns and new diagnoses represented compelling evidence to recommend a revaluation in the physician work of this procedure. The expert panel then reviewed the rank order of code 43220 along with the intra-service times for the other codes surveyed in the 43200-43232 family. Based on the comprehensive review of the family of codes surveyed, the expert panel determined that despite the 25<sup>th</sup> percentile RVW recommendation of 2.76 and the presence of compelling evidence which would otherwise merit a work value increase, the panel could not justify recommending an increase in the current valuation of code 43220 from 2.10.

As the physicians who completed the surveys were significantly limited in their choice of key reference codes within the endoscopic family, the panel felt that code 49421 represented an appropriate key reference code even though the total and intraservice times for code 43220 were less. Adjusting for the differences in times, the panel concluded that the RVW of 2.10 for code 43220 is consistent with code 49421 which is considered to be a similar to slightly less intense service (IWPUT 0.062 for 43220 compared with 0.0639 for 49421) and less than the IWPUT for code 31575 (IWPUT 0.0904). Code 57410 *Pelvic examination under anesthesia (other than local)* (000 global, 30/15/25 RVW 1.75), and code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (000 global 20/30/15 RVW 2.78), were identified as comparable codes of lesser complexity. The panel also noted that MPC code 19103 *Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance* (000 global, 20/30/15 RVW 3.69) compares appropriately with 43216 adjusting for the difference in service times and complexity.

While there was compelling evidence to recommend an increase in the wRVU times for code 43220 based on the survey times adjusted for pre-service package 1b in the facility setting the expert panel recommends that the existing wRVU value of 2.10 should be retained with physician times 27/20/15 (compared to the previous RUC valuation of 15/22/15). The expert panel also recommends that code 43220 be valued in both the facility and non-facility setting.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)



2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43220

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology	How often? Rarely
----------------------------	-------------------

Specialty	How often?
-----------	------------

Specialty	How often?
-----------	------------

Estimate the number of times this service might be provided nationally in a one-year period? 9000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. ~9,000 (Medicare data 2011 = 3,041) We believe that 90% of the previously reported procedures will now be reported using the codes specific for flexible, transoral esophagoscopy procedures.

Specialty Gastroenterology	Frequency 8100	Percentage 90.00 %
----------------------------	----------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,445

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. ~2,445 (Medicare data 2011 = 3,041) Leftover utilization not going to new code 4319X5.

Specialty Gastroenterology	Frequency 2201	Percentage 90.02 %
----------------------------	----------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? No

## Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43220

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43213      Tracking Number   C27

Original Specialty Recommended RVU: **5.00**Presented Recommended RVU: **5.00**

Global Period: 000

RUC Recommended RVU: **5.00**

CPT Descriptor: Esophagoscopy, flexible, transoral; with dilation of esophagus, by balloon or dilator, retrograde (includes fluoroscopic guidance, when performed)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 71-year-old patient with a history of esophageal cancer, post resection with esophagogastric anastomosis and gastrostomy, and treatment with radiation therapy, is unable to swallow liquids. Imaging studies reveal an occlusive stricture at the anastomosis. A previous upper endoscopy to dilate the stricture was unsuccessful. The patient is referred for retrograde dilation of the esophageal stricture through the gastrostomy and therapeutic esophagoscopy.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 53%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 22%

Description of Pre-Service Work: Review with the patient any symptoms and ascertain characteristics of the dysphagia problem when it is clear there is dysphagia. The patient's history is reviewed to assess for the need for pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed and documented; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays and other diagnostic tests are reviewed. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained and the physician must sign the consent. The physician verifies all endoscopic equipment is available and appropriate computer entries are made. The patient is positioned on the examination table. The endoscopic and moderate sedation monitoring equipment is positioned to provide access for the procedure. A time out is performed. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat. A bite block is placed in the mouth.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A flexible upper endoscope is inserted through the fistulous opening and advanced retrograde into and through the esophagus to the strictured area. A guidewire is advanced through the biopsy channel and endoscopically manipulated through the stricture and out the patient's mouth. The endoscope is withdrawn maintaining the position of the guidewire. A dilator is advanced over the guidewire through the strictured area using fluoroscopic and or endoscopic guidance when indicated. Additional dilators of increasing size are passed over the guidewire until a satisfactory dilation has been achieved. The endoscope is

reinserted to examine the strictured area and assess bleeding. The endoscope is withdrawn, allowing measurement of the squamocolumnar and gastro-esophageal junction from the incisors, assessment for presence of a hiatal hernia, and then examination of the esophageal mucosa. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. Supervision of the level of sedation and vital signs is performed during the procedure with additional measures taken to maintain an appropriate level of sedation, vital signs, airway and oxygenation as indicated. At the conclusion of the procedure, the endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. Post procedure orders are completed. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to referral source and other appropriate parties. Data is entered into procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others. Necessary prescriptions, follow-up tests and appointments are provided to the patient.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	01/2013				
<b>Presenter(s):</b>	Joel V. Brill, MD (AGA), Nicholas Nickl, MD (ASGE), Edward S. Bentley, MD (ASGE)				
<b>Specialty(s):</b>	AGA, ASGE				
<b>CPT Code:</b>	43213				
<b>Sample Size:</b>	1456	<b>Resp N:</b>	45	<b>Response:</b> 3.0 %	
<b>Description of Sample:</b>	The AGA and ASGE received permission from the Research Subcommittee to administer surveys for the specialized and less frequently performed EGD and esophagoscopy procedures, including 4320X2 to an expert panel. The expert panel included members of ASGE Special Interest Groups (SIG) who perform specific procedures (e.g. stent placement, ablation, etc.).				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	0.00	<b>2.00</b>	5.00	500.00
<b>Survey RVW:</b>	2.00	5.00	<b>5.81</b>	6.50	10.00
<b>Pre-Service Evaluation Time:</b>			<b>35.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>10.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>10.00</b>		
<b>Intra-Service Time:</b>	15.00	30.00	<b>45.00</b>	60.00	90.00
<b>Immediate Post Service-Time:</b>	<b>15.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	43213	<b>Recommended Physician Work RVU: 5.00</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>33.00</b>	<b>33.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>3.00</b>	<b>1.00</b>	<b>2.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>5.00</b>	<b>5.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>45.00</b>		
<b>Immediate Post Service-Time:</b>	<b>15.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00

<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
52342	000	5.85	RUC Time

CPT Descriptor Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31631	000	4.36	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of tracheal stent(s) (includes tracheal/bronchial dilation as required)

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 13      % of respondents: 28.8 %**

**TIME ESTIMATES (Median)**

	<b>CPT Code: 43213</b>	<b>Key Reference CPT Code: 52342</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	41.00	60.00	
Median Intra-Service Time	45.00	60.00	
Median Immediate Post-service Time	15.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>101.00</b>	<b>140.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.85	3.77
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.92	3.62
--	------	------

Urgency of medical decision making	3.92	3.85
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.62	4.46
--------------------------	------	------

Physical effort required	4.23	3.92
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.38	4.23
---	------	------

Outcome depends on the skill and judgment of physician	4.46	4.31
--	------	------

Estimated risk of malpractice suit with poor outcome	4.08	4.08
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.54	3.46
----------------------------------	------	------

Intra-Service intensity/complexity	4.54	4.23
------------------------------------	------	------

Post-Service intensity/complexity	3.46	3.31
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**

In review of the family of esophagoscopy codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In October 2012, the CPT Editorial Panel approved further revised guidelines along with addition of codes within the esophagoscopy codeset.

### Compelling Evidence

For a detailed discussion of compelling evidence, please see the Attachment to the cover letter that was submitted with the SoRs for this family of esophagoscopy codes.

### Overview of Esophagoscopy Family RVW Recommendations

Similar to the review of new EGD codes, for new codes that bundle multiple codes and/or deleted codes, the RVW recommendation is based on endoscopy multiple procedure payment policy or surgical multiple procedure payment policy, as applicable.

Code 43213 *Esophagoscopy, flexible, transoral; with dilation of esophagus, by balloon or dilator, retrograde (includes fluoroscopic guidance, when performed)* is a new code for 2014. The AGA and ASGE conducted a RUC survey and received 45 responses.

**We recommend the 25<sup>th</sup> percentile RVW of 5.00.** There is no equivalent work in the esophagoscopy family for retrograde dilation. This service would have been reported using 43499 *Unlisted procedure, esophagus*. The value appropriately ranks 43213 within the esophagoscopy family of codes.

**Pre-time Package 2b** is appropriate for 43213, with an additional 2 minutes for positioning the patient, endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

### Comparison to Key Ref 52342

Many different codes were chosen by survey respondents for this new service. Code 52342 was chosen most often. This code was surveyed and presented to the RUC in 2010. Because of the difference in time and RVW, this is not a good comparator code.

### Comparison To Other RUC-Reviewed Codes with 45 Minutes Intra-Service Time

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2010	<b>12018</b>	Rpr f/e/n/l/m >30.0 cm	3.61	0.071	64	8	2	1	<b>45</b>	8
2009	<b>31626</b>	Bronchoscopy w/markers	4.16	0.074	85	19	1	5	<b>45</b>	15
2011	<b>52315</b>	Cystoscopy and treatment	5.20	0.093	94	19	5	5	<b>45</b>	20
	<b>43213</b>	<i>Esoph, retrograde dilation</i>	<b>5.00</b>	<b>0.085</b>	<b>101</b>	<b>33</b>	<b>3</b>	<b>5</b>	<b>45</b>	<b>15</b>
2011	<b>36246</b>	Ins cath abd/l-ext art 2nd	5.27	0.088	106	33	3	5	<b>45</b>	20
2008	<b>52341</b>	Cysto w/ureter stricture tx	5.35	0.079	135	45	10	15	<b>45</b>	20
2011	<b>36251</b>	Ins cath ren art 1st unilat	5.35	0.085	116	33	3	5	<b>45</b>	30

## SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43456

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology	How often? Rarely
----------------------------	-------------------

Specialty	How often?
-----------	------------

Specialty	How often?
-----------	------------

Estimate the number of times this service might be provided nationally in a one-year period? 5000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2011 volume for 43456 (Dilation of esophagus, by balloon or dilator, retrograde) multiplied by 3 ( $1,700 \times 3$ ) = ~5,000, which will be deleted from CPT and replaced by 4320X2

Specialty Gastroenterology	Frequency 4000	Percentage 80.00 %
----------------------------	----------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,752

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2011 volume for 43456 = 1752

Specialty Gastroenterology	Frequency 1600	Percentage 91.32 %
----------------------------	----------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? No

## Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 43456



**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43214      Tracking Number C28

Original Specialty Recommended RVU: **3.86**Presented Recommended RVU: **3.78**

Global Period: 000

RUC Recommended RVU: **3.78**

CPT Descriptor: Esophagoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 69-year-old patient with malnutrition and increasing inability to swallow liquids undergoes imaging studies revealing a tapered, “bird’s beak” appearance of the distal esophagus. Esophageal motility studies confirm findings consistent with achalasia. The patient is referred for therapeutic esophagoscopy and large diameter balloon dilation of the lower esophageal sphincter.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 74%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 55%

Description of Pre-Service Work: Review with the patient any symptoms and ascertain characteristics of the dysphagia problem when it is clear there is dysphagia. The patient's history is reviewed to assess for the need for pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed and documented; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays and other diagnostic tests are reviewed. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained and the physician must sign the consent. The physician verifies all endoscopic equipment is available and appropriate computer entries are made. The patient is positioned on the examination table. The endoscopic and moderate sedation monitoring equipment is positioned to provide access for the procedure. A time out is performed. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat. A bite block is placed in the mouth.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible upper endoscope is inserted through the mouth into the oropharynx and advanced through the esophagus into the proximal stomach and, when indicated, retroflexed to allow examination of the cardia. The endoscope is withdrawn, allowing measurement of the squamocolumnar and gastro-esophageal junction from the incisors, assessment for presence of a hiatal hernia, and then examination of the esophageal mucosa. The gastroesophageal junction is identified and assessed. A guidewire is inserted through the biopsy channel of the endoscope into the stomach and the endoscope is withdrawn

maintaining the position of the guidewire. A greater than 30 cm balloon catheter is advanced over the guidewire and positioned across the lower esophageal sphincter using fluoroscopy and/or a reinserted endoscope to confirm the position. The balloon is inflated to a diameter of greater than 30 mm. The balloon catheter is deflated and the stricture is observed. Supervision of the level of sedation and vital signs is performed during the procedure with additional measures taken to maintain an appropriate level of sedation, vital signs, airway and oxygenation as indicated. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. At the conclusion of the procedure, the endoscope and dilating balloon are withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. Post procedure orders are completed. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Post procedure radiographic studies are ordered and reviewed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to referral source and other appropriate parties. Data is entered into procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others. Necessary prescriptions, follow-up tests and appointments are provided to the patient.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	01/2013				
<b>Presenter(s):</b>	Joel V. Brill, MD (AGA), Nicholas Nickl, MD (ASGE), Edward S. Bentley, MD (ASGE)				
<b>Specialty(s):</b>	AGA, ASGE				
<b>CPT Code:</b>	43214				
<b>Sample Size:</b>	1007	<b>Resp N:</b>	42	<b>Response:</b> 4.1 %	
<b>Description of Sample:</b>	The AGA and ASGE received permission from the Research Subcommittee to administer surveys for the specialized and less frequently performed EGD and esophagoscopy procedures, including 4320X3 to an expert panel. The expert panel included members of ASGE Special Interest Groups (SIG) who perform specific procedures (e.g. stent placement, ablation, etc.).				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	1.00	5.00	12.00	1100.00
<b>Survey RVW:</b>	1.00	3.86	4.87	5.85	8.59
<b>Pre-Service Evaluation Time:</b>			33.00		
<b>Pre-Service Positioning Time:</b>			10.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10.00		
<b>Intra-Service Time:</b>	10.00	21.00	30.00	30.00	60.00
<b>Immediate Post Service-Time:</b>	<b>16.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	43214	<b>Recommended Physician Work RVU: 3.78</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		33.00	33.00	0.00
<b>Pre-Service Positioning Time:</b>		3.00	1.00	2.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00
<b>Intra-Service Time:</b>		30.00		
<b>Immediate Post Service-Time:</b>	<b>16.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00

<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31631	000	4.36	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of tracheal stent(s) (includes tracheal/bronchial dilation as required)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
52342	000	5.85	RUC Time

CPT Descriptor Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 9      % of respondents: 21.4 %**

**TIME ESTIMATES (Median)**

	<b>CPT Code: 43214</b>	<b>Key Reference CPT Code: 31631</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	41.00	45.00	
Median Intra-Service Time	30.00	45.00	
Median Immediate Post-service Time	16.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>87.00</b>	<b>120.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.11	3.78
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.33	4.22
--	------	------

Urgency of medical decision making	3.56	3.78
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.56	4.44
--------------------------	------	------

Physical effort required	3.89	3.89
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.89	4.44
---	------	------

Outcome depends on the skill and judgment of physician	4.44	4.44
--	------	------

Estimated risk of malpractice suit with poor outcome	4.44	4.33
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.33	3.33
----------------------------------	------	------

Intra-Service intensity/complexity	4.44	4.33
------------------------------------	------	------

Post-Service intensity/complexity	3.44	3.33
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**

In review of the family of esophagoscopy codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In October 2012, the CPT Editorial Panel approved further revised guidelines along with addition of codes within the esophagoscopy codeset.

### Compelling Evidence

For a detailed discussion of compelling evidence, please see the Attachment to the cover letter that was submitted with the SoRs for this family of esophagoscopy codes.

### Overview of Esophagoscopy Family RVW Recommendations

Similar to the review of new EGD codes, for new codes that bundle multiple codes and/or deleted codes, the RVW recommendation is based on endoscopy multiple procedure payment policy or surgical multiple procedure payment policy, as applicable.

Code 43214 *Esophagoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)* is a new code for 2014. The AGA and ASGE conducted a RUC survey and received 42 responses.

**We recommend an RVW of 3.86.** This value is the same as the 25<sup>th</sup> percentile and is based on: 1) the sum of to-be-deleted code 43458 plus 0.5 x diagnostic esophagoscopy (43200); and 2) multiple procedure payment policy.

Code 43458 *Dilation of esophagus with balloon (30 mm diameter or larger) for achalasia* has a 000-global period and does not include endoscopy work. The new code will bundle 43458 with 43200 (esophagoscopy base) which also has a 000-global period. Payment for this bundled work would be based on the multiple procedure payment rule ( $100\% \times 43458 + 50\% \times 43200$ ) or  $3.06 + 0.5 \times 1.59 = 3.86$ .

**Pre-time Package 2b** is appropriate for 43214, with an additional 2 minutes for positioning the patient, endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

### Comparison to Key Ref 31631

Key Reference code 31631 was surveyed and presented to the RUC in 2004. The RUC agreed with the specialty presentation that the work had not changed and maintained the RVW and accepted the survey times. Code 31631 does not include the additional work/intensity of physician administered moderate sedation.

### Comparison To Other RUC-Reviewed Codes with 30 Minutes Intra-Service Time

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2011	<b>36200</b>	Place catheter in aorta	3.02	0.058	91	33	3	5	<b>30</b>	20
2012	<b>32557</b>	Insert cath pleura w/ image	3.12	0.079	67	13	3	6	<b>30</b>	15
2010	<b>31296</b>	Sinus endo w/balloon dil	3.29	0.071	88	30	3	10	<b>30</b>	15
2012	<b>52214</b>	Cystoscopy and treatment	3.50	0.082	79	19	5	5	<b>30</b>	20
	<b>43214</b>	<b>Esoph, balloon &gt;30mm</b>	<b>3.78</b>	<b>0.088</b>	<b>87</b>	<b>33</b>	<b>3</b>	<b>5</b>	<b>30</b>	<b>16</b>
2007	<b>20660</b>	Apply rem fixation device	4.00	0.093	90	20		10	<b>30</b>	30
2012	<b>52224</b>	Cystoscopy and treatment	4.05	0.101	79	19	5	5	<b>30</b>	20
2012	<b>52224</b>	Cystoscopy and treatment	4.05	0.101	79	19	5	5	<b>30</b>	20
2012	<b>52234</b>	Cystoscopy and treatment	4.62	0.120	79	19	5	5	<b>30</b>	20
2011	<b>37191</b>	Ins endovas vena cava filtr	4.71	0.120	83	30	3	5	<b>30</b>	15

### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43458 + 74360

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology                      How often? Rarely

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 5000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2011 data for 43458 (Dilation of esophagus with balloon (30 mm diameter or larger) for achalasia) multiplied by 3 (1,600\*3) = ~5,000, which will be deleted from CPT and replaced with 43214.

Specialty Gastroenterology                      Frequency 3000                      Percentage 60.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 780

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2011 data for 43458 (Dilation of esophagus with balloon (30 mm diameter or larger) for achalasia) = ~1,561 / 2. Half will be reported by 43233.

Specialty Gastroenterology                      Frequency 750                      Percentage 96.15 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? No

## Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 43458



**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43226	Tracking Number	Original Specialty Recommended RVU: <b>2.34</b>
		Presented Recommended RVU: <b>2.34</b>
Global Period: 000		RUC Recommended RVU: <b>2.34</b>

CPT Descriptor: Esophagoscopy, flexible, transoral; with insertion of guide wire followed by dilation over guide wire

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 73 year old patient with dysphagia due to a previously identified stenosis of the distal esophagus undergoes therapeutic esophagoscopy for guidewire-directed dilation of the stenosis

Percentage of Survey Respondents who found Vignette to be Typical: 100%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 79%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 74%

Description of Pre-Service Work: Review with the patient any symptoms and ascertain characteristics of the dysphagia problem when it is clear there is dysphagia. The patient's history is reviewed to assess for the need for pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed and documented; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays and other diagnostic tests are reviewed. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained and the physician must sign the consent. The physician verifies all endoscopic equipment is available and appropriate computer entries are made. The patient is positioned on the examination table. The endoscopic and moderate sedation monitoring equipment is positioned to provide access for the procedure. A time out is performed. A bite block is placed in the mouth. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible upper endoscope is inserted through the mouth into the oropharynx and advanced through the esophagus into the proximal stomach and, when indicated, retroflexed to allow examination of the cardia. The endoscope is withdrawn, allowing measurement of the squamocolumnar and gastro-esophageal junction from the incisors, assessment for presence of a hiatal hernia, and then examination of the esophageal mucosa. The endoscope is withdrawn, allowing measurement of the squamocolumnar and gastro-esophageal junction from the incisors, assessment for presence of a hiatal hernia, and then examination of the esophageal mucosa. The area to be dilated is identified at 33cm. A guidewire is placed through the endoscope into the esophagus and advanced into the stomach, beyond the area to be dilated. The endoscope is withdrawn through the mouth while visually confirming proper positioning of the guidewire. A dilator is advanced over the guidewire

through the mouth into the esophagus past the area to be dilated, while the endoscopist monitors the patient for signs of pain or discomfort. The level of sedation of the patient is reassessed and additional medication is administered as needed. The initial dilator is withdrawn, and dilators of increasing diameter are passed sequentially over the guide wire through the mouth into the esophagus in a similar manner. At the conclusion of the sequential dilations, the guidewire is withdrawn and the endoscope is inserted through the mouth into the esophagus to assess the site of dilation for bleeding, trauma and/or injury. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. The endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. Post procedure orders are completed. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to referral source and other appropriate parties. Data is entered into procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others. Necessary prescriptions, follow-up tests and appointments are provided to the patient.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	10/2012				
<b>Presenter(s):</b>	Joel V. Brill, MD (AGA), Nicholas Nickl, MD (ASGE), Edward S. Bentley, MD (ASGE), Wayne M. Koch, MD (AAO-HNS), John Lanza, MD (AAO-HNS), Michael Edye, MD (SAGES), Don J. Selzer, MD (SAGES)				
<b>Specialty(s):</b>	AGA, ASGE, AAO-HNS, SAGES				
<b>CPT Code:</b>	43226				
<b>Sample Size:</b>	5030	<b>Resp N:</b>	114	<b>Response:</b> 2.2 %	
<b>Description of Sample:</b>	The AGA and ASGE conducted a random sample of their member gastroenterologists using the Census Department office regions ( <a href="http://www.census.gov/regions/">http://www.census.gov/regions/</a> ). Between 150 and 200 gastroenterologists were randomly selected in each region for a total of 2,000 gastroenterologists. The AGA and ASGE enhanced the random sample by adding 514 members of the ASGE Special Interest Groups and 786 physicians who perform esophagoscopy EUS and stent, TNE and optical endomicroscopy and ablation provided by Industry. The AGA and ASGE also added 86 volunteers who responded to the educational article on the RUC survey process that was approved by the Research Subcommittee and was distributed to all AGA and ASGE members. The AGA and ASGE's total survey sample size was 3,386. AAO-HNS conducted a random sampling of 705 physicians. SAGES sent a total of 1,000 emails (939 successfully delivered) using a random selection of 250 members from each of the four CMS DME Regions A-D (ie, geographically distributed). The total survey sample size for AAO-HNS, SAGES, AGA and ASGE was 5,030.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	3.00	10.00	20.00	150.00
<b>Survey RVW:</b>	0.50	3.25	4.00	4.91	10.00
<b>Pre-Service Evaluation Time:</b>			25.00		
<b>Pre-Service Positioning Time:</b>			5.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			5.00		
<b>Intra-Service Time:</b>	5.00	20.00	25.00	40.00	60.00
<b>Immediate Post Service-Time:</b>	10.00				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	0.00	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	0.00	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	0.00	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	0.00	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1b-FAC Straightforw Pat Procedure(w sedate/anes)

<b>CPT Code:</b>	43226	<b>Recommended Physician Work RVU: 2.34</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		19.00	19.00	0.00
<b>Pre-Service Positioning Time:</b>		3.00	1.00	2.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00

Intra-Service Time:		25.00
Immediate Post Service-Time:	10.00	
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00
Discharge Day Mgmt:	0.00	99238x 0.0 99239x 0.0 99217x 0.00
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
49421	000	4.21	RUC Time

CPT Descriptor Insertion of tunneled intraperitoneal catheter for dialysis, open**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
31575	000	1.10	RUC Time	599,944

CPT Descriptor 1 Laryngoscopy, flexible fiberoptic; diagnostic

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
57410	000	1.75	RUC Time	3,277

CPT Descriptor 2 Pelvic examination under anesthesia (other than local)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31622	000	2.78	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 24      % of respondents: 21.0 %

**TIME ESTIMATES (Median)**

	<u>CPT Code:</u>	<u>Key Reference CPT Code:</u>	<u>Source of Time</u>
	43226	49421	Harvard Time
Median Pre-Service Time	27.00	46.00	

Median Intra-Service Time	25.00	45.00
Median Immediate Post-service Time	10.00	20.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>62.00</b>	<b>111.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered		
--	--	--

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed		
--	--	--

Urgency of medical decision making		
------------------------------------	--	--

**Technical Skill/Physical Effort (Mean)**

Technical skill required		
--------------------------	--	--

Physical effort required		
--------------------------	--	--

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality		
---	--	--

Outcome depends on the skill and judgment of physician		
--	--	--

Estimated risk of malpractice suit with poor outcome		
--	--	--

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity		
----------------------------------	--	--

Intra-Service intensity/complexity	4.94	3.42
------------------------------------	------	------

Post-Service intensity/complexity		
-----------------------------------	--	--

## Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

43226 *Esophagoscopy, flexible; transoral with insertion of guide wire followed by dilation over guide wire* RVW 2.34 physician time, 15/21/15 was previously valued by the RUC in July 1993. This code is being reviewed in response to the CMS comments in the Proposed Rule and Final Rule for CY 2012, requesting review of gastrointestinal endoscopic services as potentially misvalued.

Although this code was not specifically identified by CMS in the Final Rule, the societies that committed to a comprehensive review of gastrointestinal endoscopic services – the AGA, ACG, ASGE and SAGES – identified that code 43200 was primarily performed by otolaryngologists, while the remaining codes in the 43200-43232 family were primarily performed by gastroenterologists and endoscopic surgeons. In view of such, a coding change proposal was brought to the February 2012 CPT Editorial Panel in conjunction with the AAO-HNS and the Trilogical Society, requesting the development of new codes for trans-nasal esophagoscopy (primarily performed in the non-facility setting without moderate sedation) and rigid esophagoscopy (primarily performed in the OR setting with anesthesia administered by an anesthesia professional). While the code number, 43226, remains the same, this code is now specific for a flexible, transoral, esophagoscopy procedure.

In May 2012 the AGA, ASGE and SAGES requested that the Research Subcommittee consider a mini-survey methodology for this and the other codes in the 43200-43232 family, which was approved. The Research Subcommittee required that a standard survey be conducted of the new base code for flexible trans-oral esophagoscopy, 43200 *Esophagoscopy, flexible; transoral diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*, specifically including the elements of pre- and post-service physician work. For the remaining codes that were surveyed in the 43201-43232 family, including code 43226, the mini-survey instrument only asked the physician to address the intra-service work component for the procedure. Accordingly, the societies submitting these recommendations are using for 43226 the same pre- and post- service times as for the revised base code for flexible trans-oral esophagoscopy, 43200.

A survey of practicing physicians representing urban, suburban and rural community and academic settings was performed with 114 respondents of 5030 queried (2.2 %). Of the responses received, 90% were from Gastroenterologists, 7% were from Otolaryngologists, and 3% were from Endoscopic Surgeons. Of those who participated in the survey, 58 (51%) responded to a subsequent email asking whether the vignette was typical. Of the 58 who responded, 100% found the vignette to be typical. The median service performance rate was 10. 79% typically used moderate sedation in the facility (hospital outpatient, ambulatory surgery center) setting. In the base code survey of pre-service and post-service times, as described above, the respondents reported median pre-service evaluation, positioning, and scrub/dress/wait times of 25, 5, and 5 minutes respectively, and post service time of 10 minutes. The respondents reported a median intra-service time of 25 minutes. 24 (21%) of the respondents chose key reference service 49421, *Insertion of tunneled intraperitoneal catheter for dialysis, open*, 4.21 46/45/20 the intra-service intensity of 43226 to be 4.94, compared to the comparison code intra-service intensity of 3.42. As the mini-survey methodology only captured intra-service intensity / complexity, we are unable to provide an assessment regarding the relative intensity of the surveyed code to the comparison code on other measures. The median survey RVW was 4.00. We note that as all of the gastrointestinal endoscopy codes are being surveyed over the next two years, the reference service list (RSL) does not contain any endoscopic procedures that would be familiar to the physicians completing the surveys.

The specialty societies convened an expert panel to review the survey results and make recommendations. The panel noted that the median service performance rate (10) was substantially higher than would be expected for a typical gastroenterologist in solo or small group practice and that those who responded most likely overrepresented high volume referral centers comprising more experienced and efficient practitioners. The

expert panel felt this supported the concept that the survey respondents were more experienced than the typical practitioner, and that this should be considered in the development of work recommendations.

When 43226 is performed in the facility setting, the panel recommended pre-service package **1b**, Facility Straightforward Patient / Straightforward Procedure (With sedation / anesthesia care), which would be used for this non-incisional trans-oral endoscopic procedure. The expert panel felt the survey respondents underestimated the time necessary to complete all of the elements included in the facility pre-service package that are typically performed with 43226 and failed to consider all of the elements in their time estimation (indications and contraindications for sedation, history of relevant cardiovascular, pulmonary, and neurological conditions, focused physical examination including modified Mallampati score to predict ease of intubation, ASA physical status classification, and summative determination of sedation requirement) and therefore recommended an adjustment of times to reflect the pre-service package and work.

The panel noted there has been a change in the practice pattern for this service since it was most recently valued by the RUC in 1993. In the 1980s and 1990s when this code was first valued, flexible esophagoscopy with insertion of guide wire followed by dilation over guide wire (code 43226) was performed with fiberoptic instruments; today's standard of practice is the use of high-definition video endoscopes and high definition video monitors. In the early 1990s, conscious sedation used rapid intravenous administration of meperidine and diazepam without routine monitoring of pulse oximetry; in 2012, moderate sedation using benzodiazepines and opiates is administered in a controlled, titrated manner with automated monitoring of pulse oximetry, electrocardiogram and, in some settings, capnography. In the 1990s when this code was valued, there were no regulations and/or requirements for a complete History and Physical of the patient within 30 days of the procedure, documentation of a comprehensive examination updated on the day of procedure, a pre-sedation assessment including ASA physical status, airway and cardiac risk completed prior to the procedure, a mandatory timeout before beginning the procedure, or photodocumentation of the findings – all of which are now required to meet various local, state, payor and Medicare accreditation, quality standards, and/or patient safety requirements. In the early 1990s eosinophilic esophagitis had not been described, endoscopic management of Barrett's esophagus, endoscopic mucosal resection of tumors and stenting of esophageal cancer was in development, and endoscopic ultrasound was yet to be commercially available. The panel also noted that "open access" endoscopy, where the patient is not seen by the endoscopist until the day of the procedure, has gained increasing acceptance in a number of settings – community, academic, teaching, military, VA and public; urban, suburban and rural; single and multi-specialty group; independent and employed - during the past decade.

Medicare claims for esophagoscopy with insertion of guide wire followed by dilation over guide wire (code 43226) have declined over a seven year period from 3,551 in 2005 to 2,785 in 2011. A review of a 5% Medicare claims file from 2011 (total 2011 claims 2,785) reveals that code 43226 was reported 19.96% percent of the time by otolaryngologists, 58.69% by gastroenterologists, 12.54% by thoracic surgeons and 4.13% by general surgeons. For Medicare, the procedure was performed 66.69% in the outpatient hospital, 9.68% in the inpatient hospital, 0.53% in the physician office, and 23.02% in the ambulatory surgery center setting. As otolaryngologists and surgeons perform both rigid and flexible esophagoscopy, one can make only an estimate assumption that a percentage of the services performed by those specialties in facility settings represent rigid esophagoscopy procedures performed under general anesthesia.

The expert, multi-society panel notes that a change has occurred in the way that the work of moderate sedation is calculated for the purposes of the RUC's recommendations to CMS. Prior to 2012, the RUC and CMS affirmed that physician work of administering moderate sedation was part of the intra-service time, as in endoscopic procedures 43235 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* and 45378 *Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)* which were surveyed in the 2005 Third Five-Year review, and 43262 *Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy* which was surveyed in the 2010 Fourth Five-Year review. In fact, an overwhelming majority (89%) of codes in Appendix G in which

moderate sedation is intrinsic to the service, where moderate sedation is specifically identified in the RUC work descriptors, describe moderate sedation as occurring during the intra-service period. The decision by the RUC's Research Subcommittee to change how the physician work of administering moderate sedation is accounted for as pre-service, not intra-service work, may constitute recognition that there has been a change in the physician work of performing endoscopic procedures over the past 20 years. In view of such, the RUC's introduction of the standardized pre-service packages in 2008 which specify a difference in pre-service evaluation minutes depending on whether a procedure involves sedation / anesthesia care, and the Research Subcommittee's 2012 clarification that the administration of moderate sedation constitutes work as occurring during the pre-service period, represents an important change in the way that physician work for procedures involving moderate sedation is valued, and constitutes compelling evidence for re-valuation of the gastrointestinal endoscopy codes.

The expert panel felt that in view of the change in how the procedure was performed, new diagnoses, and new requirements to ensure patient safety, the predominance of otolaryngologists performing code 43200 vs. gastroenterologists performing the predominance of other procedures in the 43201-43232 family, and the inability to distinguish the percentage of previous services that represent rigid trans-oral, flexible trans-oral, and flexible trans-nasal procedures, the flexible, trans-oral esophagoscopy procedure has changed since the initial valuation by Harvard, providing compelling evidence for re-valuation.

After assessing the pre-service work that is performed, the expert panel determined that the assumption that all endoscopic procedures would have identical pre- and post-service time may have been incorrect. We note that the survey instrument approved by the Research Subcommittee did not allow the expert panel to draw any conclusions about the role of moderate sedation in the valuation of the pre-service work. The expert panel attempted to address this by reviewing similar services, based on whether the typical patient and typical procedure was straightforward or complex. For this procedure, we are recommending pre-service package 1b with changes of times to 19/3/5 for a total of 27 minutes of pre-service time when the procedure is performed in the facility setting, as follows:

**Evaluation:** 19 minutes, which is the package time, but less than the survey median.

**Positioning:** Addition of 2 minutes (3 min total) to account for positioning the patient, anesthesia lines, and video/scope equipment to allow access for the procedure and moderate sedation monitoring.

**Scrub/Dress/Wait:** 5 minutes, which is equal to the survey median and package time.

The panel identified several crosswalks that would be equivalent in terms of physician pre-service time to this procedure. Code 31626, *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple*, (wRVW 4.16, 25/45/15), preservice package 1b, with 25 minutes of preservice time (eval 19, positioning 1, scrub/dress/wait 5) and 15 minutes of postservice time, was reviewed by the RUC in April 2009. Code 32553, *Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple*, (wRVW 3.80, 25/45/20), preservice package 1b, with 25 minutes of preservice time (eval 19, positioning 1, scrub/dress/wait 5) and 20 minutes of postservice time, was reviewed by the RUC in April 2009. Code 55876, *Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple* (wRVW 1.73, 29/20/10), with 19 minutes of evaluation and 10 minutes of positioning time, was reviewed by the RUC in April 2010. Code 64446, *Injection, anesthetic agent; sciatic nerve, continuous infusion by catheter (including catheter placement)*, (wRVW 1.81, 29/20/15), preservice package 1b, with 29 minutes of preservice time (eval 19, positioning 5, scrub/dress/wait 5), was reviewed by the RUC in April 2008. The panel noted that in October 2010 at the 4<sup>th</sup> five-year review, the societies recommended and the RUC accepted 3 minutes positioning for 45331, *Sigmoidoscopy, flexible; with biopsy, single or multiple*. The panel believes that positioning time for 43200 is similar to that for 45331 and, while noting that CMS revised the positioning time for 45331 to 5 minutes, recommends that 3 minutes is the correct time for this element of work.

The panel noted the survey median intra-service time was 25 minutes and felt that, even though the survey group represented a more experienced referral center practitioner group, this time was acceptable as it



represented approximately half of the intra-service time for the key reference service 49421, *Insertion of tunneled intraperitoneal catheter for dialysis, open*, (000 global, 46/45/20, RVW 4.21) which was reviewed by the RUC in April 2010. The panel felt that the additional 4 minutes for 43226 over the previous time value accurately reflects the current practice of more aggressive dilation using multiple staged dilators, which is more typical than when the code was valued in 1993. The panel also compared the 25 minutes survey time to the intra-service time of 15 minutes for the base code, 43200, and felt that the 10 minutes of incremental time represents an appropriate incremental work time. The panel noted that the respondent 25<sup>th</sup> percentile and median RVW recommendation were respectively 3.25 and 4.00, which along with the changes in the practice patterns and new diagnoses represented compelling evidence to recommend a revaluation in the physician work of this procedure. The expert panel then reviewed the rank order of code 43226 along with the intra-service times for the other codes surveyed in the 43200-43232 family. Based on the comprehensive review of the family of codes surveyed, the expert panel determined that despite the 25<sup>th</sup> percentile RVW recommendation of 3.25 and the presence of compelling evidence which would otherwise merit a work value increase, the panel could not justify recommending an increase in the current valuation of code 43226 from 2.34.

As the physicians who completed the surveys were significantly limited in their choice of key reference codes within the endoscopic family, the panel felt that code 49421 represented an appropriate key reference code even though the total and intraservice times for code 43226 were less. Adjusting for the differences in times, the panel concluded that the RVW of 2.34 for code 43226 is consistent with code 49421 which is considered to be a similar to slightly less intense service (IWPUT 0.059 for 43226 compared with 0.0639 for 49421) and less than the IWPUT for code 31575 (IWPUT 0.0904). Code 57410 *Pelvic examination under anesthesia (other than local)* (000 global, 30/15/25 RVW 1.75), and code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (000 global 20/30/15 RVW 2.78), were identified as comparable codes of lesser complexity. The panel also noted that MPC code 19103 *Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance* (000 global, 20/30/15 RVW 3.69) compares appropriately with 43226 adjusting for the difference in service times and complexity.

While there was compelling evidence to recommend an increase in the wRVU times for code 43226 based on the survey times adjusted for pre-service package 1b in the facility setting the expert panel recommends that the existing wRVU value of 2.34 should be retained with physician times 27/25/15 (compared to the previous RUC valuation of 15/21/15). The expert panel also recommends that code 43226 be valued in both the facility and non-facility setting.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the

provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43226

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology                      How often? Rarely

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 8500

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. ~8,500 (Medicare data 2011 = 2,785) We believe that 90% of the previously reported procedures will now be reported using the codes specific for flexible, transoral esophagoscopy procedures..

Specialty Gastroenterology                      Frequency 7600                      Percentage 89.41 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,395

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. ~2,395 (Medicare data 2011 = 2,785) leftover utilization not going to new code 4319X6

Specialty Gastroenterology                      Frequency 2156                      Percentage 90.02 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? No

## Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43226

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

## AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 43227	Tracking Number	Original Specialty Recommended RVU: <b>3.59</b>
		Presented Recommended RVU: <b>3.26</b>
Global Period: 000		RUC Recommended RVU: <b>3.26</b>

CPT Descriptor: Esophagoscopy, flexible, transoral; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)

### CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 74 year old patient with hematemesis undergoes therapeutic esophagoscopy for control of a bleeding esophageal ulcer.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

### Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

### Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 80%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 79%

**Description of Pre-Service Work:** Review with the patient any symptoms and ascertain characteristics of the dysphagia problem when it is clear there is dysphagia. The patient's history is reviewed to assess for the need for pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed and documented; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays and other diagnostic tests are reviewed. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained and the physician must sign the consent. The physician verifies all endoscopic equipment is available and appropriate computer entries are made. The patient is positioned on the examination table. The endoscopic and moderate sedation monitoring equipment is positioned to provide access for the procedure. A time out is performed. A bite block is placed in the mouth. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat.

**Description of Intra-Service Work:** The level of sedation is assessed prior to inserting the endoscope. A standard flexible upper endoscope is inserted through the mouth into the oropharynx and advanced through the esophagus into the proximal stomach and, when indicated, retroflexed to allow examination of the cardia. The endoscope is withdrawn, allowing measurement of the squamocolumnar and gastro-esophageal junction from the incisors, assess for presence of a hiatal hernia, and then examination of the esophageal mucosa where an esophageal ulcer with active bleeding is identified at 36cm from the incisors. A bipolar cautery probe is inserted through the endoscope and positioned on the bleeding lesion; therapy is applied to control the bleeding. The level of sedation of the patient is reassessed and additional medication is

administered as needed. Photodocumentation of the exam findings including measurements of the lesion, labeling of the identified structures and magnified images of the abnormality are obtained and sent to a hard copy device. The area is observed for further bleeding. The endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. Post procedure orders are completed. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to referral source and other appropriate parties. Data is entered into procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others. Necessary prescriptions, follow-up tests and appointments are provided to the patient.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	10/2012				
<b>Presenter(s):</b>	Joel V. Brill, MD (AGA), Nicholas Nickl, MD (ASGE), Edward S. Bentley, MD (ASGE), Michael Edye, MD (SAGES), Don J. Selzer, MD (SAGES)				
<b>Specialty(s):</b>	AGA, ASGE, SAGES				
<b>CPT Code:</b>	43227				
<b>Sample Size:</b>	4325	<b>Resp N:</b>	87	<b>Response:</b> 2.0 %	
<b>Description of Sample:</b>	The AGA and ASGE conducted a random sample of their member gastroenterologists using the Census Department office regions ( <a href="http://www.census.gov/regions/">http://www.census.gov/regions/</a> ). Between 150 and 200 gastroenterologists were randomly selected in each region for a total of 2,000 gastroenterologists. The AGA and ASGE enhanced the random sample by adding 514 members of the ASGE Special Interest Groups and 786 physicians who perform esophagoscopy EUS and stent, TNE and optical endomicroscopy and ablation provided by Industry. The AGA and ASGE also added 86 volunteers who responded to the educational article on the RUC survey process that was approved by the Research Subcommittee and was distributed to all AGA and ASGE members. The AGA and ASGE's total survey sample size was 3,386. SAGES sent a total of 1,000 emails (939 successfully delivered) using a random selection of 250 members from each of the four CMS DME Regions A-D (ie, geographically distributed). The total survey sample size for SAGES, AGA and ASGE was 4,325.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	1.00	5.00	20.00	155.00
<b>Survey RVW:</b>	0.55	3.26	4.05	5.00	12.88
<b>Pre-Service Evaluation Time:</b>			25.00		
<b>Pre-Service Positioning Time:</b>			5.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			5.00		
<b>Intra-Service Time:</b>	5.00	25.00	30.00	45.00	75.00
<b>Immediate Post Service-Time:</b>	<u>10.00</u>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	43227	<b>Recommended Physician Work RVU: 3.26</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		25.00	33.00	-8.00
<b>Pre-Service Positioning Time:</b>		3.00	1.00	2.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00
<b>Intra-Service Time:</b>		30.00		
<b>Immediate Post Service-Time:</b>	<u>10.00</u>			

<u>Post Operative Visits</u>	<u>Total Min**</u>	<u>CPT Code and Number of Visits</u>			
<b>Critical Care time/visit(s):</b>	<b><u>0.00</u></b>	99291x <b>0.00</b>	99292x <b>0.00</b>		
<b>Other Hospital time/visit(s):</b>	<b><u>0.00</u></b>	99231x <b>0.00</b>	99232x <b>0.00</b>	99233x <b>0.00</b>	
<b>Discharge Day Mgmt:</b>	<b><u>0.00</u></b>	99238x <b>0.0</b>	99239x <b>0.0</b>	99217x <b>0.00</b>	
<b>Office time/visit(s):</b>	<b><u>0.00</u></b>	99211x <b>0.00</b>	12x <b>0.00</b>	13x <b>0.00</b>	14x <b>0.00</b> 15x <b>0.00</b>
<b>Prolonged Services:</b>	<b><u>0.00</u></b>	99354x <b>0.00</b>	55x <b>0.00</b>	56x <b>0.00</b>	57x <b>0.00</b>
<b>Sub Obs Care:</b>	<b><u>0.00</u></b>	99224x <b>0.00</b>	99225x <b>0.00</b>	99226x <b>0.00</b>	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
49421	000	4.21	RUC Time

CPT Descriptor Insertion of tunneled intraperitoneal catheter for dialysis, open**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
31575	000	1.10	RUC Time	599,944

CPT Descriptor 1 Laryngoscopy, flexible fiberoptic; diagnostic

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
57410	000	1.75	RUC Time	3,277

CPT Descriptor 2 Pelvic examination under anesthesia (other than local)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31622	000	2.78	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 18      % of respondents: 16.5 %

**TIME ESTIMATES (Median)**

	<u>CPT Code:</u> 43227	<u>Key Reference CPT Code:</u> 49421	<u>Source of Time</u> RUC Time
Median Pre-Service Time	33.00	46.00	
Median Intra-Service Time	30.00	45.00	

Median Immediate Post-service Time	10.00	20.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>73.00</b>	<b>111.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)**(of those that selected Key  
Reference code)**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered		
--	--	--

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed		
--	--	--

Urgency of medical decision making		
------------------------------------	--	--

**Technical Skill/Physical Effort (Mean)**

Technical skill required		
--------------------------	--	--

Physical effort required		
--------------------------	--	--

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality		
---	--	--

Outcome depends on the skill and judgment of physician		
--	--	--

Estimated risk of malpractice suit with poor outcome		
--	--	--

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity		
----------------------------------	--	--

Intra-Service intensity/complexity	4.69	3.42
------------------------------------	------	------

Post-Service intensity/complexity		
-----------------------------------	--	--

## Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

### **Rationale and comments for 43227**

43227 *Esophagoscopy, flexible, transoral; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)* RVW 3.59 physician time, 45/36/23 was previously valued by the RUC in April 1993. This code is being reviewed in response to the CMS comments in the Proposed Rule and Final Rule for CY 2012, requesting review of gastrointestinal endoscopic services as potentially misvalued.

Although this code was not specifically identified by CMS in the Final Rule, the societies that committed to a comprehensive review of gastrointestinal endoscopic services – the AGA, ACG, ASGE and SAGES – identified that code 43200 was primarily performed by otolaryngologists, while the remaining codes in the 43200-43232 family were primarily performed by gastroenterologists and endoscopic surgeons. In view of such, a coding change proposal was brought to the February 2012 CPT Editorial Panel in conjunction with the AAO-HNS and the Trilogical Society, requesting the development of new codes for trans-nasal esophagoscopy (primarily performed in the non-facility setting without moderate sedation) and rigid esophagoscopy (primarily performed in the OR setting with anesthesia administered by an anesthesia professional). While the code number, 43227, remains the same, this code is now specific for a flexible, transoral, esophagoscopy procedure.

In May 2012 the AGA, ASGE and SAGES requested that the Research Subcommittee consider a mini-survey methodology for this and the other codes in the 43200-43232 family, which was approved. The Research Subcommittee required that a standard survey be conducted of the new base code for flexible trans-oral esophagoscopy, 43200 *Esophagoscopy, flexible; transoral diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*, specifically including the elements of pre- and post-service physician work. For the remaining codes that were surveyed in the 43201-43232 family, including code 43227, the mini-survey instrument only asked the physician to address the intra-service work component for the procedure. Accordingly, the societies submitting these recommendations are using for 43227 the same pre- and post- service times as for the revised base code for flexible trans-oral esophagoscopy, 43200.

A survey of practicing physicians representing urban, suburban and rural community and academic settings was performed with 87 respondents of 4325 queried (2.0 %). Of the responses received 97% were Gastroenterologists and 3% were Endoscopic Surgeons. 100% found the vignette to be typical. The median service performance rate was 5. 80% typically used moderate sedation in the facility (hospital outpatient, ambulatory surgery center) setting. In the base code survey of pre-service and post-service times, as described above, the respondents reported median pre-service evaluation, positioning, and scrub/dress/wait times of 10, 5, and 5 minutes respectively, and post service time of 10 minutes. The respondents reported a median intra-service time of 30 minutes. 18 (16.5%) of the respondents chose key reference service 49421, *Insertion of tunneled intraperitoneal catheter for dialysis, open*, (wRVW 4.21 45/45/20). The survey intra-service intensity of 43227 was 4.69, compared to the comparison code intra-service intensity of 3.42. As the mini-survey methodology only captured intra-service intensity / complexity, we are unable to provide an assessment regarding the relative intensity of the surveyed code to the comparison code on other measures. The median survey RVW was 4.05. We note that as all of the gastrointestinal endoscopy codes are being surveyed over the next two years, the reference service list (RSL) does not contain any endoscopic procedures that would be familiar to the physicians completing the surveys.

The specialty societies convened an expert panel to review the survey results and make recommendations. The panel noted that the median service performance rate (5) was what would be expected for a typical gastroenterologist in solo or small group practice.



The panel noted there has been a change in the practice pattern for this service since it was most recently valued by the RUC in 1993. In the 1980s and 1990s when this code was first valued, flexible esophagoscopy with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator) (code 43227) was performed with fiberoptic instruments; today's standard of practice is the use of high-definition video endoscopes and high definition video monitors. In the early 1990s, conscious sedation used rapid intravenous administration of meperidine and diazepam without routine monitoring of pulse oximetry; in 2012, moderate sedation using benzodiazepines and opiates is administered in a controlled, titrated manner with automated monitoring of pulse oximetry, electrocardiogram and, in some settings, capnography. In the 1990s when this code was valued, there were no regulations and/or requirements for a complete History and Physical of the patient within 30 days of the procedure, documentation of a comprehensive examination updated on the day of procedure, a pre-sedation assessment including ASA physical status, airway and cardiac risk completed prior to the procedure, a mandatory timeout before beginning the procedure, or photodocumentation of the findings – all of which are now required to meet various local, state, payor and Medicare accreditation, quality standards, and/or patient safety requirements. In the early 1990s eosinophilic esophagitis had not been described, endoscopic management of Barrett's esophagus, endoscopic mucosal resection of tumors and stenting of esophageal cancer was in development, and endoscopic ultrasound was yet to be commercially available. The panel also noted that "open access" endoscopy, where the patient is not seen by the endoscopist until the day of the procedure, has gained increasing acceptance in a number of settings – community, academic, teaching, military, VA and public; urban, suburban and rural; single and multi-specialty group; independent and employed – during the past decade.

Medicare claims for Esophagoscopy, rigid or flexible; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator) (code 43227) have declined over a seven year period from 928 in 2005 to 521 in 2011. A review of a 5% Medicare claims file from 2011 (total 2011 claims 521) reveals that code 43227 was reported 1.10% percent of the time by otolaryngologists, 81.78% by gastroenterologists, 7.18% by internal medicine specialists, and 9.18% by general surgeons. For Medicare, the procedure was performed 24.04% in the outpatient hospital, 70.80% in the inpatient hospital, 2.20% in the physician office, and 2.58% in the ambulatory surgery center setting. As otolaryngologists and surgeons perform both rigid and flexible esophagoscopy, one can make only an estimate assumption that a percentage of the services performed by those specialties in facility settings represent rigid esophagoscopy procedures performed under general anesthesia.

The expert, multi-society panel notes that a change has occurred in the way that the work of moderate sedation is calculated for the purposes of the RUC's recommendations to CMS. Prior to 2012, the RUC and CMS affirmed that physician work of administering moderate sedation was part of the intra-service time, as in endoscopic procedures 43235 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* and 45378 *Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)* which were surveyed in the 2005 Third Five-Year review, and 43262 *Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy* which was surveyed in the 2010 Fourth Five-Year review. In fact, an overwhelming majority (89%) of codes in Appendix G in which moderate sedation is intrinsic to the service, where moderate sedation is specifically identified in the RUC work descriptors, describe moderate sedation as occurring during the intra-service period. The decision by the RUC's Research Subcommittee to change how the physician work of administering moderate sedation is accounted for as pre-service, not intra-service work, may constitute recognition that there has been a change in the physician work of performing endoscopic procedures over the past 20 years. In view of such, the RUC's introduction of the standardized pre-service packages in 2008 which specify a difference in pre-service evaluation minutes depending on whether a procedure involves sedation / anesthesia care, and the Research Subcommittee's 2012 clarification that the administration of moderate sedation constitutes work as occurring during the pre-service period, represents an important change in the way that physician work for procedures involving moderate sedation is valued, and constitutes compelling evidence for re-valuation of the gastrointestinal endoscopy codes.

The expert panel felt that in view of the change in how the procedure was performed, new diagnoses, and new requirements to ensure patient safety, the predominance of otolaryngologists performing code 43200 vs. gastroenterologists performing the predominance of other procedures in the 43201-43232 family, and the inability to distinguish the percentage of previous services that represent rigid trans-oral, flexible trans-oral, and flexible trans-nasal procedures, the flexible, trans-oral esophagoscopy procedure has changed since the initial valuation by Harvard, providing compelling evidence for re-valuation.

After assessing the pre-service work that is performed, the expert panel determined that the assumption that all endoscopic procedures would have identical pre- and post-service time may have been incorrect. We note that the survey instrument approved by the Research Subcommittee did not allow the expert panel to draw any conclusions about the role of moderate sedation in the valuation of the pre-service work. The expert panel attempted to address this by reviewing similar services, based on whether the typical patient and typical procedure was straightforward or complex. For this procedure, we are recommending pre-service package 2b with changes of times to 25/3/5 for a total of 33 minutes of pre-service time, as follows:

**Evaluation:** 25 minutes which is the survey median time, but less than the package time.

**Positioning:** Addition of 2 minutes (3 min total) to account for positioning the patient, anesthesia lines, and video/scope equipment to allow access for the procedure and moderate sedation monitoring.

**Scrub/Dress/Wait:** 5 minutes which is equal to the survey median and package time.

The panel felt that the median post-service time of 10 minutes also underestimated the elements of post service work. The panel reviewed other scope procedures that had recently been reviewed by the RUC and recommended adjusting the post service time work to 15 minutes similar to code 31622, *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)*. The panel determined that the post-service time should be less than the 20 minutes of post-service work for code 52005, *Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service*; reviewed by the RUC in October 2010 at the 4<sup>th</sup> Five-Year review.

The panel noted the survey median intra-service time was 30 minutes and felt that this time was acceptable as it represented approximately two thirds of the intra-service time for the key reference service 49421, *Insertion of tunneled intraperitoneal catheter for dialysis, open*, (000 global, 46/45/20, RVW 4.21) which was reviewed by the RUC in April 2010. The panel felt that although the intraservice time was approximately 20% less than the previous valuation the intensity of the service (i.e. the necessity to successfully perform the service without complication in a shorter period of time) had substantially increased. The panel also compared the 30 minutes survey time to the intra-service time of 15 minutes for the base code, 43200, and felt that the 10 minutes of incremental time represents an appropriate incremental work time for the typical procedure. The panel noted that the respondent 25<sup>th</sup> percentile and median RVW recommendation were respectively 3.26 and 4.05 reflecting the increased intensity of service, which along with the changes in the practice patterns and new diagnoses represented compelling evidence to recommend a revaluation in the physician work of this procedure. The expert panel then reviewed the rank order of code 43227 along with the intra-service times for the other codes surveyed in the 43200-43232 family. Based on the comprehensive review of the family of codes surveyed, the expert panel determined that despite the median RVW recommendation of 4.05 and the presence of compelling evidence which would otherwise merit a work value increase, the panel could not justify recommending an increase in the current valuation of code 43227 from 3.59.

As the physicians who completed the surveys were significantly limited in their choice of key reference codes within the endoscopic family, the panel felt that code 49421 represented an appropriate key reference code even though the total and intraservice times for code 43227 were less. Adjusting for the differences in times, the panel concluded that the current RVW of 3.59 and revised IWPOT (0.0862) for code 43227 is consistent

with code MPC code 31575 *Laryngoscopy, flexible fiberoptic; diagnostic* (000 global, 15/8/5 RVW 1.10, IWPUT 0.0904) and proportional to code 49421 *Insertion of tunneled intraperitoneal catheter for dialysis, open* (wRVW 4.21, IWPUT 0.0639). The panel also noted that MPC code 19103 *Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance* (000 global, 20/30/15 RVW 3.69, IWPUT 0.0969) compares appropriately with 43215 adjusting for the difference in service times and complexity. Code 57410 *Pelvic examination under anesthesia (other than local)* (000 global, 30/15/25, RVW 1.75, IWPUT 0.0345), and code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (000 global 20/30/15, RVW 2.78, IWPUT 0.0688), were identified as comparable codes of lesser complexity

While there was compelling evidence to recommend an increase in the wRVU times for code 43227 based on the survey times adjusted for pre-service package 2b, the expert panel recommends that the existing wRVU value of 3.59 should be retained with physician times 33/30/15 (compared to the previous RUC valuation of 45/36/23). The expert panel also recommends that code 43227 be valued in both the facility and non-facility setting.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43227

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology                      How often? Rarely

Specialty                      How often? Rarely

Specialty                      How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 1700

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. ~1,700 (Medicare data 2011 = 581\*3) We believe that 90% of the previously reported procedures will now be reported using the codes specific for flexible, transoral esophagoscopy procedures..

Specialty Gastroenterology	Frequency 1550	Percentage 91.17 %
----------------------------	----------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 581  
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. (Medicare data 2011 = 581).

Specialty Gastroenterology	Frequency 535	Percentage 92.08 %
----------------------------	---------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? No

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43227

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43229      Tracking Number   C29

Original Specialty Recommended RVU: **3.76**Presented Recommended RVU: **3.72**

Global Period: 000

RUC Recommended RVU: **3.72**

CPT Descriptor: Esophagoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 65 year old patient with heartburn unresponsive to pharmacological therapy and known Barrett's esophagus is found to have dysplasia on surveillance. The patient is referred for therapeutic esophagoscopy and thermal ablation of the dysplastic tissue.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 56%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 44%

Description of Pre-Service Work: Review with the patient any symptoms and ascertain characteristics of the dysphagia problem when it is clear there is dysphagia. The patient's history is reviewed to assess for the need for pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed and documented; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays and other diagnostic tests are reviewed. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained and the physician must sign the consent. The physician verifies all endoscopic equipment is available and appropriate computer entries are made. The patient is positioned on the examination table. The endoscopic and moderate sedation monitoring equipment is positioned to provide access for the procedure. A time out is performed. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat. A bite block is placed in the mouth.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible upper endoscope is inserted through the mouth into the oropharynx and advanced through the esophagus into the proximal stomach and, when indicated, retroflexed to allow examination of the cardia. The endoscope is withdrawn, allowing measurement of the squamocolumnar and gastro-esophageal junction from the incisors, assess for presence of a hiatal hernia, and then examination of the esophageal mucosa. Abnormal tissue in the esophagus is identified from 34-37cm, which has previously been confirmed as consistent with Barrett's esophagus, high grade dysplasia . Under endoscopic visualization, a guidewire is passed through the endoscope beyond the gastroesophageal junction, and the endoscope is

withdrawn. The endoscope tip is fitted with a blunt cap. The sizing balloon catheter is placed over the guidewire and advanced to the squamocolumnar and gastro-esophageal junction. The sizing balloon is inflated to ascertain the luminal diameter to be treated. The sizing balloon is removed and an ablation catheter is passed over the guidewire into the esophagus in a side-by-side manner with the endoscope. The level of sedation of the patient is reassessed and additional medication is administered as needed. The endoscope positions the balloon electrode to the proximal edge of the Barrett's segment and radiofrequency ablation of the lesion proceeds under direct visualization. The catheter is deflated, removed, and cleaned. The endoscope is advanced to inspect the esophageal mucosa for extent of coagulation effect. The ablation area is cleaned of coagulative debris with irrigation, suctioning, and scrapping using endoscope cap. The catheter is then reintroduced over the guidewire and positioned at the proximal end of the ablated area and a subsequent treatment is performed. The endoscope, ablation catheter, and guidewire are removed. If inadequately treated regions remain a cap electrode device, with spot ablation capability, is fitted on the tip of the endoscope. The endoscope is passed through the mouth into the esophagus to the level of lesion to be treated after anatomical landmarks have been visualized. The area is ablated and coagulative debris is removed from the ablation area, followed by removal of the endoscope and cap electrode device for electrode surface cleaning outside the body. The endoscope and cap electrode device are then reinserted to the ablated area and additional ablation is performed. At the conclusion of the ablation procedure, the area is observed for bleeding. Photodocumentation of the exam findings including measurements of the lesion, labeling of the identified structures and magnified images of the abnormality are obtained and sent to a hard copy device. The endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. Post procedure orders are completed. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to referral source and other appropriate parties. Data is entered into procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others. Necessary prescriptions, follow-up tests and appointments are provided to the patient.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	01/2013				
<b>Presenter(s):</b>	Joel V. Brill, MD (AGA), Nicholas Nickl, MD (ASGE), Edward S. Bentley, MD (ASGE)				
<b>Specialty(s):</b>	AGA, ASGE				
<b>CPT Code:</b>	43229				
<b>Sample Size:</b>	1721	<b>Resp N:</b>	51	<b>Response:</b> 2.9 %	
<b>Description of Sample:</b>	The AGA and ASGE received permission from the Research Subcommittee to administer surveys for the specialized and less frequently performed EGD and esophagoscopy procedures, including 4320X5, to an expert panel. The expert panel included physicians recommended from Industry and members of ASGE Special Interest Groups (SIG) who perform specific procedures (e.g. stent placement, ablation, etc.).				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	5.00	20.00	30.00	500.00
<b>Survey RVW:</b>	2.50	4.68	5.55	6.10	8.25
<b>Pre-Service Evaluation Time:</b>			32.00		
<b>Pre-Service Positioning Time:</b>			10.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10.00		
<b>Intra-Service Time:</b>	15.00	30.00	45.00	48.00	75.00
<b>Immediate Post Service-Time:</b>	<u>15.00</u>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	43229	<b>Recommended Physician Work RVU: 3.72</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		32.00	33.00	-1.00
<b>Pre-Service Positioning Time:</b>		3.00	1.00	2.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00
<b>Intra-Service Time:</b>		45.00		
<b>Immediate Post Service-Time:</b>	<u>15.00</u>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00

<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
52342	000	5.85	RUC Time

CPT Descriptor Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31631	000	4.36	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of tracheal stent(s) (includes tracheal/bronchial dilation as required)

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 12      % of respondents: 23.5 %**

**TIME ESTIMATES (Median)**

	<b>CPT Code: 43229</b>	<b>Key Reference CPT Code: 52342</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	40.00	40.00	
Median Intra-Service Time	45.00	10.00	
Median Immediate Post-service Time	15.00	10.00	
Median Critical Care Time	0.0	60.00	
Median Other Hospital Visit Time	0.0	20.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	



Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>100.00</b>	<b>140.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.50	4.17
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.42	4.08
--	------	------

Urgency of medical decision making	4.25	4.00
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.67	4.42
--------------------------	------	------

Physical effort required	4.17	3.92
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.67	4.42
---	------	------

Outcome depends on the skill and judgment of physician	4.75	4.50
--	------	------

Estimated risk of malpractice suit with poor outcome	4.58	4.17
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.25	3.83
----------------------------------	------	------

Intra-Service intensity/complexity	4.68	4.25
------------------------------------	------	------

Post-Service intensity/complexity	4.17	3.75
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**

In review of the family of esophagoscopy codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In October 2012, the CPT Editorial Panel approved further revised guidelines along with addition of codes within the esophagoscopy codeset.

### Compelling Evidence

For a detailed discussion of compelling evidence, please see the Attachment to the cover letter that was submitted with the SoRs for this family of esophagoscopy codes.

### Overview of Esophagoscopy Family RVW Recommendations

Similar to the review of new EGD codes, for new codes that bundle multiple codes and/or deleted codes, the RVW recommendation is based on endoscopy multiple procedure payment policy or surgical multiple procedure payment policy, as applicable.

Code 43229 *Esophagoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)* is a new/revised code for 2014 that adds dilation and passage of guidewire to the work of to-be-deleted code 43228 *Esophagoscopy, rigid or flexible; with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique*. The AGA and ASGE conducted a RUC survey and received 51 responses.

**We recommend an RVW of 3.76.** This value is less than the 25<sup>th</sup> percentile and is based on: 1) multiple endoscopy payment policy; and 2) increments approved by the RUC for esophagoscopy codes at the October 2012 meeting.

Code 43229 includes the work of esophagoscopy ablation (43228) plus the incremental work of balloon dilation (43220-43200) or 3.25 + (2.10-1.59).

**Pre-time Package 2b** is appropriate for 43229, with an additional 2 minutes for positioning the patient, endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation. In addition, the recommended evaluation time matches the survey median which is lower than the package time.

### Comparison to Key Ref 31631

Key Reference code 31631 was surveyed and presented to the RUC in 2004. The RUC agreed with the specialty presentation that the work had not changed and maintained the RVW and accepted the survey times. Code 31631 does not include the additional work/intensity of physician administered moderate sedation.

### Comparison To Other RUC-Reviewed Codes with 45 Minutes Intra-Service Time

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2010	<b>12018</b>	Rpr f/e/n/l/m >30.0 cm	3.61	0.071	64	8	2	1	<b>45</b>	8
	<b>43229</b>	Esoph; ablation lesion w-pre/post dilation	<b>3.72</b>	<b>0.058</b>	<b>100</b>	<b>32</b>	<b>3</b>	<b>5</b>	<b>45</b>	<b>15</b>
2009	<b>31626</b>	Bronchoscopy w/markers	4.16	0.074	85	19	1	5	<b>45</b>	15
2011	<b>52315</b>	Cystoscopy and treatment	5.20	0.093	94	19	5	5	<b>45</b>	20
2011	<b>36246</b>	Ins cath abd/l-ext art 2nd	5.27	0.088	106	33	3	5	<b>45</b>	20
2008	<b>52341</b>	Cysto w/ureter stricture tx	5.35	0.079	135	45	10	15	<b>45</b>	20
2011	<b>36251</b>	Ins cath ren art 1st unilat	5.35	0.085	116	33	3	5	<b>45</b>	30

## SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.

- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43228

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology                      How often? Rarely

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 13500

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2011 volume for 43228 (Esophagoscopy, rigid or flexible; with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique) multiplied by 3 ( $4,500 \times 3$ ) = ~13,500, which will be deleted from CPT and replaced by 43229.

Specialty Gastroenterology                      Frequency 11500                      Percentage 85.18 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 4,359

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2011 volume for 43228 (Esophagoscopy, rigid or flexible; with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique) = 4359, which will be deleted from CPT and replaced by 43229.

Specialty Gastroenterology                      Frequency 3800                      Percentage 84.44 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? No

## Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 43228

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43231      Tracking Number   C23

Original Specialty Recommended RVU: **3.19**Presented Recommended RVU: **3.19**

Global Period: 000

RUC Recommended RVU: **3.19**

CPT Descriptor: Esophagoscopy, flexible, transoral; with endoscopic ultrasound examination

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 72 year-old patient with recent onset dysphagia is found to have a submucosal mass on imaging studies. Diagnostic esophagoscopy with endoscopic ultrasound is performed to evaluate the lesion.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 70%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 50%

Description of Pre-Service Work: Review with the patient any symptoms including dysphagia and sleep apnea. The patient's history is reviewed to assess past problems with sedation and the need for and timing of pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's imaging studies and other diagnostic tests are reviewed. The pre-service review is documented. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained. The physician verifies all endoscopic and echoendoscopy imaging and image capture equipment is available, operational and appropriate imaging settings and computer entries are made, with special attention to the transducer balloon sheath. A time out is performed. The patient is positioned on the procedure table. The endoscopic, imaging and moderate sedation monitoring equipment is positioned to provide access for the procedure. Appropriate protective attire is applied and verification that all others in the suite are properly protected including the patient. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide when indicated, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat. A bite block is placed in the mouth.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard upper endoscope is inserted into the mouth and the oropharynx and advanced through the esophagus into the proximal stomach. Examination is conducted of the entire esophagus and of the gastric cardia in a retroflexed scope position, noting the abnormal area(s) to be evaluated by echoendoscopy and location as well as any other abnormalities present. The standard upper endoscope is withdrawn; the radial-view echoendoscope is inserted into the mouth and the oropharynx and advanced through the esophagus into the proximal stomach. Echoendoscopic evaluation is conducted of all abnormalities identified,

correlating the endoscopic and ultrasonographic images. The locations of the findings are noted, as is the relationship of abnormalities to adjoining normal and abnormal structures including the esophageal wall as well as vascular and other structures of the mediastinum. Multiple transducer frequencies are utilized as needed to fully visualize the area of interest. Doppler imaging of appropriate areas is completed when indicated. A determination of risk and benefit to sample (e.g. biopsy) the lesion is performed. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. Supervision of the level of sedation and vital signs is performed during the procedure with additional measures taken to maintain an appropriate level of sedation, vital signs, airway and oxygenation as indicated. At the conclusion of the procedure, the endoscope is withdrawn

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. The patient is assessed for physical signs and symptoms suggestive of complications, including abdominal pain, nausea/vomiting, respiratory distress, and bleeding. Post procedure orders are completed and discussed with staff. Photographs are reviewed and labeled. Radiographic images are reviewed with the technologist for entry into the image storing system. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to the referral source and other appropriate parties. Data is entered into the procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others including a discussion regarding potential procedure complications and follow-up plans or further treatments. Restrictions, prescriptions, follow-up tests, instructions and appointments are provided to the patient and pertinent others.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Bruce Cameron, MD (ACG), Joel Brill, MD (AGA), Shivan Mehta, MD (AGA), Nicholas Nickl, MD (ASGE), Edward Bentley, MD (ASGE)				
<b>Specialty(s):</b>	ACG, AGA, ASGE				
<b>CPT Code:</b>	43231				
<b>Sample Size:</b>	979	<b>Resp N:</b>	45	<b>Response:</b> 4.5 %	
<b>Description of Sample:</b>	The ACG, AGA and ASGE conducted an enhanced random sample as approved by the Research Subcommittee. The sampling methodology was a random sample of member gastroenterologists with the addition of ASGE Special Interest Group physicians identified as performers of EUS procedures and survey volunteers who responded to educational articles and identified themselves as EUS performers.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	5.00	<b>20.00</b>	30.00	550.00
<b>Survey RVW:</b>	1.50	3.60	<b>4.20</b>	5.25	10.00
<b>Pre-Service Evaluation Time:</b>			<b>35.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>5.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>5.00</b>		
<b>Intra-Service Time:</b>	10.00	20.00	<b>30.00</b>	42.00	90.00
<b>Immediate Post Service-Time:</b>	<b>20.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	43231	<b>Recommended Physician Work RVU: 3.19</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>33.00</b>	<b>33.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>3.00</b>	<b>1.00</b>	<b>2.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>5.00</b>	<b>5.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>30.00</b>		
<b>Immediate Post Service-Time:</b>	<b>20.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		

<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31631	000	4.36	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of tracheal stent(s) (includes tracheal/bronchial dilation as required)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
31622	000	2.78	RUC Time	83,969

CPT Descriptor 1 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 8      % of respondents: 17.7 %**

**TIME ESTIMATES (Median)**

	<b>CPT Code: 43231</b>	<b>Key Reference CPT Code: 31631</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	41.00	45.00	
Median Intra-Service Time	30.00	45.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	



Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>91.00</b>	<b>120.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.38	4.00
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.25	4.25
--	------	------

Urgency of medical decision making	3.63	3.75
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.88	4.63
--------------------------	------	------

Physical effort required	3.88	4.00
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.88	4.25
---	------	------

Outcome depends on the skill and judgment of physician	4.75	4.50
--	------	------

Estimated risk of malpractice suit with poor outcome	4.00	4.13
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.00	4.00
----------------------------------	------	------

Intra-Service intensity/complexity	4.50	4.50
------------------------------------	------	------

Post-Service intensity/complexity	3.50	3.50
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

## Background

In review of the family of esophagoscopy codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In October 2012, the CPT Editorial Panel approved further revised guidelines along with addition of codes within the esophagoscopy code set.

In October 2012, the RUC reviewed the survey data for 43231 and 43232 (EUS codes) and noted that the survey respondents' median performance rate was low, with the 75<sup>th</sup> percentile performance for 43232 at zero. The RUC also noted that both the intra-service time and recommended RVU for 43232 compared to 43231 were incompatible, indicating that a substantial number of respondents did not understand the survey. The specialties recommended, and the RUC agreed, that 43231 and 43232 should be re-surveyed in conjunction with the upper gastrointestinal endoscopy codes that include ultrasound examination and/or ultrasound-guided treatment. The Research Subcommittee approved the use of a random plus targeted survey sample that included physicians in a special interest group who are familiar with EUS.

## 43231 – Discussion and Recommendation

Code 43231 *Esophagoscopy, flexible, transoral; with endoscopic ultrasound examination* was identified as a family code through the MPC List screen. This service was reviewed by the RUC as a new code in 2000. Because there were only eight survey responses, the RUC recommended 4.09 based on valuing the increment of ultrasound [43259 (4.89) – 43235 (2.39) = 2.50] plus the base code 43200 (1.59). CMS accepted this value for CY 2000, however, in 2001 after the second 5-year-review which included many esophagoscopy codes, CMS refinement reduced 43231 to 3.19. There is no Federal Register discussion regarding this reduction. Summary: the RUC recommended RVW for 43231 was reduced 22% by CMS for CY 2002 and was independent of the survey data from 8 survey respondents. A new survey was conducted and 45 responses were received, with almost all respondents familiar with the procedure.

**We recommend the current RVW of 3.19.** In consideration of the reduction of intraservice time by 10 minutes which had previously been allocated to the administration of moderate sedation, the survey times support maintaining the current value.

## Comparison to Key Ref 31631

Key Reference code 31631 was surveyed and presented to the RUC in 2004. The RUC agreed with the specialty presentation that the work had not changed and maintained the RVW and accepted the survey times. Code 31631 does not include the additional work/intensity of physician administered moderate sedation.

## 43231 Comparison To MPC and Other RUC-Reviewed Codes with 30 Minutes Intra-service Time

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2010	<b>12016</b>	Rpr fe/e/en/l/m 12.6-20.0 cm	2.68	0.077	47	8	2	1	<b>30</b>	6
MPC 2005	<b>31622</b>	Dx bronchoscope/wash	2.78	0.069	65	10	5	5	<b>30</b>	15
2011	<b>36200</b>	Place catheter in aorta	3.02	0.058	91	33	3	5	<b>30</b>	20
2012	<b>32557</b>	Insert cath pleura w/ image	3.12	0.079	67	13	3	6	<b>30</b>	15
	<b>43231</b>	<b>Esoph, EUS</b>	<b>3.19</b>	<b>0.063</b>	<b>91</b>	<b>33</b>	<b>3</b>	<b>5</b>	<b>30</b>	<b>20</b>
2010	<b>31296</b>	Sinus endo w/balloon dil	3.29	0.071	88	30	3	10	<b>30</b>	15
2007	<b>50386</b>	Remove stent via transureth	3.30	0.070	90	25	10	10	<b>30</b>	15
2012	<b>52214</b>	Cystoscopy and treatment	3.50	0.082	79	19	5	5	<b>30</b>	20
2012	<b>52224</b>	Cystoscopy and treatment	4.05	0.101	79	19	5	5	<b>30</b>	20

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43231

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterologists How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1500

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2011 ~ 500. (500\*3 ~ 1,500)

Specialty Gastroenterology Frequency 1275 Percentage 85.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 500

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2011 data ~500

Specialty Gastroenterology Frequency 425 Percentage 85.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

## Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43231

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43232      Tracking Number   C24

Original Specialty Recommended RVU: **3.83**Presented Recommended RVU: **3.83**

Global Period: 000

RUC Recommended RVU: **3.83**

CPT Descriptor: Esophagoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 69 year-old patient with long-standing tobacco use is found to have mediastinal enlargement on chest CT scan. Diagnostic esophagoscopy with endoscopic ultrasound and fine needle aspiration biopsy is performed to plan therapy.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 56%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 40%

Description of Pre-Service Work: Review with the patient any symptoms including dysphagia and sleep apnea. The patient's history is reviewed to assess past problems with sedation and the need for and timing of pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's imaging studies and other diagnostic tests are reviewed. The pre-service review is documented. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained. The physician verifies all endoscopic and echoendoscopy imaging and image capture equipment is available, operational and appropriate imaging settings and computer entries are made, with special attention to the transducer balloon sheath. A time out is performed. The patient is positioned on the procedure table. The endoscopic, imaging and moderate sedation monitoring equipment is positioned to provide access for the procedure. Appropriate protective attire is applied and verification that all others in the suite are properly protected including the patient. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide when indicated, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat. A bite block is placed in the mouth.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard upper endoscope is inserted into the mouth and the oropharynx and advanced through the esophagus into the proximal stomach. Examination is conducted of the entire esophagus and of the gastric cardia in a retroflexed scope position, noting the abnormal area(s) to be evaluated by echoendoscopy and location as well as any other abnormalities present. The standard

upper endoscope is withdrawn; the radial-view echoendoscope is inserted into the mouth and the oropharynx and advanced through the esophagus into the proximal stomach. Echoendoscopic evaluation is conducted of all abnormalities identified, correlating the endoscopic and ultrasonographic images. The locations of the findings are noted, as is the relationship of abnormalities to adjoining normal and abnormal structures including the esophageal wall as well as vascular and other structures of the mediastinum. Multiple transducer frequencies are utilized as needed to fully visualize the area of interest. Doppler imaging of appropriate areas is completed when indicated including identification of vascular structures in the anticipated track of the biopsy needle. A determination of risk and benefit to sample (e.g. biopsy) the lesion is performed. The radial-view echoendoscope is withdrawn; the linear-view biopsy echoendoscope is inserted into the mouth and the oropharynx and advanced through the esophagus into the proximal stomach. The area of interest is re-imaged and fully characterized, noting the correlation of the sagittal/coronal image to the transverse image previously obtained. The fine needle aspiration (FNA) device is inserted into the endoscope. Under continuous endoscopic and ultrasound guidance the FNA needle tip is advanced intramurally or transmurally into the location to be biopsied, taking care to avoid vascular structures and using Doppler imaging as needed to identify such structures. The FNA needle is inserted into the area to be biopsied, the stylet is withdrawn, and suction is applied. The needle is thrust in and out of the region to be biopsied, taking care that the correct needle position is maintained. The needle is withdrawn and the contents of the needle are expressed on to microscope slides and/or into appropriate cytological fixative. Cytology slides are smeared and fixed. The biopsy procedure is repeated until a cytopathologist confirms that adequate tissue has been obtained; or, in the absence of immediate cytopathological evaluation, until 4-8 biopsies are obtained. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. Supervision of the level of sedation and vital signs is performed during the procedure with additional measures taken to maintain an appropriate level of sedation, vital signs, airway and oxygenation as indicated. At the conclusion of the procedure, the endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. The patient is assessed for physical signs and symptoms suggestive of complications, including abdominal pain, nausea/vomiting, respiratory distress, and bleeding. Post procedure orders are completed and discussed with staff. Photographs are reviewed and labeled. Radiographic images are reviewed with the technologist for entry into the image storing system. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to the referral source and other appropriate parties. Data is entered into the procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others including a discussion regarding potential procedure complications and follow-up plans or further treatments. Restrictions, prescriptions, follow-up tests, instructions and appointments are provided to the patient and pertinent others.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Bruce Cameron, MD (ACG), Joel Brill, MD (AGA), Shivan Mehta, MD (AGA), Nicholas Nickl, MD (ASGE), Edward Bentley, MD (ASGE)				
<b>Specialty(s):</b>	ACG, AGA, ASGE				
<b>CPT Code:</b>	43232				
<b>Sample Size:</b>	980	<b>Resp N:</b>	38	<b>Response:</b> 3.8 %	
<b>Description of Sample:</b>	The ACG, AGA and ASGE conducted an enhanced random sample as approved by the Research Subcommittee. The sampling methodology was a random sample of member gastroenterologists with the addition of ASGE Special Interest Group physicians identified as performers of EUS procedures and survey volunteers who responded to educational articles and identified themselves as EUS performers.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	10.00	20.00	48.00	400.00
<b>Survey RVW:</b>	1.70	4.36	4.82	6.44	12.00
<b>Pre-Service Evaluation Time:</b>			35.00		
<b>Pre-Service Positioning Time:</b>			10.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			8.00		
<b>Intra-Service Time:</b>	20.00	35.00	45.00	60.00	120.00
<b>Immediate Post Service-Time:</b>	<b>20.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	43232	<b>Recommended Physician Work RVU: 3.83</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		33.00	33.00	0.00
<b>Pre-Service Positioning Time:</b>		3.00	1.00	2.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00
<b>Intra-Service Time:</b>		45.00		
<b>Immediate Post Service-Time:</b>	<b>20.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		

<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31631	000	4.36	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of tracheal stent(s) (includes tracheal/bronchial dilation as required)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
31628	000	3.80	RUC Time	38,792

CPT Descriptor 1 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 9      % of respondents: 23.6 %**

**TIME ESTIMATES (Median)**

	<b>CPT Code: 43232</b>	<b>Key Reference CPT Code: 31631</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	41.00	45.00	
Median Intra-Service Time	45.00	45.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	



Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>106.00</b>	<b>120.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.22	4.00
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.33	4.11
--	------	------

Urgency of medical decision making	4.22	4.11
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.67	4.44
--------------------------	------	------

Physical effort required	4.11	3.89
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.11	4.33
---	------	------

Outcome depends on the skill and judgment of physician	4.56	4.33
--	------	------

Estimated risk of malpractice suit with poor outcome	4.44	4.33
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.78	3.89
----------------------------------	------	------

Intra-Service intensity/complexity	4.33	4.11
------------------------------------	------	------

Post-Service intensity/complexity	3.78	3.56
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

## Background

In review of the family of esophagoscopy codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In October 2012, the CPT Editorial Panel approved further revised guidelines along with addition of codes within the esophagoscopy code set.

In October 2012, the RUC reviewed the survey data for 43231 and 43232 (EUS codes) and noted that the survey respondents' median performance rate was low, with the 75<sup>th</sup> percentile performance for 43232 at zero. The RUC also noted that both the intra-service time and recommended RVU for 43232 compared to 43231 were incompatible, indicating that a substantial number of respondents did not understand the survey. The specialties recommended, and the RUC agreed, that 43232 should be re-surveyed in conjunction with the upper gastrointestinal endoscopy codes that include ultrasound examination and/or ultrasound-guided treatment. The Research Subcommittee approved the use of a random plus targeted survey sample that includes physicians in a special interest group who are familiar with EUS.

## 43232 – Discussion and Recommendation

Code 43232 *Esophagoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)* was identified as a family code through the MPC List screen. This service was reviewed by the RUC as a new code in 2000. Because there were only seven survey responses, the RUC recommended 4.71 by adding an increment for biopsy to the calculated value of 4.09 for code 43231 (w/o biopsy). The biopsy increment was based on a blend between 19291 (0.63) and the increment between 31629 and 31622. CMS accepted the RVW of 4.71 for CY 2000, however, in 2001 after the second 5-year-review which included many esophagoscopy codes, CMS refinement reduced 43232 to 4.48. There is no Federal Register discussion regarding this reduction. Summary: the RUC recommended RVW for 43231 was reduced 5% by CMS for CY 2002 and was independent of the survey data from 7 survey respondents. A new survey was conducted and 38 responses were received, with almost all respondents familiar with the procedure.

**We recommend an RVW of 3.83 which is less than the current value and less than the 25<sup>th</sup> percentile.** This establishes the increment of 0.67 RVU between 43238 and 43232, representing the additional work required to perform esophageal FNA. This value is supported by a comparison to other codes representing needle aspiration or needle biopsy (see table)

Code	Descriptor	RUC review	RVW	IS time
10021	FNA w/o image guidance	1995	1.27	17
10022	FNA w/ imaging	1995	1.27	20
19100	Breast Bx, no image guidance	1993	1.27	30
19102	Breast Bx, w/ image guidance	2000	2.00	30
32405	Lung Bx, percutaneous needle	2010	1.93	30
38505	Needle BX, lymph node		1.14	28
49082	Abd paracentesis wo/ image guidance	2010	1.24	10
49083	Abd paracentesis w/ image guidance	2010	2.00	25
49180	Needle Bx, percutaneous mass	1995	1.73	22
55700	Prostate Bx	2005	2.58	15
60100	Thyroid Bx, percutaneous needle	2000	1.56	25
60300	Thyroid cyst, aspiration	1995	0.97	15
64530	Celiac plexus block		1.58	30
76937	UTZ guidance, vascular access	2003	0.30	10

CPT Code: 43232				
76942	UTZ guidance, needle placement		0.67	30
76946	UTZ guidance, amniocentesis		0.38	15
76975	GI endoscopic UTZ, S+I	1993	0.81	34
93306	Cardiac echo with 2D, m-mode, color flow and spectral Doppler	2007	1.30	20
93307	Cardiac echo with 2D, m-mode, no Doppler	2009	0.92	18
93312	TEE, including probe placement, S+I	1996	2.20	13
93313	TEE, probe placement	1996	0.95	25
93314	TEE, S+I only	1996	1.25	25

**Pre-time Package 4** is appropriate.

#### Comparison to Key Ref 31631

Key Reference code 31631 was surveyed and presented to the RUC in 2004. The RUC agreed with the specialty presentation that the work had not changed and maintained the RVW and accepted the survey times. Code 31631 does not include the additional work/intensity of physician administered moderate sedation.

#### 43232 Comparison To MPC and Other RUC-Reviewed Codes with 40-45 Minutes Intra-Service Time

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2010	<b>12018</b>	Rpr f/e/n/l/m >30.0 cm	3.61	0.071	64	8	2	1	<b>45</b>	8
MPC 2003	<b>31628</b>	Bronchoscopy/lung bx each	3.80	0.071	90	10	10	10	<b>40</b>	20
2009	<b>49411</b>	Ins mark abd/pel for rt perq	3.82	0.072	85	19	1	5	<b>40</b>	20
	<b>43232</b>	<b>Esoph; US FNA</b>	<b>3.83</b>	<b>0.055</b>	<b>106</b>	<b>35</b>	<b>3</b>	<b>5</b>	<b>45</b>	<b>20</b>
2009	<b>31626</b>	Bronchoscopy w/markers	4.16	0.074	85	19	1	5	<b>45</b>	15
1997	<b>58558</b>	Hysteroscopy biopsy	4.74	0.091	90	30			<b>40</b>	20
2011	<b>52315</b>	Cystoscopy and treatment	5.20	0.093	94	19	5	5	<b>45</b>	20

### SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

### FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43232

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology                      How often? Rarely

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1200

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2011 volume ~ 400 ( $400 \times 3 = 1200$ )

Specialty Gastroenterology                      Frequency 936                      Percentage 78.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 400

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2011 volume ~ 400

Specialty Gastroenterology                      Frequency 312                      Percentage 78.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? No

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43232

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**Codes in Italics represent recommendations approved by RUC**

Tracking Number	Code	Description	Current RVW	RUC Rec	Pre	Intra	Post	Total	IWPUT
		<b>Esophagoscopy, Diagnostic</b>							
<b>C1</b>	43191	Esophagoscopy, <u>rigid</u> , transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed.	1.59	<b>2.78</b>	51	20	15	<b>86</b>	0.072
<b>C9</b>	43200	Esophagoscopy, <u>flexible</u> , transoral; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	1.59	<b>1.59</b>	27	15	10	<b>52</b>	0.056
<b>C7</b>	43197	Esophagoscopy, <u>flexible, transnasal</u> ; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	1.59	<b>1.59</b>	25	15	10	<b>50</b>	0.060
		<b>Esophagoscopy, submucosal injection</b>							
<b>C2</b>	43192	Esophagoscopy, <u>rigid</u> , transoral; with directed submucosal injection(s), any substance	2.09	<b>3.21</b>	56	23	20	<b>99</b>	0.072
<b>C11</b>	43201	Esophagoscopy, <u>flexible</u> , transoral; with directed submucosal injection(s), any substance	2.09	<b>1.90</b>	27	15	10	<b>52</b>	0.076
		<b>Esophagoscopy, biopsy</b>							
<b>C3</b>	43193	Esophagoscopy, <u>rigid</u> , transoral; with biopsy, single or multiple.	1.89	<b>3.36</b>	56	30	20	<b>106</b>	0.060
<b>C12</b>	43202	Esophagoscopy, <u>flexible</u> , transoral; with biopsy, single or multiple.	1.89	<b>1.89</b>	27	15	10	<b>52</b>	0.076
<b>C8</b>	43198	Esophagoscopy, <u>flexible, transnasal</u> ; with biopsy, single or multiple.	1.89	<b>1.89</b>	25	20	10	<b>55</b>	0.060
		<b>Esophagoscopy, removal of foreign body</b>							
<b>C4</b>	43194	Esophagoscopy, <u>rigid</u> , transoral; with removal of foreign body.	2.60	<b>3.99</b>	49	30	28	<b>107</b>	0.081
<b>C15</b>	43215	Esophagoscopy, <u>flexible</u> , transoral; with removal of foreign body.	2.60	<b>2.60</b>	33	20	10	<b>63</b>	0.085
		<b>Esophagoscopy, w/ balloon dilation</b>							
<b>C5</b>	43195	Esophagoscopy, <u>rigid</u> , transoral; with balloon dilation (less than 30 mm diameter).	2.10	<b>3.21</b>	49	30	15	<b>94</b>	0.064
<b>C19</b>	43220	Esophagoscopy, <u>flexible</u> , transoral; with balloon dilation (less than 30 mm diameter).	2.10	<b>2.10</b>	27	20	10	<b>57</b>	0.067
		<b>Esophagoscopy, insert of guide wire w/ dilation</b>							
<b>C6</b>	43196	Esophagoscopy, <u>rigid</u> , transoral; with insertion of guide wire followed by dilation over guide wire.	2.34	<b>3.36</b>	49	33	20	<b>102</b>	0.059
<b>C20</b>	43226	Esophagoscopy, <u>flexible</u> , transoral; with insertion of guide wire followed by dilation over guide wire.	2.34	<b>2.34</b>	27	25	10	<b>62</b>	0.063
		<b>Esophagoscopy, Other</b>							
<b>C13</b>	43204	Esophagoscopy, <u>flexible</u> , transoral; with injection sclerosis of esophageal varices	3.76	<b>2.89</b>	33	20	10	<b>63</b>	0.100
<b>C14</b>	43205	Esophagoscopy, <u>flexible</u> , transoral; with band ligation of esophageal varices	3.78	<b>3.00</b>	33	20	10	<b>63</b>	0.105
<b>C10</b>	43206	Esophagoscopy, <u>flexible</u> , transoral; with optical endomicroscopy	N/A	<b>2.39</b>	27	30	10	<b>67</b>	0.054
<b>C16</b>	43216	Esophagoscopy, <u>flexible</u> , transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	2.40	<b>2.40</b>	33	22	10	<b>65</b>	0.069
<b>C17</b>	43217	Esophagoscopy, <u>flexible</u> , transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	2.90	<b>2.90</b>	33	30	10	<b>73</b>	0.067
<b>C18</b>	43219	Esophagoscopy, <u>flexible</u> , transoral; with insertion of plastic tube or stent	2.80	<b>2.80</b>	33	20	10	<b>63</b>	0.095
<b>C21</b>	43227	Esophagoscopy, <u>flexible</u> , transoral; with control of bleeding (eg, injection, bipolar cautery, etc)	3.59	<b>3.26</b>	33	30	10	<b>73</b>	0.079
C23	43231	Esophagoscopy, flexible, transoral; with endoscopic ultrasound examination	3.19	3.19	41	30	20	91	0.063
C24	43232	Esophagoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)	4.47	3.83	41	45	20	111	0.056
<b>C25</b>	43211	Esophagoscopy, flexible, transoral; with endoscopic mucosal resection	NEW	<b>4.58</b>	41	45	18	<b>104</b>	0.074
<b>C27</b>	43213	Esophagoscopy, flexible, transoral; with dilation of esophagus, by balloon or dilator, retrograde (includes fluoroscopic guidance, when performed)	NEW	<b>5.00</b>	41	45	15	<b>101</b>	0.085
<b>C28</b>	43214	Esophagoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)	NEW	<b>3.78</b>	41	30	16	<b>87</b>	0.086
<b>C26</b>	43212	Esophagoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)	NEW	<b>3.73</b>	41	30	15	<b>86</b>	0.085
<b>C29</b>	43229	Esophagoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)	NEW	<b>3.72</b>	40	45	15	<b>100</b>	0.057

# ISSUE: Esophagoscopy

Source	CPT	DESC	Resp	IWPUT	RVW					Total Time	PRE-TIME			INTRA-TIME					IMMD POST	Pre time package
					MIN	25th	MED	75th	MAX		EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX		
REF	31622	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)	35	0.069			2.78			65	10	5	5			30			15	
CURRENT	43200	Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)		0.061			1.59			55	12	0	15			15			13	
SVY	43191	Esophagoscopy, rigid, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed.	59	0.079	1.80	2.78	3.00	3.57	10.00	90	35	10	10	5	15	20	30	60	15	
REC	43191			0.0722			2.78			86	35	6	10			20			15	4-40/3/20
REF		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple site	15	0.087			3.36			70	10	5	10			30			15	
CURRENT	43201	Esophagoscopy, rigid or flexible; with directed submucosal injection(s), any substance		0.048			2.09			65	12	0	0			25			28	
SVY	43192	Esophagoscopy, rigid, transoral; with directed submucosal injection(s), any substance.	31	0.078	2.45	3.21	3.45	4.50	11.11	103	40	10	10	10	20	23	38	60	20	
REC	43192			0.072			3.21			99	40	6	10			23			20	4-40/3/20
REF		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple site	24	0.087			3.36			70	10	5	10			30			15	
CURRENT	43202	Esophagoscopy, rigid or flexible; with biopsy, single or multiple		0.053			1.89			64	12	0	15			22			15	
SVY	43193	Esophagoscopy, rigid, transoral; with biopsy, single or multiple.	35	0.057	3.00	3.36	3.36	4.08	11.11	110	40	10	10	10	20	30	30	60	20	
REC	43193			0.060			3.36			106	40	6	10			30			20	4-40/3/20
REF		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required)	14	0.055			4.88			140	20	15	15			60			30	
CURRENT	43215	Esophagoscopy, rigid or flexible; with removal of foreign body		0.047			2.60			83	14	0	15			39			15	
SVY	43194	Esophagoscopy, rigid, transoral; with removal of foreign body.	34	0.097	3.00	3.99	4.74	4.88	28.00	118	40	10	10	10	20	30	45	90	28	
REC	43194			0.081			3.99			107	33	6	10			30			28	3 - 33/3/15
REF		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple site	9	0.087			3.36			70	10	5	10			30			15	
CURRENT	43220	Esophagoscopy, rigid or flexible; with balloon dilation (less than 30 mm diameter)		0.065			2.10			52	15	0	0			22			15	
SVY	43195	Esophagoscopy, rigid, transoral; with balloon dilation (less than 30 mm diameter).	24	0.097	3.00	3.48	4.45	4.88	11.11	105	40	10	10	15	24	30	45	75	15	
REC	43195			0.0640			3.21			94	33	6	10			30			15	3 - 33/3/15
REF		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required)	8	0.055			4.88			140	20	15	15			60			30	
CURRENT	43226	Esophagoscopy, rigid or flexible; with insertion of guide wire followed by dilation over guide wire		0.079			2.34			51	15	0	0			21			15	
SVY	43196	Esophagoscopy, rigid, transoral; with insertion of guide wire followed by dilation over guide wire.	22	0.084	2.60	4.00	4.40	4.97	11.11	115	40	10	13	15	25	33	45	80	20	
REC	43196			0.0593			3.36			102	33	6	10			33			20	3 - 33/3/15
ALT REF		Laryngoscopy, flexible fiberoptic; diagnostic	53	0.090			1.10			28	5	5	5			8			5	
REF		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)	17	0.069			2.78			65	10	5	5			30			15	
CURRENT	43200	Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)		0.061			1.59			55	12	0	15			15			13	
SVY	43197	Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	74	0.133	0.40	2.60	3.00	3.50	14.00	63	28	5	5	5	10	15	25	45	10	
REC	43197			0.0604			1.59			50	17	1	7			15			10	6

**ISSUE: Esophagoscopy**

[illegible]



# ISSUE: Esophagoscopy

Source	CPT	DESC	Resp	IWPUT	RVW					Total Time	PRE-TIME			INTRA-TIME					IMMD POST	Pre time package
					MIN	25th	MED	75th	MAX		EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX		
ALT REF		Laryngoscopy, flexible fiberoptic; diagnostic	53	0.090			1.10			28	5	5	5			8			5	
REF		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple site	19	0.087			3.36			70	10	5	10			30			15	
CURRENT	43202	Esophagoscopy, rigid or flexible; with biopsy, single or multiple		0.053			1.89			64	12	0	15			22			15	
SVY	43198	Esophagoscopy, flexible, transnasal; with biopsy, single or multiple.	75	0.116	0.50	2.85	3.36	4.23	14.50	70	25	5	5	5	15	20	30	60	15	
REC	43198			0.0603			1.89			55	17	1	7			20			10	6
REF		Insertion of tunneled intraperitoneal catheter for dialysis, open	25	0.064			4.21			111	33	3	10			45			20	
CURRENT	43200	Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)		0.061			1.59			55	12		15			15			13	
SVY	43200	Esophagoscopy, flexible, transoral: diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	121	0.123	0.48	1.80	2.78	3.39	6.52	60	25	5	5	3	10	15	20	45	10	
REC	43200			0.056			1.59			52	19	3	5			15			10	1B - 19/1/5
REF		Insertion of tunneled intraperitoneal catheter for dialysis, open	23	0.064			4.21			111	33	3	10			45			20	
CURRENT	43201	Esophagoscopy, rigid or flexible; with directed submucosal injection(s), any substance		0.048			2.09			65	12					25			28	
SVY	43201	Esophagoscopy, flexible, transoral: with directed submucosal injection(s), any substance	121	0.138	0.55	2.10	3.00	3.90	9.27	60	25	5	5	0	10	15	20	45	10	
REC	43201			0.089			1.90			52	19	3	5			15			10	1B - 19/1/5
REF		Insertion of tunneled intraperitoneal catheter for dialysis, open	24	0.064			4.21			111	33	3	10			45			20	
CURRENT	43202	Esophagoscopy, rigid or flexible; with biopsy, single or multiple		0.053			1.89			64	12		15			22			15	
SVY	43202	Esophagoscopy, flexible, transoral: with biopsy, single or multiple	120	0.138	0.50	2.00	3.00	3.65	8.60	60	25	5	5	0	10	15	20	45	10	
REC	43202			0.076			1.89			52	19	3	5			15			10	1B - 19/1/5
REF		Insertion of tunneled intraperitoneal catheter for dialysis, open	21	0.064			4.21			111	33	3	10			45			20	
CURRENT	43204	Esophagoscopy, rigid or flexible; with injection sclerosis of esophageal varices		0.063			3.76			105	17		25			43			20	
SVY	43204	Esophagoscopy, flexible, transoral: with injection sclerosis of esophageal varices	95	0.141	0.00	2.89	3.76	4.79	12.00	65	25	5	5	5	15	20	30	60	10	
REC	43204			0.143			2.89			63	25	3	5			20			10	2B - 33/1/5
REF		Insertion of tunneled intraperitoneal catheter for dialysis, open	24	0.064			4.21			111	33	3	10			45			20	
CURRENT	43205	Esophagoscopy, rigid or flexible; with band ligation of esophageal varices		0.096			3.78			70	20					30			20	
SVY	43205	Esophagoscopy, flexible, transoral: with band ligation of esophageal varices	108	0.143	0.55	3.00	3.80	4.80	10.00	65	25	5	5	5	15	20	30	60	10	
REC	43205			0.144			3.00			63	25	3	5			20			10	2B - 33/1/5
REF		Insertion of tunneled intraperitoneal catheter for dialysis, open	24	0.064			4.21			111	33	3	10			45			20	
CURRENT	43206	Esophagoscopy, flexible, transoral; with optical endomicroscopy		n/a																
SVY	43206	Esophagoscopy, flexible, transoral: with optical endomicroscopy	109	0.102	0.55	3.00	4.00	4.61	10.00	75	25	5	5	0	20	30	35	60	10	
REC	43206			0.075			2.39			67	19	3	5			30			10	1B - 19/1/5
REF		Insertion of tunneled intraperitoneal catheter for dialysis, open	23	0.064			4.21			111	33	3	10			45			20	
CURRENT	43215	Esophagoscopy, rigid or flexible; with removal of foreign body		0.047			2.60			83	14		15			39			15	
SVY	43215	Esophagoscopy, flexible, transoral:with removal of foreign body	102	0.128	0.50	2.80	3.50	4.45	28.00	65	25	5	5	2	15	20	30	60	10	
REC	43215			0.085			2.60			63	25	3	5			20			10	2B - 33/1/5
REF		Insertion of tunneled intraperitoneal catheter for dialysis, open	23	0.064			4.21			111	33	3	10			45			20	



# ISSUE: Esophagoscopy

Source	CPT	DESC	Resp	IWPUT	RVW					Total Time	PRE-TIME			INTRA-TIME					IMMD POST	Pre time package
					MIN	25th	MED	75th	MAX		EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX		
CURRENT	43216	Esophagoscopy, rigid or flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery		0.051			2.40			65	12					33			20	
SVY	43216	Esophagoscopy, flexible, transoral:with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	99	0.134	0.50	2.99	3.88	4.65	11.47	67	25	5	5	2	15	22	30	75	10	
REC	43216			0.069			2.40			65	25	3	5			22			10	2B - 33/1/5
REF		Insertion of tunneled intraperitoneal catheter for dialysis, open	19	0.064			4.21			111	33	3	10			45			20	
CURRENT	43217	Esophagoscopy, rigid or flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique		0.070			2.90			77	15		15			29			18	
SVY	43217	Esophagoscopy, flexible, transoral:with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	90	0.109	0.60	3.31	4.20	5.30	8.50	75	25	5	5	5	25	30	45	60	10	
REC	43217			0.064			2.90			83	25	3	15			30			10	2B - 33/1/5
REF		Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tiss	14	0.082			5.45			110	30					50			30	
NEW										0										
SVY	43211	Esophagoscopy, flexible, transoral; with endoscopic mucosal resection	62	0.103	1.50	4.91	6.00	7.38	14.00	113	35	5	10	10	30	45	50	80	18	
REC	43211	Esoph; endoscopic mucosal resection		0.074			4.58			104	33	3	5			45			18	2B
REF		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed	29	0.064			4.36			120	20	10	15			45			30	
NEW										0										
SVY	43212	Esophagoscopy, flexible, transoral; with placement of endoscopic stent (includes	53	0.112	2.40	4.36	5.00	5.85	8.15	110	45	10	10	20	25	30	45	75	15	
REC	43212	ESOPH; STENT W-PRE/POST DILATION		0.085			3.73			86	33	3	5			30			15	2B
REF		Insertion of tunneled intraperitoneal catheter for dialysis, open	24	0.064			4.21			111	33	3	10			45			20	
CURRENT	43220	Esophagoscopy, rigid or flexible; with balloon dilation (less than 30 mm diameter)		0.065			2.10			52	15					22			15	
SVY	43220	Esophagoscopy, flexible, transoral:with balloon dilation (less than 30 mm diameter)	109	0.131	0.50	2.76	3.55	4.25	9.50	65	25	5	5	3	15	20	30	50	10	
REC	43220			0.067			2.10			57	19	3	5			20			10	1B - 19/1/5
REF		Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon	13	0.070			5.85			140	40	10	10			60			20	
NEW										0										
SVY	43213	Esophagoscopy, flexible, transoral; with dilation of esophagus, by balloon or dil	45	0.097	2.00	5.00	5.81	6.50	10.00	115	35	10	10	15	30	45	60	90	15	
REC	43213	ESOPH; RETROGRADE DILATION		0.085			5.00			101	33	3	5			45			15	2B
REF		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed	9	0.064			4.36			120	20	10	15			45			30	
NEW										0										
SVY	43214	Esophagoscopy, flexible, transoral; with dilation of esophagus with balloon (30	42	0.115	1.00	3.86	4.87	5.85	8.59	99	33	10	10	10	21	30	30	60	16	
REC	43214	ESOPH; BALLOON >30MM W-FLUORO		0.086			3.78			87	33	3	5			30			16	2B
REF		Insertion of tunneled intraperitoneal catheter for dialysis, open	24	0.064			4.21			111	33	3	10			45			20	

ISSUE: Esophagoscopy

Source	CPT	DESC	Resp	IWPUT	RVW					Total Time	PRE-TIME			INTRA-TIME					IMMD POST	Pre time package
					MIN	25th	MED	75th	MAX		EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX		
CURRENT	43226	Esophagoscopy, rigid or flexible; with insertion of guide wire followed by dilation over guide wire		0.079			2.34			51	15					21			15	
SVY	43226	Esophagoscopy, flexible, transoral: with insertion of guide wire followed by dilation over guide wire	114	0.123	0.50	3.25	4.00	4.91	10.00	70	25	5	5	5	20	25	40	60	10	
REC	43226			0.063	2.34					62	19	3	5			25			10	1B - 19/1/5
REF		Insertion of tunneled intraperitoneal catheter for dialysis, open	18	0.064			4.21			111	33	3	10			45			20	
CURRENT	43227	Esophagoscopy, rigid or flexible; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)		0.067			3.59			104	20		25			36			23	
SVY	43227	Esophagoscopy, flexible, transoral: with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)	87	0.104	0.55	3.26	4.05	5.00	12.88	75	25	5	5	5	25	30	45	75	10	
REC	43227			0.090	3.26					73	25	3	5			30			10	2B - 33/1/5
REF		Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon)	14	0.070			5.85			140	40	10	10			60			20	
NEW										0										
SVY	43229	Esophagoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other	51	0.093	2.50	4.68	5.55	6.10	8.25	112	32	10	10	15	30	45	48	75	15	
REC	43229	ESOPH; ABLATION LESION W-PRE/POST DILATION		0.057			3.72			100	32	3	5			45			15	2B
REF		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, v	8	0.064			4.36			120	20	10	15			45			30	
RUC-00	43231	Esophagoscopy, rigid or flexible; with endoscopic ultrasound examinati		0.057			3.19			80	20					40			20	
NEW SVY	43231	Esophagoscopy, flexible, transoral; with endoscopic ultrasound e	45	0.094	1.50	3.60	4.20	5.25	10.00	95	35	5	5	10	20	30	42	90	20	
OLD SVY	43231	Esophagoscopy, flexible, transoral; with endoscopic ultrasound e	55	0.080	0.00	3.60	4.53	5.54	12.00	90	25	5	5	0	30	45	60	90	10	
REC	43231	Esoph; EUS current		0.063	3.19					91	33	3	5			30			20	
REF		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, v	9	0.064			4.36			120	20	10	15			45			30	
RUC-00	43232	Esophagoscopy, rigid or flexible; with transendoscopic ultrasound-guid		0.060			4.47			100	20					60			20	
NEW SVY	43232	Esophagoscopy, flexible, transoral; with transendoscopic ultrasou	38	0.073	1.70	4.36	4.82	6.44	12.00	118	35	10	8	20	35	45	60	120	20	
OLD SVY	43232	Esophagoscopy, flexible, transoral; with transendoscopic ultrasou	44	0.124	0.45	1.73	2.80	3.40	5.40	60	25	5	5	5	10	15	25	75	10	
REC	43232	Esoph; US FNA		0.056	3.83					106	33	3	5			45			20	



February 11, 2013

Barbara Levy, MD  
Chair, AMA / Specialty Society Relative Value Update Committee  
Scott Manaker, MD, PhD  
Chair, Practice Expense Subcommittee  
515 N. State St.  
Chicago, IL 60657

Dear Drs. Levy and Manaker,

During the January 2013 RUC meeting the Practice Expense Subcommittee recommended and the RUC approved the following changes to the American Gastroenterological Association (AGA) and the American Society for Gastrointestinal Endoscopy (ASGE) practice expense proposal for Tab 8 (Esophagogastroduodenoscopy). As per the discussion at the RUC meeting we respectfully request that the RUC apply these changes to the practice expense for the related esophagoscopy codes that were previously approved at the October 2012 RUC meeting.

Tab 8:

- Addition of 3 minutes to “Prepare room, equipment, supplies” (L037D) for code 43252 (*Esophagogastroduodenoscopy; with optical endomicroscopy*) for the technician to turn on the optical endomicroscope processor unit system added to its esophagoscopy counterpart, 43206 (*Esophagoscopy, flexible, transoral; with optical endomicroscopy*)
- Replacement of “Radiofrequency generator (Angiodynamics), liver RFA” with “RF ablation system” for 4326X9 (*Esophagogastroduodenoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)*) added to its esophagoscopy counterpart 4320X5 (*Esophagoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)*) which replaced 43228
- Addition of “Instrument pack basic (\$500 - \$1,499)” (EQ137) for 43248 (*Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by dilation of passage of dilator(s) through esophagus over guide wire*) added to its

esophagoscopy counterpart 43226 (*Esophagoscopy, flexible, transoral; with insertion of guide wire followed by dilation over guide wire*)

- Addition of “Pack, cleaning, surgical instruments” (SA043) for 43248 (*Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by dilation of passage of dilator(s) through esophagus over guide wire*) for cleaning the dilators added to its counterpart 43226 (*Esophagoscopy, flexible, transoral; with insertion of guide wire followed by dilation over guide wire*)

Please let us know if you have any questions or concerns.

Respectfully,



Joel V. Brill, MD  
AGA RUC Advisor



Nicholas Nickl, MD  
ASGE RUC Advisor

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor: Esophagoscopy, rigid, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed.

Global Period: 000

Meeting Date: October 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Our society convened an expert panel to review the practice expense inputs from the existing esophagoscopy codes used to report rigid transoral esophagoscopy (43200, 43201, 43202, 43215, 43220, and 43226). The panel was comprised of AAO-HNS RUC Advisors and Alternate Advisors as well as members of our Physician Payment Policy (3P) workgroup who are familiar with these procedures. The experts modified the practices expense as necessary and added new inputs for equipment required specifically for transnasal esophagoscopy.

If you have provided any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale: The 2003 practice expense for CPT 43200 was selected as our reference code for new CPT code 43191 given that this is the code formerly used to report the service.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

A RN/LPN/MTA staff blend provides assistance to the physician on the day prior to the procedure by completing pre-service diagnostic and referral forms, coordinating pre-surgery services, scheduling space and equipment in the facility, providing pre-service education and obtaining consent, and following up with phone calls and prescriptions.

Intra-Service Clinical Labor Activities:

Overall, there is very little clinical staff time during the intra-service period given that this procedure is only performed in the facility setting. The clinical staff will however, provide assistance during discharge of the patient on the same date of service by providing home care instructions and discharge information to the patient following the procedure.

Post-Service Clinical Labor Activities:

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor: Esophagoscopy, rigid, transoral; with directed submucosal injection(s), any substance.

Global Period: 000

Meeting Date: October 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Our society convened an expert panel to review the practice expense inputs from the existing esophagoscopy codes used to report rigid transoral esophagoscopy (43200, 43201, 43202, 43215, 43220, and 43226). The panel was comprised of AAO-HNS RUC Advisors and Alternate Advisors as well as members of our Physician Payment Policy (3P) workgroup who are familiar with these procedures. The experts modified the practices expense as necessary and added new inputs for equipment required specifically for transnasal esophagoscopy.

If you have provided any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale: CPT 31625 was selected as our reference code for new CPT code 43192 given that this was the reference code chosen by survey respondents and there was no PE file available from the 2003 review.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

A RN/LPN/MTA staff blend provides assistance to the physician on the day prior to the procedure by completing pre-service diagnostic and referral forms, coordinating pre-surgery services, scheduling space and equipment in the facility, providing pre-service education and obtaining consent, and following up with phone calls and prescriptions.

Intra-Service Clinical Labor Activities:

Overall, there is very little clinical staff time during the intra-service period given that this procedure is only performed in the facility setting. The clinical staff will however, provide assistance during discharge of the patient on the same date of service by providing home care instructions and discharge information to the patient following the procedure.

Post-Service Clinical Labor Activities:

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor: Esophagoscopy, rigid, transoral; with biopsy, single or multiple.

Global Period: 000

Meeting Date: October 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Our society convened an expert panel to review the practice expense inputs from the existing esophagoscopy codes used to report rigid transoral esophagoscopy (43200, 43201, 43202, 43215, 43220, and 43226). The panel was comprised of AAO-HNS RUC Advisors and Alternate Advisors as well as members of our Physician Payment Policy (3P) workgroup who are familiar with these procedures. The experts modified the practices expense as necessary and added new inputs for equipment required specifically for transnasal esophagoscopy.

If you have provided any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale: The 2003 practice expense for CPT 43202 was selected as our reference code for new CPT code 43193 given that this is the code formerly used to report the service.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

A RN/LPN/MTA staff blend provides assistance to the physician on the day prior to the procedure by completing pre-service diagnostic and referral forms, coordinating pre-surgery services, scheduling space and equipment in the facility, providing pre-service education and obtaining consent, and following up with phone calls and prescriptions.

Intra-Service Clinical Labor Activities:

Overall, there is very little clinical staff time during the intra-service period given that this procedure is only performed in the facility setting. The clinical staff will however, provide assistance during discharge of the patient on the same date of service by providing home care instructions and discharge information to the patient following the procedure.

Post-Service Clinical Labor Activities:

CPT Code: 43194  
Specialty Society('s) AAO-HNS

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor: Esophagoscopy, rigid, transoral; with removal of foreign body.

Global Period: 000

Meeting Date: October 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Our society convened an expert panel to review the practice expense inputs from the existing esophagoscopy codes used to report rigid transoral esophagoscopy (43200, 43201, 43202, 43215, 43220, and 43226). The panel was comprised of AAO-HNS RUC Advisors and Alternate Advisors as well as members of our Physician Payment Policy (3P) workgroup who are familiar with these procedures. The experts modified the practices expense as necessary and added new inputs for equipment required specifically for transnasal esophagoscopy.

If you have provided any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale: The 2003 practice expense for CPT 43215 was selected as our reference code for new CPT code 43194 given that this is the code formerly used to report the service.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

A RN/LPN/MTA staff blend provides assistance to the physician on the day prior to the procedure by completing pre-service diagnostic and referral forms, coordinating pre-surgery services, scheduling space and equipment in the facility, providing pre-service education and obtaining consent, and following up with phone calls and prescriptions.

Intra-Service Clinical Labor Activities:

Overall, there is very little clinical staff time during the intra-service period given that this procedure is only performed in the facility setting. The clinical staff will however, provide assistance during discharge of the patient on the same date of service by providing home care instructions and discharge information to the patient following the procedure.

Post-Service Clinical Labor Activities:



**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor:

Immunohisto-chemistry or immunocyto-chemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear; first separately identifiable antibody per slide

(When multiple antibodies are applied to the same slide, use one unit of 88342 for the first separately identifiable antibody and one unit of 8834XX for each additional separately identifiable antibody)

(Do not report 88342 in conjunction with 88360 or 88361 for the same antibody)

(For quantitative or semiquantitative immunohistochemistry, see 88360, 88361)

Global Period: XXX Meeting Date: October 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Individuals with expertise in this service were consulted through a series of conference calls in order to develop the typical practice expense inputs. CAP's expert panel reviewed and compiled PE inputs and made adjustments to the clinical labor, supplies, and equipment. These inputs were further refined with individual pathologists who perform this service.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:  
88342 is the service being revised.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

N/A

Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

N/A

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor: Esophagoscopy, rigid, transoral; with insertion of guide wire followed by dilation over guide wire.

Global Period: 000 Meeting Date: October 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Our society convened an expert panel to review the practice expense inputs from the existing esophagoscopy codes used to report rigid transoral esophagoscopy (43200, 43201, 43202, 43215, 43220, and 43226). The panel was comprised of AAO-HNS RUC Advisors and Alternate Advisors as well as members of our Physician Payment Policy (3P) workgroup who are familiar with these procedures. The experts modified the practices expense as necessary and added new inputs for equipment required specifically for transnasal esophagoscopy.

If you have provided any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale: The 2003 practice expense for CPT 43226 was selected as our reference code for new CPT code 43196 given that this is the code formerly used to report the service.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

A RN/LPN/MTA staff blend provides assistance to the physician on the day prior to the procedure by completing pre-service diagnostic and referral forms, coordinating pre-surgery services, scheduling space and equipment in the facility, providing pre-service education and obtaining consent, and following up with phone calls and prescriptions.

Intra-Service Clinical Labor Activities:

Overall, there is very little clinical staff time during the intra-service period given that this procedure is only performed in the facility setting. The clinical staff will however, provide assistance during discharge of the patient on the same date of service by providing home care instructions and discharge information to the patient following the procedure.

Post-Service Clinical Labor Activities:

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor:

Immunohisto-chemistry or immunocyto-chemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear; first separately identifiable antibody per slide

(When multiple antibodies are applied to the same slide, use one unit of 88342 for the first separately identifiable antibody and one unit of 8834XX for each additional separately identifiable antibody)

(Do not report 88342 in conjunction with 88360 or 88361 for the same antibody)

(For quantitative or semiquantitative immunohistochemistry, see 88360, 88361)

Global Period: XXX Meeting Date: \_\_ October 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Individuals with expertise in this service were consulted through a series of conference calls in order to develop the typical practice expense inputs. CAP's expert panel reviewed and compiled PE inputs and made adjustments to the clinical labor, supplies, and equipment. These inputs were further refined with individual pathologists who perform this service.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: 88342 is the service being revised.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Initially, the immunohistochemistry stain order is verified and accessioned into the laboratory information system. Control blocks have been previously embedded in paraffin as per routine histology procedures and are specific for each immunohistochemical antibody used. The histotechnologist pulls and verifies the patient tissue block and the correct control block and carefully cuts the positive control tissue on the microtome per routine histology procedures. The patient tissue block is then cut on the microtome and placed on the same slide with the positive control tissue. The patient tissue block is then again cut on the microtome and placed on a separate slide for the negative control.

The slides then are placed in the isotemp oven, incubated for 60 minutes, and removed.

Patient data is entered into the Ventana Ultra system with the specific antibodies to be used. Slide barcode labels are generated and placed on slides.

The histotechnologist typically then removes the detection kit and antibodies from refrigerator, loads the antibody, detection kit dispensers and required reagents onto the reagent tray and places the tray on the automated slide stainer. The slides are loaded onto the automated slide stainer, and the equipment is started. The slides are removed from the instrument after they are stained, placed in a slide holder, and rinsed in soapy water so that the coverslip material is removed. Slides are then dehydrated, cleared, and coverslipped by hand with permanent mounting media.

Positive and negative control slides are reviewed. Workload recordings are logged, and the slides and paperwork are collated. Slides and paperwork are then delivered to the pathologist.

Service Clinical Labor Activities:

None.

Post-Service Clinical Labor Activities:

Typically, the histotechnologist then re-files the block, unloads and stores the antibody, the detection kit and reagents. The lab technician cleans the equipment and work station in the histology lab. The lab technician then disposes the hazardous waste material and specimens.

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor: Esophagoscopy, flexible, transnasal; diagnostic, includes collection of specimen(s) by brushing, when performed.

Global Period: 000 Meeting Date: October 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Our societies convened an expert panel to review the practice expense inputs from the existing esophagoscopy code used to report diagnostic transnasal esophagoscopy (43200). The panel was comprised of the AGA/ASGE/AAO-HNS RUC Advisors and Alternate Advisors as well as several identified TNE experts in the Otolaryngology community. The experts modified the practices expense as necessary and added new inputs for equipment required specifically for transnasal esophagoscopy.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: 31622 was selected as our reference code for new CPT code 43197. We selected this reference code because it was chosen as the key reference code by survey respondents.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Our expert panel felt there were no clinical inputs for the day prior to the procedure when performed in the office setting.

Service Clinical Labor Activities:

After the patient arrives at the office for their transnasal esophagoscopy (43197), the Medical Technical Assistant greets the patient and gowns them. They ensure the appropriate medical records are available, obtain vital signs, provide pre-service education and obtain consent. They prepare the room, equipment, supplies, set up the scope and prepare and position the patient. They also assist with applying topical anesthesia.

During the procedure, the Assistant assists the physician performing the procedure and is present for the entire intra service period to assist in the procedure.

Following the procedure, the Assistant monitors the patient and checks monitors, cleans the room and equipment, cleans the scope, and cleans the surgical instruments.

Post-Service Clinical Labor Activities:

Following the procedure, the Assistant will call in prescriptions

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor: Esophagoscopy, flexible, transnasal; with biopsy, single or multiple.

Global Period: 000 Meeting Date: October 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Our societies convened an expert panel to review the practice expense inputs from the existing esophagoscopy code used to report transnasal esophagoscopy with biopsy (43202). The panel was comprised of the AGA/ASGE/AAO-HNS RUC Advisors and Alternate Advisors as well as several identified TNE experts in the Otolaryngology community. The experts modified the practices expense as necessary and added new inputs for equipment required specifically for transnasal esophagoscopy.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: 31625 was selected as our reference code for new CPT code 43198. We selected this reference code because it was chosen as the key reference code by survey respondents.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Our expert panel felt there were no clinical inputs for the day prior to the procedure when performed in the office setting.

Service Clinical Labor Activities:

After the patient arrives at the office for their transnasal esophagoscopy with biopsy (43198), the Medical Technical Assistant greets the patient and gowns them. They ensure the appropriate medical records are available, obtain vital signs, provide pre-service education and obtain consent. They prepare the room, equipment, supplies, set up the scope and prepare and position the patient. They also assist with applying topical anesthesia.

During the procedure, the Assistant assists the physician performing the procedure and is present for the entire intra service period to assist in the procedure.

Following the procedure, the Assistant monitors the patient and checks monitors, cleans the room and equipment, cleans the scope, and cleans the surgical instruments.

Post-Service Clinical Labor Activities:

Following the procedure, the Assistant will call in prescriptions

CPT Code: 43198

Specialty Society(s) AAO-HNS / AGA/ ASGE

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor: Esophagoscopy, flexible, transnasal; with biopsy, single or multiple.

Global Period: 000

Meeting Date: October 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Our societies convened an expert panel to review the practice expense inputs from the existing esophagoscopy code used to report transnasal esophagoscopy with biopsy (43202). The panel was comprised of the AGA/ASGE/AAO-HNS RUC Advisors and Alternate Advisors as well as several identified TNE experts in the Otolaryngology community. The experts modified the practices expense as necessary and added new inputs for equipment required specifically for transnasal esophagoscopy.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: 31625 was selected as our reference code for new CPT code 43198. We selected this reference code because it was chosen as the key reference code by survey respondents.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

In the facility setting, a Medical Technical Assistant provides assistance to the physician on the day prior to the procedure by completing pre-service diagnostic and referral forms, coordinating pre-surgery services, scheduling space and equipment in the facility, providing pre-service education and obtaining consent, and following up with phone calls and prescriptions.

Service Clinical Labor Activities:

Given that this procedure is typically performed in the non-facility setting, there are no clinical staff time inputs for the service period for CPT 43198.

Post-Service Clinical Labor Activities:

Given that this procedure is typically performed in the non-facility setting, there are no clinical staff time inputs for the post-service period for CPT 43198.

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor: Esophagoscopy, flexible, transoral: diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)

Global Period: 000Meeting Date: Oct 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The AGA, ASGE, SAGES and AAO-HNS convened a group from a broad range of geographic locations with differing practice circumstances and settings - community, academic, teaching, and public; urban, suburban and rural; single and multi-specialty group; independent and employed - who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

Code 43200 *Esophagoscopy, flexible; transoral diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* was previously reviewed for practice expense in January 2003. All codes in the family of 43200-43232 are being reviewed for practice expense and physician work.

Our specialties have identified the following reference codes for the Practice Expense inputs recommended for this code.

- Code 31575, *Laryngoscopy, flexible fiberoptic; diagnostic* was reviewed for practice expense in January 2003.
- Code 43236, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any substance* was reviewed for practice expense when the RUC reviewed this code in April 2002.
- Code 43246, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube* was reviewed for practice expense in February 2005.
- Code 91110, *Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report* was reviewed for practice expense when the RUC reviewed this code in April 2003
- Code 91038, *Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)* was reviewed for practice expense in February 2010.

Please describe in detail the clinical activities of your staff:



Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- Schedule space and equipment in facility
- Provide pre-service education/ obtain consent
- Follow-up phone calls and prescriptions

Service Clinical Labor Activities:

- None

Post-Service Clinical Labor Activities:

- Conduct phone calls /call in prescriptions

**AMA/Specialty Society Update Process**  
**Practice Expense Summary of Recommendation**  
**Non Facility Direct Inputs**

CPT Long Descriptor: Esophagoscopy, flexible, transoral: diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)

Global Period: 000 Meeting Date: Oct 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The AGA, ASGE, SAGES and AAO-HNS convened a group from a broad range of geographic locations with differing practice circumstances and settings - community, academic, teaching, and public; urban, suburban and rural; single and multi-specialty group; independent and employed - who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

Code 43200 *Esophagoscopy, flexible; transoral diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* was previously reviewed for practice expense in January 2003. All codes in the family of 43200-43232 are being reviewed for practice expense and physician work

Our specialties have identified the following reference codes for the Practice Expense inputs recommended for this code.

- Code 31575, *Laryngoscopy, flexible fiberoptic; diagnostic* was reviewed for practice expense in January 2003.
- Code 43236, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any substance* was reviewed for practice expense when the RUC reviewed this code in April 2002.
- Code 43246, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube* was reviewed for practice expense in February 2005.
- Code 91110, *Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report* was reviewed for practice expense when the RUC reviewed this code in April 2003
- Code 91038, *Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)* was reviewed for practice expense in February 2010.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

**Non-facility**

- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- Follow-up phone calls & prescriptions

Service Clinical Labor Activities:

**Non-Facility**

○ **Pre-Service**

- Greet patient, provide gowning, ensure appropriate medical records are available
- Obtain vital signs
- Provide pre-service education / obtain consent
- Enter pre-service procedure information into electronic medical record
- Enter pre-service vital signs into electronic medical record
- Prepare room, equipment, supplies
- Set up dilators
- Review / confirm procedure
- Prepare and position patient / monitor patient / set up IV
- Moderate sedation / observe (wait) anesthesia care

○ **Intra-service**

- Moderate sedation (RN, 100%, cannot perform any other tasks)
- Assist physician in performing procedure (RN, LPN, MTA, 100%)

○ **Post-service**

- Monitor patient following service.
- Check tubes, monitors, drains
- Clean room / equipment by physician staff
- Clean dilators
- Complete diagnostic forms, lab & X-ray requisitions
- Enter procedure information into electronic medical record
- Document that patient is stable for discharge from office
- Enter post-procedure information into electronic medical record
- Check dressings / home care instructions / coordinate office visits / prescriptions

○ **End: Patient leaves office**

Post-Service Clinical Labor Activities:

**Non-facility**

- Phone call

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor: Esophagoscopy, flexible, transoral; with optical endomicroscopy

Global Period: 000 Meeting Date: Oct 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The AGA, ASGE, and SAGES convened a group from a broad range of geographic locations with differing practice circumstances and settings - community, academic, teaching, and public; urban, suburban and rural; single and multi-specialty group; independent and employed - who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

Code 43206 *Esophagoscopy, flexible, transoral; with optical endomicroscopy* is a new code in this family referred to the RUC for evaluation by the CPT Editorial Panel in April 2012. All codes in the family of 43200-43232 are being reviewed for practice expense and physician work.

Our specialties have identified the following reference codes for the Practice Expense inputs recommended for this code.

- Code 31575, *Laryngoscopy, flexible fiberoptic; diagnostic* was reviewed for practice expense in January 2003.
- Code 43236, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any substance* was reviewed for practice expense when the RUC reviewed this code in April 2002.
- Code 43246, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube* was reviewed for practice expense in February 2005.
- Code 91110, *Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report* was reviewed for practice expense when the RUC reviewed this code in April 2003
- Code 91038, *Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)* was reviewed for practice expense in February 2010.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- Schedule space and equipment in facility
- Provide pre-service education/ obtain consent
- Follow-up phone calls and prescriptions

Service Clinical Labor Activities:

- None

Post-Service Clinical Labor Activities:

- Conduct phone calls /call in prescriptions

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor: Esophagoscopy, flexible, transoral; with optical endomicroscopy

Global Period: 000 Meeting Date: Oct 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The AGA, ASGE, and SAGES convened a group from a broad range of geographic locations with differing practice circumstances and settings - community, academic, teaching, and public; urban, suburban and rural; single and multi-specialty group; independent and employed - who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

Code 43206 *Esophagoscopy, flexible, transoral; with optical endomicroscopy* is a new code in this family referred to the RUC for evaluation by the CPT Editorial Panel in April 2012. All codes in the family of 43200-43232 are being reviewed for practice expense and physician work

Our specialties have identified the following reference codes for the Practice Expense inputs recommended for this code.

- Code 31575, *Laryngoscopy, flexible fiberoptic; diagnostic* was reviewed for practice expense in January 2003.
- Code 43236, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any substance* was reviewed for practice expense when the RUC reviewed this code in April 2002.
- Code 43246, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube* was reviewed for practice expense in February 2005.
- Code 91110, *Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report* was reviewed for practice expense when the RUC reviewed this code in April 2003
- Code 91038, *Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)* was reviewed for practice expense in February 2010.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

**Non-facility**

- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- Follow-up phone calls & prescriptions

Service Clinical Labor Activities:

**Non-Facility**

○ **Pre-Service**

- Greet patient, provide gowning, ensure appropriate medical records are available
- Obtain vital signs
- Provide pre-service education / obtain consent
- Enter pre-service procedure information into electronic medical record
- Enter pre-service vital signs into electronic medical record
- Prepare room, equipment, supplies
- Set up dilators
- Review / confirm procedure
- Prepare and position patient / monitor patient / set up IV
- Moderate sedation / observe (wait) anesthesia care

○ **Intra-service**

- Moderate sedation (RN, 100%, cannot perform any other tasks)
- Assist physician in performing procedure (RN, LPN, MTA, 100%)

○ **Post-service**

- Monitor patient following service.
- Check tubes, monitors, drains
- Clean room / equipment by physician staff
- Clean dilators
- Complete diagnostic forms, lab & X-ray requisitions
- Enter procedure information into electronic medical record
- Document that patient is stable for discharge from office
- Enter post-procedure information into electronic medical record
- Check dressings / home care instructions / coordinate office visits / prescriptions

○ **End: Patient leaves office**

Post-Service Clinical Labor Activities:

**Non-facility**

- Phone call

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor: Esophagoscopy, flexible, transoral; with directed submucosal injection(s), any substance

Global Period: 000 Meeting Date: Oct 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The AGA, ASGE, and SAGES convened a group from a broad range of geographic locations with differing practice circumstances and settings - community, academic, teaching, and public; urban, suburban and rural; single and multi-specialty group; independent and employed - who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

Code 43201, *Esophagoscopy, flexible, transoral; with directed submucosal injection(s), any substance* was last reviewed by the RUC in April 2002. All codes in the family of 43200-43232 are being reviewed for practice expense and physician work.

Our specialties have identified the following reference codes for the Practice Expense inputs recommended for this code.

- Code 31575, *Laryngoscopy, flexible fiberoptic; diagnostic* was reviewed for practice expense in January 2003.
- Code 43236, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any substance* was reviewed for practice expense when the RUC reviewed this code in April 2002.
- Code 43246, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube* was reviewed for practice expense in February 2005.
- Code 91110, *Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report* was reviewed for practice expense when the RUC reviewed this code in April 2003
- Code 91038, *Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)* was reviewed for practice expense in February 2010.

Please describe in detail the clinical activities of your staff:



Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- Schedule space and equipment in facility
- Provide pre-service education/ obtain consent
- Follow-up phone calls and prescriptions

Service Clinical Labor Activities:

- None

Post-Service Clinical Labor Activities:

- Conduct phone calls /call in prescriptions

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor: Esophagoscopy, flexible, transoral; with directed submucosal injection(s), any substance

Global Period: 000 Meeting Date: Oct 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The AGA, ASGE, and SAGES convened a group from a broad range of geographic locations with differing practice circumstances and settings - community, academic, teaching, and public; urban, suburban and rural; single and multi-specialty group; independent and employed - who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

Code 43201, *Esophagoscopy, flexible, transoral; with directed submucosal injection(s), any substance* was last reviewed by the RUC in April 2002. All codes in the family of 43200-43232 are being reviewed for practice expense and physician work

Our specialties have identified the following reference codes for the Practice Expense inputs recommended for this code.

- Code 31575, *Laryngoscopy, flexible fiberoptic; diagnostic* was reviewed for practice expense in January 2003.
- Code 43236, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any substance* was reviewed for practice expense when the RUC reviewed this code in April 2002.
- Code 43246, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube* was reviewed for practice expense in February 2005.
- Code 91110, *Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report* was reviewed for practice expense when the RUC reviewed this code in April 2003
- Code 91038, *Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)* was reviewed for practice expense in February 2010.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

**Non-facility**

- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- Follow-up phone calls & prescriptions

Service Clinical Labor Activities:

**Non-Facility**

○ **Pre-Service**

- Greet patient, provide gowning, ensure appropriate medical records are available
- Obtain vital signs
- Provide pre-service education / obtain consent
- Enter pre-service procedure information into electronic medical record
- Enter pre-service vital signs into electronic medical record
- Prepare room, equipment, supplies
- Set up dilators
- Review / confirm procedure
- Prepare and position patient / monitor patient / set up IV
- Moderate sedation / observe (wait) anesthesia care

○ **Intra-service**

- Moderate sedation (RN, 100%, cannot perform any other tasks)
- Assist physician in performing procedure (RN, LPN, MTA, 100%)

○ **Post-service**

- Monitor patient following service.
- Check tubes, monitors, drains
- Clean room / equipment by physician staff
- Clean dilators
- Complete diagnostic forms, lab & X-ray requisitions
- Enter procedure information into electronic medical record
- Document that patient is stable for discharge from office
- Enter post-procedure information into electronic medical record
- Check dressings / home care instructions / coordinate office visits / prescriptions

○ **End: Patient leaves office**

Post-Service Clinical Labor Activities:

**Non-facility**

- Phone call

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor: Esophagoscopy, flexible, transoral; with biopsy, single or multiple

Global Period: 000 Meeting Date: Oct 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The AGA, ASGE, SAGES and AAO-HNS convened a group from a broad range of geographic locations with differing practice circumstances and settings - community, academic, teaching, and public; urban, suburban and rural; single and multi-specialty group; independent and employed - who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

Code 43202, *Esophagoscopy, flexible, transoral; with biopsy, single or multiple* was previously reviewed for practice expense in January 2003. All codes in the family of 43200-43232 are being reviewed for practice expense and physician work.

Our specialties have identified the following reference codes for the Practice Expense inputs recommended for this code.

- Code 31575, *Laryngoscopy, flexible fiberoptic; diagnostic* was reviewed for practice expense in January 2003.
- Code 43236, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any substance* was reviewed for practice expense when the RUC reviewed this code in April 2002.
- Code 43246, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube* was reviewed for practice expense in February 2005.
- Code 91110, *Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report* was reviewed for practice expense when the RUC reviewed this code in April 2003
- Code 91038, *Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)* was reviewed for practice expense in February 2010.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic and referral forms

- Coordinate pre-surgery services
- Schedule space and equipment in facility
- Provide pre-service education/ obtain consent
- Follow-up phone calls and prescriptions

Service Clinical Labor Activities:

- None

Post-Service Clinical Labor Activities:

- Conduct phone calls /call in prescriptions

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor: Esophagoscopy, flexible, transoral; with biopsy, single or multiple

Global Period: 000 Meeting Date: Oct 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The AGA, ASGE, SAGES and AAO-HNS convened a group from a broad range of geographic locations with differing practice circumstances and settings - community, academic, teaching, and public; urban, suburban and rural; single and multi-specialty group; independent and employed - who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

Code 43202, *Esophagoscopy, flexible, transoral; with biopsy, single or multiple* was previously reviewed for practice expense in January 2003. All codes in the family of 43200-43232 are being reviewed for practice expense and physician work

Our specialties have identified the following reference codes for the Practice Expense inputs recommended for this code.

- Code 31575, *Laryngoscopy, flexible fiberoptic; diagnostic* was reviewed for practice expense in January 2003.
- Code 43236, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any substance* was reviewed for practice expense when the RUC reviewed this code in April 2002.
- Code 43246, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube* was reviewed for practice expense in February 2005.
- Code 91110, *Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report* was reviewed for practice expense when the RUC reviewed this code in April 2003
- Code 91038, *Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)* was reviewed for practice expense in February 2010.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

**Non-facility**

- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- Follow-up phone calls & prescriptions

Service Clinical Labor Activities:

**Non-Facility**

○ **Pre-Service**

- Greet patient, provide gowning, ensure appropriate medical records are available
- Obtain vital signs
- Provide pre-service education / obtain consent
- Enter pre-service procedure information into electronic medical record
- Enter pre-service vital signs into electronic medical record
- Prepare room, equipment, supplies
- Set up dilators
- Review / confirm procedure
- Prepare and position patient / monitor patient / set up IV
- Moderate sedation / observe (wait) anesthesia care

○ **Intra-service**

- Moderate sedation (RN, 100%, cannot perform any other tasks)
- Assist physician in performing procedure (RN, LPN, MTA, 100%)

○ **Post-service**

- Monitor patient following service.
- Check tubes, monitors, drains
- Clean room / equipment by physician staff
- Clean dilators
- Complete diagnostic forms, lab & X-ray requisitions
- Enter procedure information into electronic medical record
- Document that patient is stable for discharge from office
- Enter post-procedure information into electronic medical record
- Check dressings / home care instructions / coordinate office visits / prescriptions

○ **End: Patient leaves office**

Post-Service Clinical Labor Activities:

**Non-facility**

- Phone call

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor: Esophagoscopy, flexible, transoral; with injection sclerosis of esophageal varices

Global Period: 000 Meeting Date: Oct 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The AGA, ASGE, and SAGES convened a group from a broad range of geographic locations with differing practice circumstances and settings - community, academic, teaching, and public; urban, suburban and rural; single and multi-specialty group; independent and employed - who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

Code 43204, *Esophagoscopy, flexible, transoral; with injection sclerosis of esophageal varices* was last reviewed by the Practice Expense Subcommittee in January 2003. All codes in the family of 43200-43232 are being reviewed for practice expense and physician work.

Our specialties have identified the following reference codes for the Practice Expense inputs recommended for this code.

- Code 31575, *Laryngoscopy, flexible fiberoptic; diagnostic* was reviewed for practice expense in January 2003.
- Code 43236, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any substance* was reviewed for practice expense when the RUC reviewed this code in April 2002.
- Code 43246, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube* was reviewed for practice expense in February 2005.
- Code 91110, *Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report* was reviewed for practice expense when the RUC reviewed this code in April 2003
- Code 91038, *Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)* was reviewed for practice expense in February 2010.

Please describe in detail the clinical activities of your staff:



Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- Schedule space and equipment in facility
- Provide pre-service education/ obtain consent
- Follow-up phone calls and prescriptions

Service Clinical Labor Activities:

- None

Post-Service Clinical Labor Activities:

- Conduct phone calls /call in prescriptions

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor: Esophagoscopy, flexible, transoral; with band ligation of esophageal varices

Global Period: 000 Meeting Date: Oct 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The AGA, ASGE, and SAGES convened a group from a broad range of geographic locations with differing practice circumstances and settings - community, academic, teaching, and public; urban, suburban and rural; single and multi-specialty group; independent and employed - who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

Code 43205, *Esophagoscopy, flexible, transoral; with band ligation of esophageal varices* was last reviewed by the Practice Expense Subcommittee in January 2003. All codes in the family of 43200-43232 are being reviewed for practice expense and physician work.

Our specialties have identified the following reference codes for the Practice Expense inputs recommended for this code.

- Code 31575, *Laryngoscopy, flexible fiberoptic; diagnostic* was reviewed for practice expense in January 2003.
- Code 43236, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any substance* was reviewed for practice expense when the RUC reviewed this code in April 2002.
- Code 43246, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube* was reviewed for practice expense in February 2005.
- Code 91110, *Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report* was reviewed for practice expense when the RUC reviewed this code in April 2003
- Code 91038, *Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)* was reviewed for practice expense in February 2010.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- Schedule space and equipment in facility
- Provide pre-service education/ obtain consent
- Follow-up phone calls and prescriptions

Service Clinical Labor Activities:

- None

Post-Service Clinical Labor Activities:

- Conduct phone calls /call in prescriptions

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor: Esophagoscopy, flexible, transoral; with removal of foreign body

Global Period: 000

Meeting Date: Oct 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The AGA, ASGE, SAGES and AAO-HNS convened a group from a broad range of geographic locations with differing practice circumstances and settings - community, academic, teaching, and public; urban, suburban and rural; single and multi-specialty group; independent and employed - who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

Code 43215, *Esophagoscopy, flexible, transoral; with removal of foreign body* was previously reviewed for practice expense in January 2003. All codes in the family of 43200-43232 are being reviewed for practice expense and physician work.

Our specialties have identified the following reference codes for the Practice Expense inputs recommended for this code.

- Code 31575, *Laryngoscopy, flexible fiberoptic; diagnostic* was reviewed for practice expense in January 2003.
- Code 43236, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any substance* was reviewed for practice expense when the RUC reviewed this code in April 2002.
- Code 43246, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube* was reviewed for practice expense in February 2005.
- Code 91110, *Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report* was reviewed for practice expense when the RUC reviewed this code in April 2003
- Code 91038, *Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)* was reviewed for practice expense in February 2010.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- Schedule space and equipment in facility
- Provide pre-service education/ obtain consent
- Follow-up phone calls and prescriptions

Service Clinical Labor Activities:

- None

Post-Service Clinical Labor Activities:

- Conduct phone calls /call in prescriptions

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor: Esophagoscopy, flexible, transoral; with removal of foreign body

Global Period: 000 Meeting Date: Oct 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The AGA, ASGE, SAGES and AAO-HNS convened a group from a broad range of geographic locations with differing practice circumstances and settings - community, academic, teaching, and public; urban, suburban and rural; single and multi-specialty group; independent and employed - who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

Code 43215, *Esophagoscopy, flexible, transoral; with removal of foreign body* was previously reviewed for practice expense in January 2003. All codes in the family of 43200-43232 are being reviewed for practice expense and physician work

Our specialties have identified the following reference codes for the Practice Expense inputs recommended for this code.

- Code 31575, *Laryngoscopy, flexible fiberoptic; diagnostic* was reviewed for practice expense in January 2003.
- Code 43236, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any substance* was reviewed for practice expense when the RUC reviewed this code in April 2002.
- Code 43246, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube* was reviewed for practice expense in February 2005.
- Code 91110, *Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report* was reviewed for practice expense when the RUC reviewed this code in April 2003
- Code 91038, *Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)* was reviewed for practice expense in February 2010.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

**Non-facility**

- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- Follow-up phone calls & prescriptions

Service Clinical Labor Activities:

**Non-Facility**

○ **Pre-Service**

- Greet patient, provide gowning, ensure appropriate medical records are available
- Obtain vital signs
- Provide pre-service education / obtain consent
- Enter pre-service procedure information into electronic medical record
- Enter pre-service vital signs into electronic medical record
- Prepare room, equipment, supplies
- Set up dilators
- Review / confirm procedure
- Prepare and position patient / monitor patient / set up IV
- Moderate sedation / observe (wait) anesthesia care

○ **Intra-service**

- Moderate sedation (RN, 100%, cannot perform any other tasks)
- Assist physician in performing procedure (RN, LPN, MTA, 100%)

○ **Post-service**

- Monitor patient following service.
- Check tubes, monitors, drains
- Clean room / equipment by physician staff
- Clean dilators
- Complete diagnostic forms, lab & X-ray requisitions
- Enter procedure information into electronic medical record
- Document that patient is stable for discharge from office
- Enter post-procedure information into electronic medical record
- Check dressings / home care instructions / coordinate office visits / prescriptions

○ **End: Patient leaves office**

Post-Service Clinical Labor Activities:

**Non-facility**

- Phone call

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor: Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery

Global Period: 000 Meeting Date: Oct 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The AGA, ASGE, and SAGES convened a group from a broad range of geographic locations with differing practice circumstances and settings - community, academic, teaching, and public; urban, suburban and rural; single and multi-specialty group; independent and employed - who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

Code 43216, *Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery* was last reviewed by the Practice Expense Subcommittee in January 2004. All codes in the family of 43200-43232 are being reviewed for practice expense and physician work.

Our specialties have identified the following reference codes for the Practice Expense inputs recommended for this code.

- Code 31575, *Laryngoscopy, flexible fiberoptic; diagnostic* was reviewed for practice expense in January 2003.
- Code 43236, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any substance* was reviewed for practice expense when the RUC reviewed this code in April 2002.
- Code 43246, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube* was reviewed for practice expense in February 2005.
- Code 91110, *Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report* was reviewed for practice expense when the RUC reviewed this code in April 2003
- Code 91038, *Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)* was reviewed for practice expense in February 2010.



Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- Schedule space and equipment in facility
- Provide pre-service education/ obtain consent
- Follow-up phone calls and prescriptions

Service Clinical Labor Activities:

- None

Post-Service Clinical Labor Activities:

- Conduct phone calls /call in prescriptions

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 93582	Tracking Number U1	Original Specialty Recommended RVU: <b>14.00</b>
		Presented Recommended RVU: <b>14.00</b>
Global Period: 000		RUC Recommended RVU: <b>14.00</b>

CPT Descriptor: Percutaneous transcatheter closure of patent ductus arteriosus

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 10-month old presents for evaluation of a continuous heart murmur and is discovered to have a hemodynamically significant patent ductus arteriosus (PDA) by transthoracic echocardiography. The child is asymptomatic with good growth and appetite, yet has moderate left heart enlargement due to chronic left-to-right shunting via the PDA. Due to concern for the long-term effects of this volume overload the child is referred for catheter based intervention.

Percentage of Survey Respondents who found Vignette to be Typical: 71%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 44%

Is moderate sedation inherent to this procedure in the office setting?

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The patient's history, records, laboratory and diagnostic tests are reviewed. This may include review of the echocardiographic or other imaging studies. Physical examination is conducted. A clinical note is generated summarizing the clinical information if a recent note is not available. The patient is prepared for the procedure with careful documentation of baseline clinical findings such as vital signs, arterial pulses, allergies, electrocardiographic findings, laboratory results, family contact information, and other data. Appropriate pharmacologic therapy important for patient safety is ensured. Additional pre-procedure functions include writing orders for adequate sedation and patient support, and a review of study arrangements and procedures with technical, nursing and other assisting personnel. Appropriate communication is conducted with the patient and family as well as other medical professionals as needed. The procedure is reviewed with the patient and family. The risks and benefits of the procedure are presented, as well as the alternatives. Informed consent is obtained. Necessary equipment, instruments and supplies for the procedure are confirmed to be available and operational. The patient is positioned on the procedural table, attached to cardiac electrodes and an oxygen saturation monitor. A sterile table is prepared. The potential access sites are scrubbed in sterile fashion. A sterile drape is placed over the patient. The injection manifold and hemodynamic monitoring tubes and cables are set up. The patient's information is loaded in the hemodynamic monitoring equipment and into the angiographic digital archive in order to retain the data from the upcoming study. A "Time Out" occurs during which confirmation of critical information is ensured, such as the patient's identity, planned procedure, access route, allergies, completion of the consent process, availability of proper equipment, and any unusual circumstances which might influence the procedure. Conscious sedation is administered for those patients who have not required general anesthesia.

Description of Intra-Service Work: Percutaneous venous access is obtained, typically through the femoral vein. A thin-walled needle is inserted percutaneously into the vein through which a flexible guide wire is inserted into the vein. The needle is removed over the wire, a sheath/dilator system is inserted over the guide wire, the dilator is removed, and sidearm of the sheath is flushed to remove any clot or air. A pulmonary artery catheter is inserted through the sheath, a balloon on the tip of the catheter is inflated, and congenital right heart catheterization is performed. The catheter is passed through to the inferior vena cava, superior vena cava, right atrium, right ventricle and into the pulmonary artery. As the catheter tip passes through the heart into the lungs, pressure measurements are obtained within each cardiac chamber or major vessel. The catheter may be advanced further to a point that the balloon tip occludes the pulmonary artery. The pressure transduced from the tip of the catheter in this position represents a pulmonary wedge pressure, an indirect measurement of left atrial and left ventricular end diastolic pressure. Oxygen saturation measurements are obtained to assess for intracardiac shunts and to assess cardiac output. Blood gas measurements may also be performed. Measurements of cardiac output may be obtained. The shunt fraction is calculated. Serial injections may be performed through the catheter to measure thermodilution cardiac output.

A thin-walled needle is inserted percutaneously into a peripheral artery, through which a flexible guide wire is inserted into the artery. The needle is removed over the wire, a sheath/dilator system is inserted over the guide wire, the dilator is removed, and the sidearm of the sheath is flushed to remove any clot or air. An appropriate catheter is inserted over the wire through the sheath into the arterial system under fluoroscopic guidance. The catheter is advanced retrograde through the arterial system to the ascending aorta. The wire is removed and the catheter is attached to the pressure manifold. Pressure is measured in the aortic root. The catheter is then used to cross the aortic valve retrograde into the left ventricle. Left ventricular pressure is measured. The catheter is carefully pulled back across the aortic valve to assess for an aortic valve gradient. The catheter is then pulled back across the aortic arch and then into the descending aorta to assess for coarctation of the aorta.

The pigtail catheter is withdrawn to the level of the patent ductus arteriosus and biplane thoracic aortography is performed to visualize the ductus. More than one aortogram may be required to assess the ductus. Quantitative angiographic measurements are performed on the PDA. The length of the PDA and the diameters of the aortic end, pulmonary end, and body of the PDA are calculated.

Appropriate anticoagulation is administered to therapeutic levels. A catheter is advanced from the femoral artery and placed in the aorta and directed toward the patent ductus arteriosus. Another catheter is advanced into the left pulmonary artery (LPA) at the level of the PDA. A guide wire is advanced through the aortic catheter and attempts are initiated to cross the PDA from the aorta into the LPA. Frequently this requires several different catheters to find the best shape to direct the wire into the PDA. This requires several catheter exchanges over a guide wire to position the different catheters in the aorta at the level of the PDA. Multiple repositioning of the catheter(s) and multiple attempts to cross the PDA are generally required. This frequently also requires multiple angulations of the camera to help direct the wire across. Once the wire is across the PDA marking its location, a separate wire is advanced through the catheter in the LPA and a similar approach is used to try to direct a wire from the LPA across the PDA into the aorta. If this is not successful (as the wire is working against flow from the aorta through the ODA to the LPA), a loop snare is advanced through the PA catheter and positioned in the LPA at the position of the PDA entry site. The snare is used to capture the wire coming from the aorta across the PDA and into the LPA. Typically this requires multiple repositioning of the PA catheter. Once the wire is passed through the snare, the snare is tightened to capture the wire and the wire is brought back through the right heart chambers and out through the femoral vein sheath. This creates a "rail" from the femoral vein, through the right heart, through the LPA, across the PDA into the aorta, and down the aorta to the femoral artery and then out of the body. Exquisite attention is required to prevent wire trauma to the pulmonary valve, tricuspid valve and the subvalvular apparatus.

Once a wire position is established from the LPA across the PDA to the aorta, an appropriate catheter is advanced over the wire from the femoral vein through the right heart, through the PDA and into the descending aorta. The wire is withdrawn through the catheter and replaced with a stiff wire. Next a delivery sheath is advanced over the wire from the femoral vein through the right heart, through the LPA, across the PDA into the aorta, and down into the descending aorta. The sheath is flushed. An appropriate size occlude device is selected. A pigtail catheter is now advanced from the femoral artery up to the level of the PDA again and connected to a power injector. The occluder is advanced through the delivery sheath to near the distal end of the sheath. The sheath is withdrawn back to the aortic entrance to the PDA. The distal end of the occluder is extruded from the sheath and the sheath and occlude are pulled back to seat the device in the aortic entrance to the PDA. Biplane aortogram is performed to ensure the device is seated appropriately at the aortic end. The sheath is then withdrawn while holding tension on the occluder delivery cable to keep it in place. The device is thus deployed in the PDA back to its pulmonary end. Biplane aortogram is now performed to ensure the device is seated appropriately at both the

aortic and pulmonary ends. If the device is not appropriately seated or sized, the delivery sheath is advanced over the device to recapture the occluder. The occluder is removed and the same procedure is performed with a better sized device. Once the device is in proper position angiographically, the device is released by unscrewing its delivery cable from the occluder. At this point, the patient is monitored for device embolization under fluoroscopy.

The patient is then observed for a period of time to ensure the device does not move. Aortography is typically performed again to assess PDA closure and to ensure no aortic trauma. The pigtail is used to recross the aortic valve and remeasure left ventricular end diastolic pressure to ensure the left ventricle is tolerating the increased afterload. The occluder delivery sheath is removed over a wire and a pulmonary artery catheter is often used to repeat the right heart catheterization to assess hemodynamics using the same technique as described for the initial right heart catheterization.

The patient's arterial pressure, electrocardiogram, and oxygen saturation are constantly monitored through the procedure. All catheters are removed once angiography is completed. Images are reviewed to ensure no additional views are required before leaving the procedure suite. Angiography of the access site may be performed to assess for any complications and suitability for a percutaneous closure device. The catheters and sheaths are removed and hemostasis is achieved by appropriate means by the physician or technician under the physician's supervision.

Description of Post-Service Work: Angiographic images and hemodynamics are reviewed and a formal report is generated. The patient family and the referring physician are notified of the results. When appropriate, a plan of management is developed and implemented and discussed with the patient and family. The patient is observed to ensure no bleeding from the access site prior to disposition. Post procedural vital signs and telemetry are monitored to ensure no immediate complication.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	01/2013				
<b>Presenter(s):</b>	Richard Wright, MD; Cliff Kavinsky, MD				
<b>Specialty(s):</b>	ACC, SCAI				
<b>CPT Code:</b>	93582				
<b>Sample Size:</b>	86	<b>Resp N:</b>	41	<b>Response:</b> 47.6 %	
<b>Description of Sample:</b>	Random: survey was distributed to the entire SCAI membership to identify volunteers and surveys were sent to those who indicated they would complete.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	6.00	<b>12.00</b>	20.00	40.00
<b>Survey RVW:</b>	5.00	14.00	<b>15.00</b>	18.00	24.30
<b>Pre-Service Evaluation Time:</b>			<b>65.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>15.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>15.00</b>		
<b>Intra-Service Time:</b>	20.00	60.00	<b>60.00</b>	90.00	150.00
<b>Immediate Post Service-Time:</b>	<b>45.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

**Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:** 3 -FAC Straightforward Patient/Difficult Procedure

<b>CPT Code:</b>	93582	<b>Recommended Physician Work RVU: 14.00</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>33.00</b>	<b>33.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>3.00</b>	<b>3.00</b>	<b>0.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>15.00</b>	<b>15.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>60.00</b>		
<b>Immediate Post Service-Time:</b>	<b>45.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
93580	000	17.97	RUC Time

CPT Descriptor Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
-----------------------	---------------	-----------------	--------------------	---

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
-----------------------	---------------	-----------------	--------------------	---

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
---------------------------------	---------------	-----------------	--------------------

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 33      % of respondents: 80.4 %

**TIME ESTIMATES (Median)**

	<b>CPT Code:</b> 93582	<b>Key Reference CPT Code:</b> 93580	<b>Source of Time</b> RUC Time
Median Pre-Service Time	51.00	30.00	
Median Intra-Service Time	60.00	120.00	
Median Immediate Post-service Time	45.00	60.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
<b>Median Total Time</b>	<b>156.00</b>	<b>210.00</b>	
<b>Other time if appropriate</b>			

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.21	3.55
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.18	3.61
--	------	------

Urgency of medical decision making	2.85	2.97
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.88	4.03
--------------------------	------	------

Physical effort required	3.33	3.48
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.61	3.91
---	------	------

Outcome depends on the skill and judgment of physician	4.03	4.24
--	------	------

Estimated risk of malpractice suit with poor outcome	3.82	4.12
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.85	3.09
----------------------------------	------	------

Intra-Service intensity/complexity	3.52	3.82
------------------------------------	------	------

Post-Service intensity/complexity	2.94	3.09
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Code 93582 will be used to report transcatheter repair of patent ductus arteriosus (PDA closure). This service has previously been reported with codes 37204 and 75894. These two codes are used to report a wide array of cardiovascular embolization procedures, and were identified as frequently reported together. ACC, ACR, SIR, and SVS referred the issue to CPT for creation of new bundled codes for relevant services. 93582 addresses only the transcatheter PDA closure service.

An email seeking survey volunteers was sent to the entire membership of the Society for Cardiovascular Angiography and Interventions (SCAI). Surveys were distributed to those who responded, a method previously accepted as random by the RUC. The survey was completed by physicians who have experience providing the service.

A RUC panel from ACC and SCAI reviewed the preservice time and selected package 4 for a difficult procedure on a difficult patient undergoing a procedure in a facility with adjustment to the time for scrub/dress/wait to reflect the survey.

The key reference service is 93580, Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant. Survey respondents indicated that 93582 takes less time and is less intense/complex to perform than 93580. The median survey RVU was 15.00.

We recommend a work RVU of 14.00, the survey 25<sup>th</sup> percentile. The RUC panel determined it is more appropriate than the median for this service. The resulting increase in intensity compared to the key reference code is reasonable since this rare procedure is performed by few cardiologists on infants.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) In 2010, code 37204 (reported with 75894) appeared on the RAW screen identifying codes reported together 75% or more with recommendation made by ACC, ACR, SIR and SVS to refer this service to CPT for the development of new bundled codes that will more accurately reflect the current clinical practice of these procedures. Codes 37204/75894 are currently used to report a very wide array of cardiovascular embolization procedures. This proposal seeks to create a bundled code specific for reporting transcatheter PDA closure. Additionally, commercial carriers' coding guidelines for PDA have not been consistent across the country with at least one carrier recommending use of an unlisted code for one type of transcatheter PDA closure. Using an unlisted code to report such a well-established, typically covered procedure creates an undue burden on practices performing these procedures and carriers claims processing systems.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty cardiology                      How often? Rarely

Specialty                      How often?



Specialty

How often?

Estimate the number of times this service might be provided nationally in a one-year period? 4800

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Without a specific code to report and track utilization for transcatheter PDA closure, we do not have precise utilization estimates. The preliminary number of U.S. births in 2010 was 4,000,279. (Source: [http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60\\_02.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_02.pdf); viewed 6/6/12). From available sources (<http://emedicine.medscape.com/article/891096-overview#a0156>), PDA occurs in 0.002 to 0.008%, supporting estimates of 2,000 to 32,000 babies born each year suffering from PDA. Depending on the physiology, PDA may be treated medically or surgically using either open or transcatheter-based techniques. Using the highest estimates of incidence, and assuming that 15% of these children eventually require treatment using the minimally invasive transcatheter techniques, approximately 4,800 patients could be treated each year with transcatheter PDA closure.

Specialty cardiology	Frequency less than 4800	Percentage 100.00 %
----------------------	--------------------------	---------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States?

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 93580

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor: Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique

Global Period: 000 Meeting Date: Oct 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The AGA, ASGE, and SAGES convened a group from a broad range of geographic locations with differing practice circumstances and settings - community, academic, teaching, and public; urban, suburban and rural; single and multi-specialty group; independent and employed - who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

Code 43217, *Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique* was last reviewed by the Practice Expense Subcommittee in January 2003. All codes in the family of 43200-43232 are being reviewed for practice expense and physician work.

Our specialties have identified the following reference codes for the Practice Expense inputs recommended for this code.

- Code 31575, *Laryngoscopy, flexible fiberoptic; diagnostic* was reviewed for practice expense in January 2003.
- Code 43236, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any substance* was reviewed for practice expense when the RUC reviewed this code in April 2002.
- Code 43246, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube* was reviewed for practice expense in February 2005.
- Code 91110, *Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report* was reviewed for practice expense when the RUC reviewed this code in April 2003
- Code 91038, *Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)* was reviewed for practice expense in February 2010.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- Schedule space and equipment in facility
- Provide pre-service education/ obtain consent
- Follow-up phone calls and prescriptions

Service Clinical Labor Activities:

- None

Post-Service Clinical Labor Activities:

- Conduct phone calls /call in prescriptions

**AMA/Specialty Society Update Process**  
**Practice Expense Summary of Recommendation**  
**Non Facility Direct Inputs**

CPT Long Descriptor: Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique

Global Period: 000 Meeting Date: Oct 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The AGA, ASGE, and SAGES convened a group from a broad range of geographic locations with differing practice circumstances and settings - community, academic, teaching, and public; urban, suburban and rural; single and multi-specialty group; independent and employed - who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

Code 43217, *Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique* was last reviewed by the Practice Expense Subcommittee in January 2003. All codes in the family of 43200-43232 are being reviewed for practice expense and physician work

Our specialties have identified the following reference codes for the Practice Expense inputs recommended for this code.

- Code 31575, *Laryngoscopy, flexible fiberoptic; diagnostic* was reviewed for practice expense in January 2003.
- Code 43236, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any substance* was reviewed for practice expense when the RUC reviewed this code in April 2002.
- Code 43246, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube* was reviewed for practice expense in February 2005.
- Code 91110, *Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report* was reviewed for practice expense when the RUC reviewed this code in April 2003
- Code 91038, *Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)* was reviewed for practice expense in February 2010.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

**Non-facility**

- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- Follow-up phone calls & prescriptions

Service Clinical Labor Activities:

**Non-Facility**

○ **Pre-Service**

- Greet patient, provide gowning, ensure appropriate medical records are available
- Obtain vital signs
- Provide pre-service education / obtain consent
- Enter pre-service procedure information into electronic medical record
- Enter pre-service vital signs into electronic medical record
- Prepare room, equipment, supplies
- Set up dilators
- Review / confirm procedure
- Prepare and position patient / monitor patient / set up IV
- Moderate sedation / observe (wait) anesthesia care

○ **Intra-service**

- Moderate sedation (RN, 100%, cannot perform any other tasks)
- Assist physician in performing procedure (RN, LPN, MTA, 100%)

○ **Post-service**

- Monitor patient following service.
- Check tubes, monitors, drains
- Clean room / equipment by physician staff
- Clean dilators
- Complete diagnostic forms, lab & X-ray requisitions
- Enter procedure information into electronic medical record
- Document that patient is stable for discharge from office
- Enter post-procedure information into electronic medical record
- Check dressings / home care instructions / coordinate office visits / prescriptions

○ **End: Patient leaves office**

Post-Service Clinical Labor Activities:

**Non-facility**

- Phone call

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor: Esophagoscopy, flexible, transoral; with insertion of plastic tube or stent

Global Period: 000 Meeting Date: Oct 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The AGA, ASGE, and SAGES convened a group from a broad range of geographic locations with differing practice circumstances and settings - community, academic, teaching, and public; urban, suburban and rural; single and multi-specialty group; independent and employed - who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

Code 43219, *Esophagoscopy, flexible, transoral; with insertion of plastic tube or stent* was last reviewed by the Practice Expense Subcommittee in January 2003. All codes in the family of 43200-43232 are being reviewed for practice expense and physician work.

Our specialties have identified the following reference codes for the Practice Expense inputs recommended for this code.

- Code 31575, *Laryngoscopy, flexible fiberoptic; diagnostic* was reviewed for practice expense in January 2003.
- Code 43236, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any substance* was reviewed for practice expense when the RUC reviewed this code in April 2002.
- Code 43246, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube* was reviewed for practice expense in February 2005.
- Code 91110, *Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report* was reviewed for practice expense when the RUC reviewed this code in April 2003
- Code 91038, *Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)* was reviewed for practice expense in February 2010.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- Schedule space and equipment in facility
- Provide pre-service education/ obtain consent
- Follow-up phone calls and prescriptions

Service Clinical Labor Activities:

- None

Post-Service Clinical Labor Activities:

- Conduct phone calls /call in prescriptions

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor: Esophagoscopy, flexible, transoral; with balloon dilation (less than 30 mm diameter)

Global Period: 000 Meeting Date: Oct 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The AGA, ASGE, and SAGES convened a group from a broad range of geographic locations with differing practice circumstances and settings - community, academic, teaching, and public; urban, suburban and rural; single and multi-specialty group; independent and employed - who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

Code 43220, *Esophagoscopy, flexible, transoral; with balloon dilation (less than 30 mm diameter)* was last reviewed by the Practice Expense Subcommittee in January 2003. All codes in the family of 43200-43232 are being reviewed for practice expense and physician work.

Our specialties have identified the following reference codes for the Practice Expense inputs recommended for this code.

- Code 31575, *Laryngoscopy, flexible fiberoptic; diagnostic* was reviewed for practice expense in January 2003.
- Code 43236, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any substance* was reviewed for practice expense when the RUC reviewed this code in April 2002.
- Code 43246, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube* was reviewed for practice expense in February 2005.
- Code 91110, *Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report* was reviewed for practice expense when the RUC reviewed this code in April 2003
- Code 91038, *Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)* was reviewed for practice expense in February 2010.

Please describe in detail the clinical activities of your staff:



Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- Schedule space and equipment in facility
- Provide pre-service education/ obtain consent
- Follow-up phone calls and prescriptions

Service Clinical Labor Activities:

- None

Post-Service Clinical Labor Activities:

- Conduct phone calls /call in prescriptions

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor: Esophagoscopy, flexible, transoral; with balloon dilation (less than 30 mm diameter)

Global Period: 000 Meeting Date: Oct 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The AGA, ASGE, and SAGES convened a group from a broad range of geographic locations with differing practice circumstances and settings - community, academic, teaching, and public; urban, suburban and rural; single and multi-specialty group; independent and employed - who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

Code 43220, *Esophagoscopy, flexible, transoral; with balloon dilation (less than 30 mm diameter)* was last reviewed by the Practice Expense Subcommittee in January 2003. All codes in the family of 43200-43232 are being reviewed for practice expense and physician work

Our specialties have identified the following reference codes for the Practice Expense inputs recommended for this code.

- Code 31575, *Laryngoscopy, flexible fiberoptic; diagnostic* was reviewed for practice expense in January 2003.
- Code 43236, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any substance* was reviewed for practice expense when the RUC reviewed this code in April 2002.
- Code 43246, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube* was reviewed for practice expense in February 2005.
- Code 91110, *Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report* was reviewed for practice expense when the RUC reviewed this code in April 2003
- Code 91038, *Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)* was reviewed for practice expense in February 2010.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

**Non-facility**

- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- Follow-up phone calls & prescriptions

Service Clinical Labor Activities:

**Non-Facility**

○ **Pre-Service**

- Greet patient, provide gowning, ensure appropriate medical records are available
- Obtain vital signs
- Provide pre-service education / obtain consent
- Enter pre-service procedure information into electronic medical record
- Enter pre-service vital signs into electronic medical record
- Prepare room, equipment, supplies
- Set up dilators
- Review / confirm procedure
- Prepare and position patient / monitor patient / set up IV
- Moderate sedation / observe (wait) anesthesia care

○ **Intra-service**

- Moderate sedation (RN, 100%, cannot perform any other tasks)
- Assist physician in performing procedure (RN, LPN, MTA, 100%)

○ **Post-service**

- Monitor patient following service.
- Check tubes, monitors, drains
- Clean room / equipment by physician staff
- Clean dilators
- Complete diagnostic forms, lab & X-ray requisitions
- Enter procedure information into electronic medical record
- Document that patient is stable for discharge from office
- Enter post-procedure information into electronic medical record
- Check dressings / home care instructions / coordinate office visits / prescriptions

○ **End: Patient leaves office**

Post-Service Clinical Labor Activities:

**Non-facility**

- Phone call

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor: Esophagoscopy, flexible, transoral; with insertion of guide wire followed by dilation over guide wire

Global Period: 000

Meeting Date: Oct 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The AGA, ASGE, SAGES and AAO-HNS convened a group from a broad range of geographic locations with differing practice circumstances and settings - community, academic, teaching, and public; urban, suburban and rural; single and multi-specialty group; independent and employed - who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

Code 43226, *Esophagoscopy, flexible, transoral; with insertion of guide wire followed by dilation over guide wire* was previously reviewed for practice expense in January 2003. All codes in the family of 43200-43232 are being reviewed for practice expense and physician work.

Our specialties have identified the following reference codes for the Practice Expense inputs recommended for this code.

- Code 31575, *Laryngoscopy, flexible fiberoptic; diagnostic* was reviewed for practice expense in January 2003.
- Code 43236, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any substance* was reviewed for practice expense when the RUC reviewed this code in April 2002.
- Code 43246, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube* was reviewed for practice expense in February 2005.
- Code 91110, *Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report* was reviewed for practice expense when the RUC reviewed this code in April 2003
- Code 91038, *Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)* was reviewed for practice expense in February 2010.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- Schedule space and equipment in facility
- Provide pre-service education/ obtain consent
- Follow-up phone calls and prescriptions

Service Clinical Labor Activities:

- None

Post-Service Clinical Labor Activities:

- Conduct phone calls /call in prescriptions

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor: Esophagoscopy, flexible, transoral; with insertion of guide wire followed by dilation over guide wire

Global Period: 000 Meeting Date: Oct 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The AGA, ASGE, SAGES and AAO-HNS convened a group from a broad range of geographic locations with differing practice circumstances and settings - community, academic, teaching, and public; urban, suburban and rural; single and multi-specialty group; independent and employed - who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

Code 43226, *Esophagoscopy, flexible, transoral; with insertion of guide wire followed by dilation over guide wire* was previously reviewed for practice expense in January 2003. All codes in the family of 43200-43232 are being reviewed for practice expense and physician work

Our specialties have identified the following reference codes for the Practice Expense inputs recommended for this code.

- Code 31575, *Laryngoscopy, flexible fiberoptic; diagnostic* was reviewed for practice expense in January 2003.
- Code 43236, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any substance* was reviewed for practice expense when the RUC reviewed this code in April 2002.
- Code 43246, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube* was reviewed for practice expense in February 2005.
- Code 91110, *Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report* was reviewed for practice expense when the RUC reviewed this code in April 2003
- Code 91038, *Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)* was reviewed for practice expense in February 2010.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

**Non-facility**

- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- Follow-up phone calls & prescriptions

Service Clinical Labor Activities:

**Non-Facility**

○ **Pre-Service**

- Greet patient, provide gowning, ensure appropriate medical records are available
- Obtain vital signs
- Provide pre-service education / obtain consent
- Enter pre-service procedure information into electronic medical record
- Enter pre-service vital signs into electronic medical record
- Prepare room, equipment, supplies
- Set up dilators
- Review / confirm procedure
- Prepare and position patient / monitor patient / set up IV
- Moderate sedation / observe (wait) anesthesia care

○ **Intra-service**

- Moderate sedation (RN, 100%, cannot perform any other tasks)
- Assist physician in performing procedure (RN, LPN, MTA, 100%)

○ **Post-service**

- Monitor patient following service.
- Check tubes, monitors, drains
- Clean room / equipment by physician staff
- Clean dilators
- Complete diagnostic forms, lab & X-ray requisitions
- Enter procedure information into electronic medical record
- Document that patient is stable for discharge from office
- Enter post-procedure information into electronic medical record
- Check dressings / home care instructions / coordinate office visits / prescriptions

○ **End: Patient leaves office**

Post-Service Clinical Labor Activities:

**Non-facility**

- Phone call

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor: Esophagoscopy, flexible, transoral; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)

Global Period: 000 Meeting Date: Oct 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The AGA, ASGE, and SAGES convened a group from a broad range of geographic locations with differing practice circumstances and settings - community, academic, teaching, and public; urban, suburban and rural; single and multi-specialty group; independent and employed - who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

Code 43227, *Esophagoscopy, flexible, transoral; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)* was last reviewed by the Practice Expense Subcommittee in January 2003. All codes in the family of 43200-43232 are being reviewed for practice expense and physician work.

Our specialties have identified the following reference codes for the Practice Expense inputs recommended for this code.

- Code 31575, *Laryngoscopy, flexible fiberoptic; diagnostic* was reviewed for practice expense in January 2003.
- Code 43236, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any substance* was reviewed for practice expense when the RUC reviewed this code in April 2002.
- Code 43246, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube* was reviewed for practice expense in February 2005.
- Code 91110, *Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report* was reviewed for practice expense when the RUC reviewed this code in April 2003
- Code 91038, *Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)* was reviewed for practice expense in February 2010.



Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- Schedule space and equipment in facility
- Provide pre-service education/ obtain consent
- Follow-up phone calls and prescriptions

Service Clinical Labor Activities:

- None

Post-Service Clinical Labor Activities:

- Conduct phone calls /call in prescriptions

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor: Esophagoscopy, flexible, transoral; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)

Global Period: 000 Meeting Date: Oct 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The AGA, ASGE, and SAGES convened a group from a broad range of geographic locations with differing practice circumstances and settings - community, academic, teaching, and public; urban, suburban and rural; single and multi-specialty group; independent and employed - who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

Code 43227, *Esophagoscopy, flexible, transoral; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)* was last reviewed by the Practice Expense Subcommittee in January 2003. All codes in the family of 43200-43232 are being reviewed for practice expense and physician work

Our specialties have identified the following reference codes for the Practice Expense inputs recommended for this code.

- Code 31575, *Laryngoscopy, flexible fiberoptic; diagnostic* was reviewed for practice expense in January 2003.
- Code 43236, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any substance* was reviewed for practice expense when the RUC reviewed this code in April 2002.
- Code 43246, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube* was reviewed for practice expense in February 2005.
- Code 91110, *Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report* was reviewed for practice expense when the RUC reviewed this code in April 2003
- Code 91038, *Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)* was reviewed for practice expense in February 2010.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

**Non-facility**

- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- Follow-up phone calls & prescriptions

Service Clinical Labor Activities:

**Non-Facility**

- **Pre-Service**
  - Greet patient, provide gowning, ensure appropriate medical records are available
  - Obtain vital signs
  - Provide pre-service education / obtain consent
  - Enter pre-service procedure information into electronic medical record
  - Enter pre-service vital signs into electronic medical record
  - Prepare room, equipment, supplies
  - Set up dilators
  - Review / confirm procedure
  - Prepare and position patient / monitor patient / set up IV
  - Moderate sedation / observe (wait) anesthesia care
- **Intra-service**
  - Moderate sedation (RN, 100%, cannot perform any other tasks)
  - Assist physician in performing procedure (RN, LPN, MTA, 100%)
- **Post-service**
  - Monitor patient following service.
  - Check tubes, monitors, drains
  - Clean room / equipment by physician staff
  - Clean dilators
  - Complete diagnostic forms, lab & X-ray requisitions
  - Enter procedure information into electronic medical record
  - Document that patient is stable for discharge from office
  - Enter post-procedure information into electronic medical record
  - Check dressings / home care instructions / coordinate office visits / prescriptions
- **End: Patient leaves office**

Post-Service Clinical Labor Activities:

**Non-facility**

- Phone call

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor:

43231	Esophagoscopy, flexible, transoral; with endoscopic ultrasound examination
43232	Esophagoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)

Global Period: 000

Meeting Date: April 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The ACG, AGA and ASGE convened a group from a broad range of geographic locations with differing practice circumstances and settings - community, academic, teaching, and public; urban, suburban and rural; single and multi-specialty group; independent and employed - who typically perform these services. The committee served as the consensus panel to develop PE recommendations.

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

Current Time data					Survey Code Recommendation			
CPT	Source	Pre	Intra	Post	CPT	Pre	Intra	Post
43231	PEAC-03	19	0	3	<b>43231</b>	19	0	3
43232	PEAC-03	19	0	3	<b>43232</b>	19	0	3

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time: NA

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence: NA

5. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

For all codes shown above:

- Three minutes to complete pre-service diagnostic and referral forms.
- Five minutes to coordinate pre-surgery services with other qualified healthcare providers
- Three minutes for scheduling space and equipment in facility
- Five minutes to perform pre-service education/ obtain consent
- Three minutes for pre-op prescriptions

Intra-Service Clinical Labor Activities:

NA

Post-Service Clinical Labor Activities:

For all codes shown above:

- Three minutes for a follow-up phone call to patient

## AMA/Specialty Society Update Process Practice Expense Summary of Recommendation **Facility Direct Inputs**

**CPT Code / Long Descriptor:**

<b>43211</b>	Esophagoscopy, flexible, transoral; with endoscopic mucosal resection
<b>43213</b>	Esophagoscopy, flexible, transoral; with dilation of esophagus, by balloon or dilator, retrograde (includes fluoroscopic guidance, when performed)
<b>43214</b>	Esophagoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)
<b>43212</b>	Esophagoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)
<b>43229</b>	Esophagoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)

**Global Period: 000**

**Meeting Date: January 2013**

**1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:**

The AGA and ASGE convened a group from a broad range of geographic locations with differing practice circumstances and settings - community, academic, teaching, and public; urban, suburban and rural; single and multi-specialty group; independent and employed - who typically perform these services. The committee served as the consensus panel to develop PE recommendations.

**2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

These are all new services. Reference codes chosen are matched where possible with the similar service for esophagoscopy. All crosswalk reference codes were just reviewed and approved by the PE Subcommittee in October 2012.

Crosswalk Code Data					Survey Code Recommendation			
CPT	Source	Pre	Intra	Post	CPT	Pre	Intra	Post
<b>43217</b>	RUC-12	19	0	3	<b>43211</b>	19	0	3
<b>43220</b>	RUC-12	19	0	3	<b>43213</b>	19	0	3
<b>43220</b>	RUC-12	19	0	3	<b>43214</b>	19	0	3
<b>43219</b>	RUC-12	19	0	3	<b>43212</b>	19	0	3
<b>43228</b>	RUC-12	19	0	3	<b>43229</b>	19	0	3

**3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:**

N/A

**4. Please describe in detail the clinical activities of your staff:**

Pre-Service Clinical Labor Activities:

- Three minutes to complete pre-service diagnostic and referral forms.
- Five minutes to coordinate pre-surgery services with other qualified healthcare providers
- Three minutes for scheduling space and equipment in facility
- Five minutes to perform pre-service education/ obtain consent
- Three minutes for pre-op prescriptions

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

- Three minutes for a follow-up phone call to patient

## AMA/Specialty Society Update Process Practice Expense Summary of Recommendation **Non-Facility Direct Inputs**

**Tab 9 - CPT Code / Long Descriptor:**

<b>43211</b>	N/A NON-FACILITY ONLY
<b>43213</b>	Esophagoscopy, flexible, transoral; with dilation of esophagus, by balloon or dilator, retrograde (includes fluoroscopic guidance, when performed)
<b>43214</b>	N/A NON-FACILITY ONLY
<b>43212</b>	N/A NON-FACILITY ONLY
<b>43229</b>	Esophagoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)

**Global Period: 000**

**Meeting Date: January 2013**

**1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:**

The AGA and ASGE convened a group from a broad range of geographic locations with differing practice circumstances and settings - community, academic, teaching, and public; urban, suburban and rural; single and multi-specialty group; independent and employed - who typically perform these services. The committee served as the consensus panel to develop PE recommendations.

**2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

These are all new services. Reference codes chosen are matched where possible with a similar service for esophagoscopy. All crosswalk reference codes were just reviewed and approved by the PE Subcommittee in October 2012.

Crosswalk Code Data (non-RN*)					Survey Code non-RN* Recommendation			
CPT	Source	Pre	Intra	Post	CPT	Pre	Intra	Post
<b>43220</b>	RUC-12	9	78	3	<b>43213</b>	9	103	3
<b>43228</b>	RUC-12	9	93	3	<b>43229</b>	9	103	3

**\* Note: RN time** will be equal to 2 minutes (standard for sedate apply MS) PLUS 100% physician time for scope-in-scope out PLUS 15 minutes to monitor the patient after scope out during anesthesia reversal

**3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:**

N/A – these are new codes.

**4. Please describe in detail the clinical activities of your staff:**

Pre-Service Clinical Labor Activities:

- Three minutes to complete pre-service diagnostic and referral forms.
- Five minutes to coordinate pre-surgery services with other qualified healthcare providers
- Three minutes for pre-op prescriptions

Intra-Service Clinical Labor Activities:

- Three minutes: Greet patient, provide gowning, ensure appropriate medical records are available
- Five minutes: 4-6 vitals
- Three minutes: Provide pre-service education/obtain consent
- Two minutes: Prepare room, equipment, supplies
- Five minutes: Setup scope (non facility setting only)
- Two minutes: Prepare and position patient/ monitor patient/ set up IV
- Minutes vary with procedure – 100% MD time to assist physician in performing procedure
- Three minutes: Clean room/equipment by physician staff
- Thirty minutes: Clean flexible scope
- Two minutes: Complete diagnostic forms, lab & X-ray requisitions
- Three minutes: Check dressings & wound/ home care instructions /coordinate office visits /prescriptions

Post-Service Clinical Labor Activities:

- Three minutes for a follow-up phone call to patient



			Reference CPT Code # 31622		RECOMMENDED CPT Code 43197						Reference CPT Code # 31625		RECOMMENDED CPT Code 43198			
Meeting Date: October 2012 Tab: 10 Specialty: AAO-HNS			Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)				Esophagoscopy, flexible, transnasal; diagnostic, includes collection of specimen(s) by brushing, when performed.				Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple site				Esophagoscopy, flexible, transnasal; with biopsy, single or multiple.	
	CMS Code	Staff Type			CMS Code	Staff Type			CMS Code	Staff Type			CMS Code	Staff Type		
LOCATION			Non Fac	Facility			Non Fac	Facility			Non Fac	Facility			Non Fac	Facility
GLOBAL PERIOD 000			000	000			000	000			000	000			000	000
TOTAL CLINICAL LABOR TIME	L307D	RN/LPN/MTA	91.0	15.0	L026A	Medical/Technical Assistant	72.0	0.0	L307D	RN/LPN/MTA	97.0	15.0	L026A	Medical/Technical Assistant	79.0	0.0
TOTAL CLINICAL LABOR TIME	L051A	RN	42.0	0.0	L051A	RN	0.0	0.0	L051A	RN	52.0	0.0	L051A	RN	0.0	0.0
TOTAL PRE-SERV CLINICAL LABOR TIME	L307D	RN/LPN/MTA	15.0	15.0	L026A	Medical/Technical Assistant	0.0	0.0	L307D	RN/LPN/MTA	18.0	15.0	L026A	Medical/Technical Assistant	0.0	0.0
TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L307D	RN/LPN/MTA	76.0	0.0	L026A	Medical/Technical Assistant	69.0	0.0	L307D	RN/LPN/MTA	79.0	0.0	L026A	Medical/Technical Assistant	76.0	0.0
TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	42.0	0.0	L051A	RN	0.0	0.0	L051A	RN	52.0	0.0	L051A	RN	0.0	0.0
TOTAL POST-SERV CLINICAL LABOR TIME	L307D	RN/LPN/MTA	0.0	0.0	L026A	Medical/Technical Assistant	3.0	0.0	L307D	RN/LPN/MTA	0.0	0.0	L026A	Medical/Technical Assistant	3.0	0.0
PRE-SERVICE																
Start: Following visit when decision for surgery or procedure made																
Complete pre-service diagnostic & referral forms	L307D	RN/LPN/MTA	5	5	L026A	Medical/Technical Assistant	0	0	L307D	RN/LPN/MTA	5	5	L026A	Medical/Technical Assistant	0	0
Coordinate pre-surgery services	L307D	RN/LPN/MTA	3	5	L026A	Medical/Technical Assistant	0	0	L307D	RN/LPN/MTA	3	5	L026A	Medical/Technical Assistant	0	0
Schedule space and equipment in facility	L307D	RN/LPN/MTA	0	3	L026A	Medical/Technical Assistant	0	0	L307D	RN/LPN/MTA	0	3	L026A	Medical/Technical Assistant	0	0
Provide pre-service education/obtain consent	L307D	RN/LPN/MTA	5	0	L026A	Medical/Technical Assistant	0	0	L307D	RN/LPN/MTA	7	0	L026A	Medical/Technical Assistant	0	0
Follow-up phone calls & prescriptions	L307D	RN/LPN/MTA	2	2	L026A	Medical/Technical Assistant	0	0	L307D	RN/LPN/MTA	3	2	L026A	Medical/Technical Assistant	0	0
Other Clinical Activity - specify:																
End: When patient enters office/facility for surgery/procedure																
SERVICE PERIOD																
Start: When patient enters office/facility for surgery/procedure:																
Greet patient, provide gowning, ensure appropriate medical records are available	L307D	RN/LPN/MTA	5	0	L026A	Medical/Technical Assistant	1	0	L307D	RN/LPN/MTA	5	0	L026A	Medical/Technical Assistant	1	0
Obtain vital signs	L307D	RN/LPN/MTA	5	0	L026A	Medical/Technical Assistant	3	0	L307D	RN/LPN/MTA	5	0	L026A	Medical/Technical Assistant	3	0
Provide pre-service education/obtain consent	L307D	RN/LPN/MTA	0	0	L026A	Medical/Technical Assistant	3	0	L307D	RN/LPN/MTA	0	0	L026A	Medical/Technical Assistant	3	0
Prepare room, equipment, supplies	L307D	RN/LPN/MTA	2	0	L026A	Medical/Technical Assistant	2	0	L307D	RN/LPN/MTA	2	0	L026A	Medical/Technical Assistant	2	0
Setup scope (non facility setting only)	L307D	RN/LPN/MTA	5	0	L026A	Medical/Technical Assistant	5	0	L307D	RN/LPN/MTA	5	0	L026A	Medical/Technical Assistant	5	0
Prepare and position patient/ monitor patient/ set up IV	L307D	RN/LPN/MTA	2	0	L026A	Medical/Technical Assistant	2	0	L307D	RN/LPN/MTA	2	0	L026A	Medical/Technical Assistant	2	0
Sedate/apply anesthesia	L051A	RN	2	0	L026A	Medical/Technical Assistant	2	0	L051A	RN	2	0	L026A	Medical/Technical Assistant	2	0

			Reference CPT Code # 31622		RECOMMENDED CPT Code 43197						Reference CPT # 31625		Code	RECOMMENDED CPT Code 43198			
Meeting Date: October 2012 Tab: 10 Specialty: AAO-HNS			Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)				Esophagoscopy, flexible, transnasal; diagnostic, includes collection of specimen(s) by brushing, when performed.				Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple site				Esophagoscopy, flexible, transnasal; with biopsy, single or multiple.		
	CMS Code	Staff Type			CMS Code	Staff Type			CMS Code	Staff Type			CMS Code	Staff Type			
LOCATION			Non Fac	Facility			Non Fac	Facility			Non Fac	Facility			Non Fac	Facility	
GLOBAL PERIOD 000			000	000			000	000			000	000			000	000	
TOTAL CLINICAL LABOR TIME	L307D	RN/LPN/MTA	91.0	15.0	L026A	Medical/Technical Assistant	72.0	0.0	L307D	RN/LPN/MTA	97.0	15.0	L026A	Medical/Technical Assistant	79.0	0.0	
TOTAL CLINICAL LABOR TIME	L051A	RN	42.0	0.0	L051A	RN	0.0	0.0	L051A	RN	52.0	0.0	L051A	RN	0.0	0.0	
TOTAL PRE-SERV CLINICAL LABOR TIME	L307D	RN/LPN/MTA	15.0	15.0	L026A	Medical/Technical Assistant	0.0	0.0	L307D	RN/LPN/MTA	18.0	15.0	L026A	Medical/Technical Assistant	0.0	0.0	
TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L307D	RN/LPN/MTA	76.0	0.0	L026A	Medical/Technical Assistant	69.0	0.0	L307D	RN/LPN/MTA	79.0	0.0	L026A	Medical/Technical Assistant	76.0	0.0	
TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	42.0	0.0	L051A	RN	0.0	0.0	L051A	RN	52.0	0.0	L051A	RN	0.0	0.0	
TOTAL POST-SERV CLINICAL LABOR TIME	L307D	RN/LPN/MTA	0.0	0.0	L026A	Medical/Technical Assistant	3.0	0.0	L307D	RN/LPN/MTA	0.0	0.0	L026A	Medical/Technical Assistant	3.0	0.0	
Intra-service																	
Assist physician in performing procedure - Conscious sedation	L051A	RN	25	0	L051A	RN	0	0	L051A	RN	30	0	L051A	RN	0	0	
Assist physician in performing procedure	L307D	RN/LPN/MTA	17	0	L026A	Medical/Technical Assistant	15	0	L307D	RN/LPN/MTA	20	0	L026A	Medical/Technical Assistant	20	0	
Post-Service																	
Monitor pt. following service/check tubes, monitors, drains	L051A	RN	15	0	L026A	Medical/Technical Assistant	3	0	L051A	RN	20	0	L026A	Medical/Technical Assistant	3	0	
Clean room/equipment by physician staff	L307D	RN/LPN/MTA	3	0	L026A	Medical/Technical Assistant	3	0	L307D	RN/LPN/MTA	3	0	L026A	Medical/Technical Assistant	3	0	
Clean Scope	L307D	RN/LPN/MTA	30	0	L026A	Medical/Technical Assistant	30	0	L307D	RN/LPN/MTA	30	0	L026A	Medical/Technical Assistant	30	0	
Clean Surgical Instrument Package	L307D	RN/LPN/MTA	0	0	L026A	Medical/Technical Assistant	0	0	L307D	RN/LPN/MTA	0	0	L026A	Medical/Technical Assistant	0	0	
Complete diagnostic forms, lab & X-ray requisitions	L307D	RN/LPN/MTA	4	0	L026A	Medical/Technical Assistant	0	0	L307D	RN/LPN/MTA	4	0	L026A	Medical/Technical Assistant	2	0	
Review/read X-ray, lab, and pathology reports	L307D	RN/LPN/MTA	0	0	L026A	Medical/Technical Assistant	0	0	L307D	RN/LPN/MTA	0	0	L026A	Medical/Technical Assistant	0	0	
Review history, systems, and medications	L307D	RN/LPN/MTA	0	0	L026A	Medical/Technical Assistant	0	0	L307D	RN/LPN/MTA	0	0	L026A	Medical/Technical Assistant	0	0	
Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L307D	RN/LPN/MTA	3	0	L026A	Medical/Technical Assistant	0	0	L307D	RN/LPN/MTA	3	0	L026A	Medical/Technical Assistant	0	0	
Other Clinical Activity - specify:							0	0							0	0	
Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			n/a				n/a	0			n/a	n/a			n/a	0	
Dischrg mgmt (1.0 x 99238) (enter 12 min)			n/a				n/a	0			n/a	n/a			n/a	0	
Dischrg mgmt (1.0 x 99239) (enter 15 min)			n/a				n/a	0			n/a	n/a			n/a	0	
End: Patient leaves office																	
POST-SERVICE Period																	
Start: Patient leaves office/facility																	
Conduct phone calls/call in prescriptions			0	0	L026A	Medical/Technical Assistant	3	0			0	0	L026A	Medical/Technical Assistant	3	0	
Office visits: List Number and Level of Office Visits			# visits	# visits			# visits	# visits			# visits	# visits			# visits	# visits	
99211 16 minutes		16				16				16				16			
99212 27 minutes		27				27				27				27			
99213 36 minutes		36				36				36				36			
99214 53 minutes		53				53				53				53			
99215 63 minutes		63				63				63				63			
Total Office Visit Time			0.0	0.0			0.0	0.0			0.0	0.0			0.0	0.0	
Other Clinical Activity - specify:																	
End: with last office visit before end of global period																	

			Reference CPT Code # 31622		RECOMMENDED CPT Code 43197						Reference CPT Code # 31625		RECOMMENDED CPT Code 43198			
Meeting Date: October 2012 Tab: 10 Specialty: AAO-HNS			Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)				Esophagoscopy, flexible, transnasal; diagnostic, includes collection of specimen(s) by brushing, when performed.				Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple site				Esophagoscopy, flexible, transnasal; with biopsy, single or multiple.	
	CMS Code	Staff Type			CMS Code	Staff Type			CMS Code	Staff Type			CMS Code	Staff Type		
LOCATION			Non Fac	Facility			Non Fac	Facility			Non Fac	Facility			Non Fac	Facility
GLOBAL PERIOD 000			000	000			000	000			000	000			000	000
TOTAL CLINICAL LABOR TIME	L307D	RN/LPN/MTA	91.0	15.0	L026A	Medical/Technical Assistant	72.0	0.0	L307D	RN/LPN/MTA	97.0	15.0	L026A	Medical/Technical Assistant	79.0	0.0
TOTAL CLINICAL LABOR TIME	L051A	RN	42.0	0.0	L051A	RN	0.0	0.0	L051A	RN	52.0	0.0	L051A	RN	0.0	0.0
TOTAL PRE-SERV CLINICAL LABOR TIME	L307D	RN/LPN/MTA	15.0	15.0	L026A	Medical/Technical Assistant	0.0	0.0	L307D	RN/LPN/MTA	18.0	15.0	L026A	Medical/Technical Assistant	0.0	0.0
TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L307D	RN/LPN/MTA	76.0	0.0	L026A	Medical/Technical Assistant	69.0	0.0	L307D	RN/LPN/MTA	79.0	0.0	L026A	Medical/Technical Assistant	76.0	0.0
TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	42.0	0.0	L051A	RN	0.0	0.0	L051A	RN	52.0	0.0	L051A	RN	0.0	0.0
TOTAL POST-SERV CLINICAL LABOR TIME	L307D	RN/LPN/MTA	0.0	0.0	L026A	Medical/Technical Assistant	3.0	0.0	L307D	RN/LPN/MTA	0.0	0.0	L026A	Medical/Technical Assistant	3.0	0.0
MEDICAL SUPPLIES	CODE	UNIT					Non-facility (4319X7)	Facility (4319X7)					CODE	UNIT	Non-facility (4319X8)	Facility (4319X8)
Procedure supplies - day of service:																
drape, sheet	11106	item					1	0					11106	item	1	0
disposable atmoizer tips	93809	item					1	0					93809	item	1	0
oxymetazoline (Afrin)	SJ037	item					10	0					SJ037	item	10	0
xylocaine, topical 4%	SH050	ml					5	0					SH050	ml	5	0
endoscope anti-fog solution	SM014	item					1	0					SM014	item	1	0
pack, cleaning and disinfecting, endoscope	SA042	pack					1	0					SA042	pack	1	0
drape, sterile, for Mayo stand	SB012	item					1	0					SB012	item	1	0
mask, surgical	SB033	item					2	0					SB033	item	2	0
towel, non-sterile	SB042	item					2	0					SB042	item	2	0
canister, suction	SD009	item					1	0					SD009	item	1	0
tubing, suction, non-latex (6ft uou)	SD132	item					1	0					SD132	item	1	0
water, sterile for irrigation (250-1000ml uou)	SH074	item					1	0					SH074	item	1	0
basin, emesis	SJ010	item					1	0					SJ010	item	1	0
swab-pad, alcohol	SJ053	item					1	0					SJ053	item	1	0
cup, biopsy-specimen 86oz	SL034	item					0	0					SL037	item	1	0
enzymatic detergent	SM015	oz					4	0					SM015	oz	4	0
cotton balls, sterile / pledgets	SG082	item					2	0					SG082	item	2	0
paper, photo printing (8.5 x 11)	SK058	item					2	0					SK058	item	2	0
Biopsy forceps	SD066	item					0	0					SD066	item	0	0
canister, suction	SD009	item					1	0					SD009	item	1	0
EQUIPMENT	Code	UNIT					Non-facility (4319X7)	Facility (4319X7)	Code	UNIT			Code	UNIT	Non-facility (4319X8)	Facility (4319X8)
fiberoptic exam light	EQ170	1					39	0					EQ170	1	46	0
reclining exam chair with headrest	EF008	1					39	0					EF008	1	46	0
SMR suction cabinet	EQ234	1					39	0					EQ234	1	46	0
DIGITAL video system with photo documentation (for scope) (camera, monitor, ETC)	ES031	1					39	0					ES031	1	46	0
Mayo stand	EF015	1					39	0					EF015	1	46	0
video add on camera system	ES026	1					39	0					ES026	1	46	0
video printer, color	ED036	1					39	0					ED036	1	46	0
Transnasal Esophagoscope 80K Series	ER095	1					66	0					ER095	1	73	0



	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U
1				PEAC 2003		Recommendation		Recommendation		RUC 2002		Recommendation		PEAC 2003		Recommendation		PEAC 2003		Recommendation	
2				43200		43200		43206 NEW		43201		43201		43202		43202		43204		43204	
3	Meeting Date: October 2012 Tab: 10 Specialty: GI	CMS Code	Staff Type	Esophagoscopy, flexible, transoral: diagnostic, with or without collection of specimen(s) by brushing or washing (separate	Esophagoscopy, flexible, transoral: diagnostic, with or without collection of specimen(s) by brushing or washing (separate	Esophagoscopy, flexible, transoral: with optical endomicroscopy		Esophagoscopy, flexible, transoral: with directed submucosal injection(s), any substance		Esophagoscopy, flexible, transoral: with directed submucosal injection(s), any substance		Esophagoscopy, flexible, transoral: with biopsy, single or multiple		Esophagoscopy, flexible, transoral: with biopsy, single or multiple		Esophagoscopy, flexible, transoral: with injection sclerosis of esophageal varices		Esophagoscopy, flexible, transoral: with injection sclerosis of esophageal varices			
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000
6	TOTAL CLINICAL LABOR TIME	L051A	RN	0	0	32	0	47	0	42	0	32	0	39	0	32	0	0	0	0	0
7	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	84	33	85	22	103	22	55	28	85	22	56	28	85	22	0	22	0	22
8	PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	18	30	9	19	9	19	9	19	9	19	9	19	9	19	0	19	0	19
9	SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	0	0	32	0	47	0	42	0	32	0	39	0	32	0	0	0	0	0
10	SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	66	0	73	0	91	0	43	6	73	0	47	6	73	0	0	0	0	0
11	POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	3	3	3	3	3	3	3	3	3	0	3	3	3	0	3	0	3
12	PRE-SERVICE																				
13	Start: Following visit when decision for surgery or procedure made																				
14	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	3	5	3	3	3	3	3	3	3	3	3	3	3	3		3	0	3
15	Coordinate pre-surgery services	L037D	RN/LPN/MTA	5	10	3	5	3	5	3	5	3	5	3	5	3	5		5	0	5
16	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0	5	0	3	0	3	0	3	0	3	0	3	0	3		3	0	3
17	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	7	7	0	5	0	5	0	5	0	5	0	5	0	5		5	0	5
18	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3	3	3	3	3	3	3	3	3	3	3	3	3	3		3	0	3
20	End: When patient enters office/facility for surgery/procedure																				
21	SERVICE PERIOD																				
22	Start: When patient enters office/facility for surgery/procedure:																				
23	Review charts [N/A in 2012]	L037D	RN/LPN/MTA	2		0		0		2		0		2		0					
24	Review history, systems, and meds [N/A in 2012]	L037D	RN/LPN/MTA	3		0		0		3		0		3		0					
25	Greet patient, provide gowning, ensure appropriate	L037D	RN/LPN/MTA	3		3		3		3		3		3		3					
26	Obtain vital signs	L037D	RN/LPN/MTA	3		5		5		3		5		3		5					
27	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	5		3		3		5		3		5		3					
28	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2		2		5		2		2		2		2					
29	Setup scope (non facility setting only)	L037D	RN/LPN/MTA			5		5				5				5					
30	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	2		2		2				2		2		2					
31	Sedate/apply anesthesia	L051A	RN	0		2		2		2		2		2		2					
32	Intra-service																				
33	Moderate sedation	L051A	RN	0		15		30		25		15		22		15					
34	Assist physician in performing procedure	L037D	RN/LPN/MTA	15		15		30		17		15		15		15					
35	Post-Service																				
36	Monitor pt. following service/check tubes, monitors,	L051A	RN			15		15		15		15		15		15					
37	Monitor pt. following service/check tubes, monitors,	L037D	RN/LPN/MTA	10																	
38	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	7		3		3		3		3		7		3					
39	Clean Scope	L037D	RN/LPN/MTA			30		30				30				30					
41	Clean Surgical Instrument Package	L037D	RN/LPN/MTA																		
42	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA	2		2		2		2		2		2		2					
44	Check dressings & wound/ home care instructions	L037D	RN/LPN/MTA	3		3		3		3		3		3		3					
45	Other Clinical Activity - specify: phone call	L037D	RN/LPN/MTA	3																	
46	Other Clinical Activity - specify: CMS data entry error	L037D	RN/LPN/MTA	6																	
47	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)	L037D	RN/LPN/MTA							6				6							
48	Dischrg mgmt (1.0 x 99238) (enter 12 min)	L037D	RN/LPN/MTA																		
49	Dischrg mgmt (1.0 x 99239) (enter 15 min)	L037D	RN/LPN/MTA																		
50	End: Patient leaves office																				
51	POST-SERVICE Period																				
52	Start: Patient leaves office/facility																				
53	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	0	3	3	3	3	3	3	3	3	3	0	3	3	3		3	0	3
62	End: with last office visit before end of global period																				
63	MEDICAL SUPPLIES	CODE	UNIT																		
64	SCRUB, DRESS, DRAPE																				
65	pack, minimum multi-specialty visit	SA048	pack	1		1		1		1		1		1		1					
66	gown, staff, impervious	SB027	item	2		2		2				2		2		2					
67	cap, surgical	SB001	item	2		3		3		3		3		2		3					
68	mask, surgical, with face shield	SB034	item	2		3		3		3		3		2		3					
69	shoe covers, surgical	SB039	pair	2		3		3		3		3		2		3					
70	scrub brush (impregnated)	SM023	item	2		3		3		3		3		2		3					

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U
1				PEAC 2003		Recommendation		Recommendation		RUC 2002		Recommendation		PEAC 2003		Recommendation		PEAC 2003		Recommendation	
2				43200		43200		43206 NEW		43201		43201		43202		43202		43204		43204	
3	Meeting Date: October 2012 Tab: 10 Specialty: GI	CMS Code	Staff Type	Esophagoscopy, flexible, transoral: diagnostic, with or without collection of specimen(s) by brushing or washing (separate	Esophagoscopy, flexible, transoral: diagnostic, with or without collection of specimen(s) by brushing or washing (separate	Esophagoscopy, flexible, transoral: with optical endomicroscopy	Esophagoscopy, flexible, transoral: with directed submucosal injection(s), any substance	Esophagoscopy, flexible, transoral: with directed submucosal injection(s), any substance	Esophagoscopy, flexible, transoral: with biopsy, single or multiple	Esophagoscopy, flexible, transoral: with injection sclerosis of esophageal varices	Esophagoscopy, flexible, transoral: with injection sclerosis of esophageal varices										
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000
71	drape, non-sterile, sheet 40in x 60in	SB006	item	1		1		1				1		1		1					
72	basin, emesis	SJ010	item	1		1		1		1		1		1		1					
73	denture cup	SJ016	item			1		1				1				1					
74	MODERATE SEDATION																				
75	pack, moderate sedation	SA044	pack			1		1		1		1		1		1					
76	electrode, ECG (single)	SD053	item							1		0									
77	nasal cannula	SD100	item							1		0		1		0					
78	bite block	SD006	item			1		1		1		1				1				0	
79	PROCEDURE INSTRUMENTS / SUPPLIES																				
80	Instrument pack basic (\$500 - \$1,499)	EQ137	pack																		
81	Pack, cleaning, surgical instruments	SA043	pack																		
82	endoscope anti-fog solution	SM014	ml	1		1		1				1		1		1					
83	endoscopic cytology brush	SD067	item	1		1		0						1		1					
84	endoscopic biopsy forceps	SD066	item													1					
85	endoscopic polypectomy snare (proxy for endoscopic grasping forceps)	SD068	item																		
86	endosheath (proxy for endoscopic hood)	SD070	item																		
87	endoscopic polypectomy snare	SD068	item																		
88	endoscopic clip	NEW	item																		
89	guidewire, STIFF (proxy for endoscopic guidewire)	SD090	item																		
90	catheter, balloon, ureteral-GI (strictures) (proxy for endoscopic balloon, dilation)	SD019	item																		
91	needle, endoscopic ultrasound, cytology	NEW	Item																		
92	needle, micropigmentation (tattoo)	SC079	item									0									
93	syringe 5-6ml	SC057	item							3		3									
94	cautery, patient ground pad with cord	SF021	item																		
95	cautery, bipolar cord	SF012	item																		
96	cautery, bipolar, probe, endoscopy	NEW	item																		
97	catheter, optical endomicroscopy	NEW	item					1													
98	kit, probe, radiofrequency, Xli-enhanced RF probe (proxy for catheter, RF ablation, endoscopic)	SA100	kit																		
99	canister, suction	SD009	item	1		1		1		1		1		1		1					
100	tubing, suction, non-latex (6ft uou)	SD132	item	1		1		1				1		1		1					
101	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item	1		1		1				1		1		1					
102	syringe 50-60ml	SC056	item	1		1		1				1		1		1					
103	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item			1		1				1				1					
104	gauze, non-sterile 4in x 4in	SG051	item	1		1		1				1		1		1					
105	cup, biopsy-specimen non-sterile 4oz	SL035	item	1		1		1				0		1		1					
106	paper, photo printing (8.5 x 11)	SK058	item			1		1				1				1					
107	skin marking ink (tattoo) (proxy for ink, endoscopy, tattoo)	SK073	ml									2									
108	applicator, cotton-tipped, non-sterile 6in	SG008	item	3		0		0						3		0					
109	lubricating jelly (K-Y) (5gm uou)	SJ032	item	4		4		4		2		4		4		4					
110	swab-pad, alcohol	SJ053	item	2		0		0						1		0					
111	SCOPE CLEANING																				
112	pack, cleaning and disinfecting, endoscope	SA042	pack			1		1				1				1					
113	gloves, non-sterile	SB022	pair	1		0		0		1		0		1		0					
114	basin, irrigation	SJ009	item	1		0		0		1		0		1		0					
115	cleaning brush, endoscope	SM010	item	1		0		0		1		0		1		0					
116	enzymatic detergent	SM015	oz	1		0		0						1		0					
117	glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)	SM018	oz	6		0		0						6		0					
118	glutaraldehyde test strips (Cidex, Metrex)	SM019	item	1		0		0						1		0					
119	EQUIPMENT	CODE																			
120	videoscope, gastroscopy	ES034		60		70		88		30		73		35		75					
121	videoscope, endoscopic ultrasound	NEW																			
122	stretcher	EF018				0		0		60		0		60		0					

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U
1				PEAC 2003		Recommendation		Recommendation		RUC 2002		Recommendation		PEAC 2003		Recommendation		PEAC 2003		Recommendation	
2				43200		43200		43206 NEW		43201		43201		43202		43202		43204		43204	
3	Meeting Date: October 2012 Tab: 10 Specialty: GI	CMS Code	Staff Type	Esophagoscopy, flexible, transoral: diagnostic, with or without collection of specimen(s) by brushing or washing (separate		Esophagoscopy, flexible, transoral: diagnostic, with or without collection of specimen(s) by brushing or washing (separate		Esophagoscopy, flexible, transoral: with optical endomicroscopy		Esophagoscopy, flexible, transoral: with directed submucosal injection(s), any substance		Esophagoscopy, flexible, transoral: with directed submucosal injection(s), any substance		Esophagoscopy, flexible, transoral: with biopsy, single or multiple		Esophagoscopy, flexible, transoral: with biopsy, single or multiple		Esophagoscopy, flexible, transoral: with injection sclerosis of esophageal varices		Esophagoscopy, flexible, transoral: with injection sclerosis of esophageal varices	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000
123	IV infusion pump	EQ032				77		92		87		80		84		82					
124	table, power	EF031		60		43		61		30		46		35		48					
125	video system, endoscopy (processor, digital capture, monitor, printer, cart)	ES031		60		43		61		30		46		35		48					
126	suction machine (Gomco)	EQ235		60		43		61				46		35		48					
127	table, instrument, mobile	EF027				77		92		87		80		84		82					
128	electrosurgical generator, gastrocautery	EQ113												35							
129	RF Ablation system NEW																				
130	endoscopic ultrasound processor unit system	ER094																			
131	optical endomicroscope processor unit system	EQ355						61													
132	endoscope disinfectant, rigid or fiberoptic, w-cart	ES005		40		30		30				30		40		30					
133	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011				77		92		87		80		84		82					



	A	B	C	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM
1				PEAC 2003		Recommendation		PEAC 2003		Recommendation		PEAC 2004		Recommendation		PEAC 2003		Recommendation		PEAC 2003	
2				43205		43205		43215		43215		43216		43216		43217		43217		43219	
3	Meeting Date: October 2012 Tab: 10 Specialty: GI	CMS Code	Staff Type	Esophagoscopy, flexible, transoral: with band ligation of esophageal varices		Esophagoscopy, flexible, transoral: with band ligation of esophageal varices		Esophagoscopy, flexible, transoral:with removal of foreign body		Esophagoscopy, flexible, transoral:with removal of foreign body		Esophagoscopy, flexible, transoral:with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar		Esophagoscopy, flexible, transoral:with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar		Esophagoscopy, flexible, transoral:with removal of tumor(s), polyp(s), or other lesion(s) by snare technique		Esophagoscopy, flexible, transoral:with removal of tumor(s), polyp(s), or other lesion(s) by snare technique		Esophagoscopy, flexible, transoral:with insertion of plastic tube or stent	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000
6	TOTAL CLINICAL LABOR TIME	L051A	RN	0	0	0	0	0	0	37	0	50	0	39	0	46	0	47	0	0	0
7	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	22	0	22	0	22	90	22	95	25	92	22	60	22	100	22	0	33
8	PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	19	0	19	0	19	9	19	9	19	9	19	9	19	9	19	0	30
9	SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	0	0	0	0	0	0	37	0	50	0	39	0	46	0	47	0	0	0
10	SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	0	0	0	0	0	78	0	83	0	80	0	51	0	88	0	0	0
11	POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	3	0	3	0	3	3	3	3	6	3	3	0	3	3	3	0	3
12	PRE-SERVICE																				
13	Start: Following visit when decision for surgery or procedure made																				
14	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		3	0	3		3	3	3	3	3	3	3	3	3	3	3		5
15	Coordinate pre-surgery services	L037D	RN/LPN/MTA		5	0	5		5	3	5	3	5	3	5	3	5	3	5		10
16	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3	0	3		3	0	3	0	3	0	3	0	3	0	3		5
17	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5	0	5		5	0	5	0	5	0	5	0	5	0	5		7
18	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		3	0	3		3	3	3	3	3	3	3	3	3	3	3		3
20	End: When patient enters office/facility for surgery/procedure																				
21	SERVICE PERIOD																				
22	Start: When patient enters office/facility for surgery/procedure:																				
23	Review charts [N/A in 2012]	L037D	RN/LPN/MTA									2		0		2		0			
24	Review history, systems, and meds [N/A in 2012]	L037D	RN/LPN/MTA													3		0			
25	Greet patient, provide gowning, ensure appropriate	L037D	RN/LPN/MTA							3		3		3		3		3			
26	Obtain vital signs	L037D	RN/LPN/MTA							5		3		5		3		5			
27	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA							3		5		3		5		3			
28	Prepare room, equipment, supplies	L037D	RN/LPN/MTA							2		2		2		2		2			
29	Setup scope (non facility setting only)	L037D	RN/LPN/MTA							5		5		5		5		5			
30	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA							2		2		2		2		2			
31	Sedate/apply anesthesia	L051A	RN							2		2		2		2		2			
32	Intra-service																				
33	Moderate sedation	L051A	RN							20		33		22		29		30			
34	Assist physician in performing procedure	L037D	RN/LPN/MTA							20		22		22		19		30			
35	Post-Service																				
36	Monitor pt. following service/check tubes, monitors,	L051A	RN							15		15		15		15		15			
37	Monitor pt. following service/check tubes, monitors,	L037D	RN/LPN/MTA																		
38	Clean room/equipment by physician staff	L037D	RN/LPN/MTA							3		3		3		7		3			
39	Clean Scope	L037D	RN/LPN/MTA							30		30		30				30			
41	Clean Surgical Instrument Package	L037D	RN/LPN/MTA																		
42	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA							2		3		2		2		2			
44	Check dressings & wound/ home care instructions	L037D	RN/LPN/MTA							3		3		3		3		3			
45	Other Clinical Activity - specify: phone call	L037D	RN/LPN/MTA																		
46	Other Clinical Activity - specify: CMS data entry error	L037D	RN/LPN/MTA																		
47	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)	L037D	RN/LPN/MTA																		
48	Dischrg mgmt (1.0 x 99238) (enter 12 min)	L037D	RN/LPN/MTA																		
49	Dischrg mgmt (1.0 x 99239) (enter 15 min)	L037D	RN/LPN/MTA																		
50	End: Patient leaves office																				
51	POST-SERVICE Period																				
52	Start: Patient leaves office/facility																				
53	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA		3	0	3		3	3	3	3	6	3	3	0	3	3	3		3
62	End: with last office visit before end of global period																				
63	MEDICAL SUPPLIES	CODE	UNIT																		
64	SCRUB, DRESS, DRAPE																				
65	pack, minimum multi-specialty visit	SA048	pack							1				1		1		1			
66	gown, staff, impervious	SB027	item							2				2		2		2			
67	cap, surgical	SB001	item							3				3		2		3			
68	mask, surgical, with face shield	SB034	item							3				3		2		3			
69	shoe covers, surgical	SB039	pair							3				3		2		3			
70	scrub brush (impregnated)	SM023	item							3				3		2		3			

	A	B	C	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM
1				PEAC 2003		Recommendation		PEAC 2003		Recommendation		PEAC 2004		Recommendation		PEAC 2003		Recommendation		PEAC 2003	
2				43205		43205		43215		43215		43216		43216		43217		43217		43219	
3	Meeting Date: October 2012 Tab: 10 Specialty: GI	CMS Code	Staff Type	Esophagoscopy, flexible, transoral: with band ligation of esophageal varices		Esophagoscopy, flexible, transoral: with band ligation of esophageal varices		Esophagoscopy, flexible, transoral:with removal of foreign body		Esophagoscopy, flexible, transoral:with removal of foreign body		Esophagoscopy, flexible, transoral:with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar		Esophagoscopy, flexible, transoral:with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar		Esophagoscopy, flexible, transoral:with removal of tumor(s), polyp(s), or other lesion(s) by snare technique		Esophagoscopy, flexible, transoral:with removal of tumor(s), polyp(s), or other lesion(s) by snare technique		Esophagoscopy, flexible, transoral:with insertion of plastic tube or stent	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000
71	drape, non-sterile, sheet 40in x 60in	SB006	item							1				1		1		1			
72	basin, emesis	SJ010	item							1				1		1		1			
73	denture cup	SJ016	item							1				1				1			
74	MODERATE SEDATION																				
75	pack, moderate sedation	SA044	pack							1				1		1		1			
76	electrode, ECG (single)	SD053	item																		
77	nasal cannula	SD100	item													1		0			
78	bite block	SD006	item			0				1				1				1			
79	PROCEDURE INSTRUMENTS / SUPPLIES																				
80	Instrument pack basic (\$500 - \$1,499)	EQ137	pack																		
81	Pack, cleaning, surgical instruments	SA043	pack																		
82	endoscope anti-fog solution	SM014	ml							1				1		1		1			
83	endoscopic cytology brush	SD067	item							1				1		1		1			
84	endoscopic biopsy forceps	SD066	item											1							
85	endoscopic polypectomy snare (proxy for endoscopic grasping forceps)	SD068	item							1								1			
86	endosheath (proxy for endoscopic hood)	SD070	item							1											
87	endoscopic polypectomy snare	SD068	item													1		1			
88	endoscopic clip	NEW	item																		
89	guidewire, STIFF (proxy for endoscopic guidewire)	SD090	item																		
90	catheter, balloon, ureteral-GI (strictures) (proxy for endoscopic balloon, dilation)	SD019	item																		
91	needle, endoscopic ultrasound, cytology	NEW	Item																		
92	needle, micropigmentation (tattoo)	SC079	item																		
93	syringe 5-6ml	SC057	item																		
94	cautery, patient ground pad with cord	SF021	item											1				1			
95	cautery, bipolar cord	SF012	item											1				1			
96	cautery, bipolar, probe, endoscopy	NEW	item															0			
97	catheter, optical endomicroscopy	NEW	item																		
98	kit, probe, radiofrequency, XLI-enhanced RF probe (proxy for catheter, RF ablation, endoscopic)	SA100	kit																		
99	canister, suction	SD009	item							1				1		1		1			
100	tubing, suction, non-latex (6ft uou)	SD132	item							1				1		1		1			
101	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item							1				1		1		1			
102	syringe 50-60ml	SC056	item							1				1		1		1			
103	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item							1				1				1			
104	gauze, non-sterile 4in x 4in	SG051	item							1				1		1		1			
105	cup, biopsy-specimen non-sterile 4oz	SL035	item							1				1		1		1			
106	paper, photo printing (8.5 x 11)	SK058	item							1				1				1			
107	skin marking ink (tattoo) (proxy for ink, endoscopy, tattoo)	SK073	ml																		
108	applicator, cotton-tipped, non-sterile 6in	SG008	item													1		0			
109	lubricating jelly (K-Y) (5gm uou)	SJ032	item							4				4		4		4			
110	swab-pad, alcohol	SJ053	item													2		0			
111	SCOPE CLEANING																				
112	pack, cleaning and disinfecting, endoscope	SA042	pack							1				1				1			
113	gloves, non-sterile	SB022	pair													1		0			
114	basin, irrigation	SJ009	item													1		0			
115	cleaning brush, endoscope	SM010	item													1		0			
116	enzymatic detergent	SM015	oz													1		0			
117	glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)	SM018	oz													6		0			
118	glutaraldehyde test strips (Cidex, Metrex)	SM019	item													1		0			
119	EQUIPMENT	CODE																			
120	videoscope, gastroscopy	ES034								75				77		42	42	85			
121	videoscope, endoscopic ultrasound	NEW																			
122	stretcher	EF018								0				0		60	60	0			



	A	B	C	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM
1				PEAC 2003		Recommendation		PEAC 2003		Recommendation		PEAC 2004		Recommendation		PEAC 2003		Recommendation		PEAC 2003	
2				43205		43205		43215		43215		43216		43216		43217		43217		43219	
3	Meeting Date: October 2012 Tab: 10 Specialty: GI	CMS Code	Staff Type	Esophagoscopy, flexible, transoral: with band ligation of esophageal varices		Esophagoscopy, flexible, transoral: with band ligation of esophageal varices		Esophagoscopy, flexible, transoral:with removal of foreign body		Esophagoscopy, flexible, transoral:with removal of foreign body		Esophagoscopy, flexible, transoral:with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar		Esophagoscopy, flexible, transoral:with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar		Esophagoscopy, flexible, transoral:with removal of tumor(s), polyp(s), or other lesion(s) by snare technique		Esophagoscopy, flexible, transoral:with removal of tumor(s), polyp(s), or other lesion(s) by snare technique		Esophagoscopy, flexible, transoral:with insertion of plastic tube or stent	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000
123	IV infusion pump	EQ032								82				84		91	91	92			
124	table, power	EF031								48				50		42	42	58			
125	video system, endoscopy (processor, digital capture, monitor, printer, cart)	ES031								48				50		42	42	58			
126	suction machine (Gomco)	EQ235								48				50		42	42	58			
127	table, instrument, mobile	EF027								82				84		91	91	92			
128	electrosurgical generator, gastrocautery	EQ113												50		42	42	58			
129	RF Ablation system	NEW																			
130	endoscopic ultrasound processor unit system	ER094																			
131	optical endomicroscope processor unit system	EQ355																			
132	endoscope disinfectant, rigid or fiberoptic, w-cart	ES005								30				30		40	40	30			
133	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011								82				84		91	91	92			

	A	B	C	AN	AO	AP	AQ	AR	AS	AT	AU	AV	AW	AX	AY	AZ	BA	BB	BC	BD	BE
1				Recommendation	PEAC 2003	Recommendation	PEAC 2003	Recommendation	PEAC 2003	Recommendation	PEAC 2003	Recommendation	PEAC 2003	Recommendation	PEAC 2003	Recommendation	PEAC 2003	Recommendation	PEAC 2003	Recommendation	PEAC 2003
2				43219	43220	43220	43226	43226	43226	43227	43227	43227	43227	43227	43227	43227	43227	43228	43228	43228	43228
3	Meeting Date: October 2012 Tab: 10 Specialty: GI	CMS Code	Staff Type	Esophagoscopy, flexible, transoral:with insertion of plastic tube or stent	Esophagoscopy, flexible, transoral:with balloon dilation (less than 30 mm diameter)	Esophagoscopy, flexible, transoral:with balloon dilation (less than 30 mm diameter)	Esophagoscopy, flexible, transoral: with insertion of guide wire followed by dilation over guide wire	Esophagoscopy, flexible, transoral: with insertion of guide wire followed by dilation over guide wire	Esophagoscopy, flexible, transoral: with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater	Esophagoscopy, flexible, transoral: with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater	Esophagoscopy, flexible, transoral: with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater	Esophagoscopy, flexible, transoral: with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater	Esophagoscopy, flexible, transoral: with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater	Esophagoscopy, flexible, transoral: with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater	Esophagoscopy, flexible, transoral: with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater	Esophagoscopy, flexible, transoral: with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater	Esophagoscopy, flexible, transoral: with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater	Esophagoscopy, flexible, transoral: with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater	Esophagoscopy, flexible, transoral: with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater	Esophagoscopy, flexible, transoral: with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater	Esophagoscopy, flexible, transoral: with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000
6	TOTAL CLINICAL LABOR TIME	L051A	RN	0	0	0	0	37	0	0	0	42	0	0	0	47	0	0	0	52	0
7	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	19	0	22	90	22	0	22	105	22	0	22	100	22	0	22	105	22
8	PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	19	0	19	9	19	0	19	9	19	0	19	9	19	0	19	9	19
9	SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	0	0	0	0	37	0	0	0	42	0	0	0	47	0	0	0	52	0
10	SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	0	0	0	78	0	0	0	93	0	0	0	88	0	0	0	93	0
11	POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	0	0	3	3	3	0	3	3	3	0	3	3	3	0	3	3	3
12	PRE-SERVICE																				
13	Start: Following visit when decision for surgery or procedure made																				
14	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	0	3		3	3	3		3	3	3		3	3	3		3	3	3
15	Coordinate pre-surgery services	L037D	RN/LPN/MTA	0	5		5	3	5		5	3	5		5	3	5		5	3	5
16	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0	3		3	0	3		3	0	3		3	0	3		3	0	3
17	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0	5		5	0	5		5	0	5		5	0	5		5	0	5
18	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	0	3		3	3	3		3	3	3		3	3	3		3	3	3
20	End: When patient enters office/facility for surgery/procedure																				
21	SERVICE PERIOD																				
22	Start: When patient enters office/facility for surgery/procedure:																				
23	Review charts [N/A in 2012]	L037D	RN/LPN/MTA																		
24	Review history, systems, and meds [N/A in 2012]	L037D	RN/LPN/MTA																		
25	Greet patient, provide gowning, ensure appropriate	L037D	RN/LPN/MTA					3				3				3				3	
26	Obtain vital signs	L037D	RN/LPN/MTA					5				5				5				5	
27	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA					3				3				3				3	
28	Prepare room, equipment, supplies	L037D	RN/LPN/MTA					2				2				2				2	
29	Setup scope (non facility setting only)	L037D	RN/LPN/MTA					5				5				5				5	
30	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA					2				2				2				2	
31	Sedate/apply anesthesia	L051A	RN					2				2				2				2	
32	Intra-service																				
33	Moderate sedation	L051A	RN					20				25				30				35	
34	Assist physician in performing procedure	L037D	RN/LPN/MTA					20				25				30				35	
35	Post-Service																				
36	Monitor pt. following service/check tubes, monitors,	L051A	RN					15				15				15				15	
37	Monitor pt. following service/check tubes, monitors,	L037D	RN/LPN/MTA																		
38	Clean room/equipment by physician staff	L037D	RN/LPN/MTA					3				3				3				3	
39	Clean Scope	L037D	RN/LPN/MTA					30				30				30				30	
41	Clean Surgical Instrument Package	L037D	RN/LPN/MTA									10									
42	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA					2				2				2				2	
44	Check dressings & wound/ home care instructions	L037D	RN/LPN/MTA					3				3				3				3	
45	Other Clinical Activity - specify: phone call	L037D	RN/LPN/MTA																		
46	Other Clinical Activity - specify: CMS data entry error	L037D	RN/LPN/MTA																		
47	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)	L037D	RN/LPN/MTA																		
48	Dischrg mgmt (1.0 x 99238) (enter 12 min)	L037D	RN/LPN/MTA																		
49	Dischrg mgmt (1.0 x 99239) (enter 15 min)	L037D	RN/LPN/MTA																		
50	End: Patient leaves office																				
51	POST-SERVICE Period																				
52	Start: Patient leaves office/facility																				
53	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	0	0		3	3	3		3	3	3		3	3	3		3	3	3
62	End: with last office visit before end of global period																				
63	MEDICAL SUPPLIES	CODE	UNIT																		
64	SCRUB, DRESS, DRAPE																				
65	pack, minimum multi-specialty visit	SA048	pack					1				1				1				1	
66	gown, staff, impervious	SB027	item					2				2				2				2	
67	cap, surgical	SB001	item					3				3				3				3	
68	mask, surgical, with face shield	SB034	item					3				3				3				3	
69	shoe covers, surgical	SB039	pair					3				3				3				3	
70	scrub brush (impregnated)	SM023	item					3				3				3				3	

	A	B	C	AN	AO	AP	AQ	AR	AS	AT	AU	AV	AW	AX	AY	AZ	BA	BB	BC	BD	BE
1				Recommendation		PEAC 2003		Recommendation		PEAC 2003		Recommendation		PEAC 2003		Recommendation		PEAC 2003		Recommendation	
2				43219		43220		43220		43226		43226		43227		43227		43228		43228	
3	Meeting Date: October 2012 Tab: 10 Specialty: GI	CMS Code	Staff Type	Esophagoscopy, flexible, transoral:with insertion of plastic tube or stent		Esophagoscopy, flexible, transoral:with balloon dilation (less than 30 mm diameter)		Esophagoscopy, flexible, transoral:with balloon dilation (less than 30 mm diameter)		Esophagoscopy, flexible, transoral: with insertion of guide wire followed by dilation over guide wire		Esophagoscopy, flexible, transoral: with insertion of guide wire followed by dilation over guide wire		Esophagoscopy, flexible, transoral: with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater		Esophagoscopy, flexible, transoral: with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater		Esophagoscopy, flexible, transoral: with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by		Esophagoscopy, flexible, transoral: with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000
71	drape, non-sterile, sheet 40in x 60in	SB006	item					1				1				1				1	
72	basin, emesis	SJ010	item					1				1				1				1	
73	denture cup	SJ016	item					1				1				1				1	
74	MODERATE SEDATION																				
75	pack, moderate sedation	SA044	pack					1				1				1				1	
76	electrode, ECG (single)	SD053	item																		
77	nasal cannula	SD100	item																		
78	bite block	SD006	item	0				1				1				1				1	
79	PROCEDURE INSTRUMENTS / SUPPLIES																				
80	Instrument pack basic (\$500 - \$1,499)	EQ137	pack									1									
81	Pack, cleaning, surgical instruments	SA043	pack									1									
82	endoscope anti-fog solution	SM014	ml					1				1				1				1	
83	endoscopic cytology brush	SD067	item					1				1				1				1	
84	endoscopic biopsy forceps	SD066	item																		
85	endoscopic polypectomy snare (proxy for endoscopic grasping forceps)	SD068	item																		
86	endosheath (proxy for endoscopic hood)	SD070	item																		
87	endoscopic polypectomy snare	SD068	item																		
88	endoscopic clip	NEW	item													1					
89	guidewire, STIFF (proxy for endoscopic guidewire)	SD090	item					0				1								1	
90	catheter, balloon, ureteral-GI (strictures) (proxy for endoscopic balloon, dilation)	SD019	item					3												1	
91	needle, endoscopic ultrasound, cytology	NEW	Item																		
92	needle, micropigmentation (tattoo)	SC079	item																		
93	syringe 5-6ml	SC057	item																		
94	cautery, patient ground pad with cord	SF021	item													1					
95	cautery, bipolar cord	SF012	item													1					
96	cautery, bipolar, probe, endoscopy	NEW	item													1					
97	catheter, optical endomicroscopy	NEW	item																		
98	kit, probe, radiofrequency, Xli-enhanced RF probe (proxy for catheter, RF ablation, endoscopic)	SA100	kit																	1	
99	canister, suction	SD009	item					1				1				1				2	
100	tubing, suction, non-latex (6ft uou)	SD132	item					1				1				1				1	
101	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item					1				1				1				1	
102	syringe 50-60ml	SC056	item					1				1				1				1	
103	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item					1				1				1				1	
104	gauze, non-sterile 4in x 4in	SG051	item					1				1				1				1	
105	cup, biopsy-specimen non-sterile 4oz	SL035	item					0				0				1				1	
106	paper, photo printing (8.5 x 11)	SK058	item					1				1				1				1	
107	skin marking ink (tattoo) (proxy for ink, endoscopy, tattoo)	SK073	ml																		
108	applicator, cotton-tipped, non-sterile 6in	SG008	item																		
109	lubricating jelly (K-Y) (5gm uou)	SJ032	item					4				4				4				4	
110	swab-pad, alcohol	SJ053	item																		
111	SCOPE CLEANING																				
112	pack, cleaning and disinfecting, endoscope	SA042	pack					1				1				1				1	
113	gloves, non-sterile	SB022	pair																		
114	basin, irrigation	SJ009	item																		
115	cleaning brush, endoscope	SM010	item																		
116	enzymatic detergent	SM015	oz																		
117	glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)	SM018	oz																		
118	glutaraldehyde test strips (Cidex, Metrex)	SM019	item																		
119	EQUIPMENT	CODE																			
120	videoscope, gastroscopy	ES034						75				80				85				79	
121	videoscope, endoscopic ultrasound	NEW																			
122	stretcher	EF018						0				0				0				93	

	A	B	C	AN	AO	AP	AQ	AR	AS	AT	AU	AV	AW	AX	AY	AZ	BA	BB	BC	BD	BE
1				Recommendation	PEAC 2003	Recommendation	PEAC 2003	Recommendation	PEAC 2003	Recommendation	PEAC 2003	Recommendation	PEAC 2003	Recommendation	PEAC 2003	Recommendation	PEAC 2003	Recommendation	PEAC 2003	Recommendation	PEAC 2003
2				43219	43220	43220	43226	43226	43226	43227	43227	43227	43227	43227	43227	43227	43227	43228	43228	43228	43228
3	Meeting Date: October 2012 Tab: 10 Specialty: GI	CMS Code	Staff Type	Esophagoscopy, flexible, transoral:with insertion of plastic tube or stent	Esophagoscopy, flexible, transoral:with balloon dilation (less than 30 mm diameter)	Esophagoscopy, flexible, transoral:with balloon dilation (less than 30 mm diameter)	Esophagoscopy, flexible, transoral: with insertion of guide wire followed by dilation over guide wire	Esophagoscopy, flexible, transoral: with insertion of guide wire followed by dilation over guide wire	Esophagoscopy, flexible, transoral: with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater	Esophagoscopy, flexible, transoral: with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater	Esophagoscopy, flexible, transoral: with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by	Esophagoscopy, flexible, transoral: with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by	Esophagoscopy, flexible, transoral: with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by	Esophagoscopy, flexible, transoral: with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by	Esophagoscopy, flexible, transoral: with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by	Esophagoscopy, flexible, transoral: with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by	Esophagoscopy, flexible, transoral: with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by	Esophagoscopy, flexible, transoral: with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by	Esophagoscopy, flexible, transoral: with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by	Esophagoscopy, flexible, transoral: with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by	Esophagoscopy, flexible, transoral: with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000
123	IV infusion pump	EQ032						82				87				92				72	
124	table, power	EF031						34				53				58				49	
125	video system, endoscopy (processor, digital capture, monitor, printer, cart)	ES031						48				53				58				49	
126	suction machine (Gomco)	EQ235						48				53				58				49	
127	table, instrument, mobile	EF027						82				87				92				49	
128	electrosurgical generator, gastrocautery	EQ113														58				49	
129	RF Ablation system	NEW																		49	
130	endoscopic ultrasound processor unit system	ER094																			
131	optical endomicroscope processor unit system	EQ355																			
132	endoscope disinfecter, rigid or fiberoptic, w-cart	ES005						30				30				30				30	
133	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011						82				87				92				72	



	A	B	C	BF	BG	BH	BI	BJ	BK	BL	BM
1				<b>PEAC 2003</b>		<b>Recommendation</b>		<b>PEAC 2003</b>		<b>Recommendation</b>	
2				<b>43231</b>		<b>43231</b>		<b>43232</b>		<b>43232</b>	
3	Meeting Date: October 2012 Tab: 10 Specialty: GI	CMS Code	Staff Type	Esophagoscopy, flexible, transoral:with endoscopic ultrasound examination		Esophagoscopy, flexible, transoral:with endoscopic ultrasound examination		Esophagoscopy, flexible, transoral:with transendoscopic ultrasound-guided intramural or transmural		Esophagoscopy, flexible, transoral:with transendoscopic ultrasound-guided intramural or transmural	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	000	000	000	000
6	TOTAL CLINICAL LABOR TIME	L051A	RN	0	0	47	0	0	0	62	0
7	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	22	100	22	0	22	115	22
8	PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	19	9	19	0	19	9	19
9	SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	0	0	47	0	0	0	62	0
10	SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	0	88	0	0	0	103	0
11	POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	3	3	3	0	3	3	3
12	PRE-SERVICE										
13	Start: Following visit when decision for surgery or procedure made										
14	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		3	3	3		3	3	3
15	Coordinate pre-surgery services	L037D	RN/LPN/MTA		5	3	5		5	3	5
16	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3	0	3		3	0	3
17	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5	0	5		5	0	5
18	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		3	3	3		3	3	3
20	End: When patient enters office/facility for surgery/procedure										
21	SERVICE PERIOD										
22	Start: When patient enters office/facility for surgery/procedure:										
23	Review charts [N/A in 2012]	L037D	RN/LPN/MTA								
24	Review history, systems, and meds [N/A in 2012]	L037D	RN/LPN/MTA								
25	Greet patient, provide gowning, ensure appropriate	L037D	RN/LPN/MTA			3				3	
26	Obtain vital signs	L037D	RN/LPN/MTA			5				5	
27	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA			3				3	
28	Prepare room, equipment, supplies	L037D	RN/LPN/MTA			2				2	
29	Setup scope (non facility setting only)	L037D	RN/LPN/MTA			5				5	
30	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA			2				2	
31	Sedate/apply anesthesia	L051A	RN			2				2	
32	Intra-service										
33	Moderate sedation	L051A	RN			30				45	
34	Assist physician in performing procedure	L037D	RN/LPN/MTA			30				45	
35	Post-Service										
36	Monitor pt. following service/check tubes, monitors,	L051A	RN			15				15	
37	Monitor pt. following service/check tubes, monitors,	L037D	RN/LPN/MTA								
38	Clean room/equipment by physician staff	L037D	RN/LPN/MTA			3				3	
39	Clean Scope	L037D	RN/LPN/MTA			30				30	
41	Clean Surgical Instrument Package	L037D	RN/LPN/MTA								
42	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA			2				2	
44	Check dressings & wound/ home care instructions	L037D	RN/LPN/MTA			3				3	
45	Other Clinical Activity - specify: phone call	L037D	RN/LPN/MTA								
46	Other Clinical Activity - specify: CMS data entry error	L037D	RN/LPN/MTA								
47	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)	L037D	RN/LPN/MTA								
48	Dischrg mgmt (1.0 x 99238) (enter 12 min)	L037D	RN/LPN/MTA								
49	Dischrg mgmt (1.0 x 99239) (enter 15 min)	L037D	RN/LPN/MTA								
50	End: Patient leaves office										
51	POST-SERVICE Period										
52	Start: Patient leaves office/facility										
53	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA		3	3	3		3	3	3
62	End: with last office visit before end of global period										
63	MEDICAL SUPPLIES	CODE	UNIT								
64	SCRUB, DRESS, DRAPE										
65	pack, minimum multi-specialty visit	SA048	pack			1				1	
66	gown, staff, impervious	SB027	item			2				2	
67	cap, surgical	SB001	item			3				3	
68	mask, surgical, with face shield	SB034	item			3				3	
69	shoe covers, surgical	SB039	pair			3				3	
70	scrub brush (impregnated)	SM023	item			3				3	

	A	B	C	BF	BG	BH	BI	BJ	BK	BL	BM
1				<b>PEAC 2003</b>		<b>Recommendation</b>		<b>PEAC 2003</b>		<b>Recommendation</b>	
2				<b>43231</b>		<b>43231</b>		<b>43232</b>		<b>43232</b>	
3	Meeting Date: October 2012 Tab: 10 Specialty: GI	CMS Code	Staff Type	Esophagoscopy, flexible, transoral:with endoscopic ultrasound examination		Esophagoscopy, flexible, transoral:with endoscopic ultrasound examination		Esophagoscopy, flexible, transoral:with transendoscopic ultrasound-guided intramural or transmural		Esophagoscopy, flexible, transoral:with transendoscopic ultrasound-guided intramural or transmural	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	000	000	000	000
71	drape, non-sterile, sheet 40in x 60in	SB006	item			1				1	
72	basin, emesis	SJ010	item			1				1	
73	denture cup	SJ016	item			1				1	
74	<b>MODERATE SEDATION</b>										
75	pack, moderate sedation	SA044	pack			1				1	
76	electrode, ECG (single)	SD053	item								
77	nasal cannula	SD100	item								
78	bite block	SD006	item			1				1	
79	<b>PROCEDURE INSTRUMENTS / SUPPLIES</b>										
80	Instrument pack basic (\$500 - \$1,499)	EQ137	pack								
81	Pack, cleaning, surgical instruments	SA043	pack								
82	endoscope anti-fog solution	SM014	ml							1	
83	endoscopic cytology brush	SD067	item			1				1	
84	endoscopic biopsy forceps	SD066	item								
85	endoscopic polypectomy snare (proxy for endoscopic grasping forceps)	SD068	item								
86	endosheath (proxy for endoscopic hood)	SD070	item								
87	endoscopic polypectomy snare	SD068	item								
88	endoscopic clip	NEW	item								
89	guidewire, STIFF (proxy for endoscopic guidewire)	SD090	item								
90	catheter, balloon, ureteral-GI (strictures) (proxy for endoscopic balloon, dilation)	SD019	item								
91	needle, endoscopic ultrasound, cytology	NEW	item							1	
92	needle, micropigmentation (tattoo)	SC079	item								
93	syringe 5-6ml	SC057	item								
94	cautery, patient ground pad with cord	SF021	item								
95	cautery, bipolar cord	SF012	item								
96	cautery, bipolar, probe, endoscopy	NEW	item								
97	catheter, optical endomicroscopy	NEW	item								
98	kit, probe, radiofrequency, Xli-enhanced RF probe (proxy for catheter, RF ablation, endoscopic)	SA100	kit								
99	canister, suction	SD009	item			1				1	
100	tubing, suction, non-latex (6ft uou)	SD132	item			1				1	
101	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item			1				1	
102	syringe 50-60ml	SC056	item			1				1	
103	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item			1				1	
104	gauze, non-sterile 4in x 4in	SG051	item			1				1	
105	cup, biopsy-specimen non-sterile 4oz	SL035	item			0				1	
106	paper, photo printing (8.5 x 11)	SK058	item			1				1	
107	skin marking ink (tattoo) (proxy for ink, endoscopy, tattoo)	SK073	ml								
108	applicator, cotton-tipped, non-sterile 6in	SG008	item								
109	lubricating jelly (K-Y) (5gm uou)	SJ032	item			4				4	
110	swab-pad, alcohol	SJ053	item								
111	<b>SCOPE CLEANING</b>										
112	pack, cleaning and disinfecting, endoscope	SA042	pack			1				1	
113	gloves, non-sterile	SB022	pair								
114	basin, irrigation	SJ009	item								
115	cleaning brush, endoscope	SM010	item								
116	enzymatic detergent	SM015	oz								
117	glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)	SM018	oz								
118	glutaraldehyde test strips (Cidex, Metrex)	SM019	item								
119	<b>EQUIPMENT</b>	<b>CODE</b>									
120	videoscope, gastroscopy	ES034				74				89	
121	videoscope, endoscopic ultrasound	NEW				100				115	
122	stretcher	EF018				0				0	

	A	B	C	BF	BG	BH	BI	BJ	BK	BL	BM
1				PEAC 2003		Recommendation		PEAC 2003		Recommendation	
2				43231		43231		43232		43232	
3	Meeting Date: October 2012 Tab: 10 Specialty: GI	CMS Code	Staff Type	Esophagoscopy, flexible, transoral:with endoscopic ultrasound examination		Esophagoscopy, flexible, transoral:with endoscopic ultrasound examination		Esophagoscopy, flexible, transoral:with transendoscopic ultrasound-guided intramural or transmural		Esophagoscopy, flexible, transoral:with transendoscopic ultrasound-guided intramural or transmural	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	000	000	000	000
123	IV infusion pump	EQ032				107				122	
124	table, power	EF031				73				88	
125	video system, endoscopy (processor, digital capture, monitor, printer, cart)	ES031				73				88	
126	suction machine (Gomco)	EQ235				73				88	
127	table, instrument, mobile	EF027				107				122	
128	electrosurgical generator, gastrocautery	EQ113									
129	RF Ablation system	NEW									
130	endoscopic ultrasound processor unit system	ER094				73				88	
131	optical endomicroscope processor unit system	EQ355									
132	endoscope disinfectant, rigid or fiberoptic, w-cart	ES005				30				30	
133	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011				107				122	

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U
1				PEAC 2003		Recommendation		Recommendation		RUC 2002		Recommendation		PEAC 2003		Recommendation		PEAC 2003		Recommendation	
2				43200		43200		43206 NEW		43201		43201		43202		43202		43204		43204	
3	Meeting Date: October 2012 Tab: 10 Specialty: GI	CMS Code	Staff Type	Esophagoscopy, flexible, transoral: diagnostic, with or without collection of specimen(s) by brushing or washing (separate	Esophagoscopy, flexible, transoral: diagnostic, with or without collection of specimen(s) by brushing or washing (separate	Esophagoscopy, flexible, transoral: with optical endomicroscopy		Esophagoscopy, flexible, transoral: with directed submucosal injection(s), any substance		Esophagoscopy, flexible, transoral: with directed submucosal injection(s), any substance		Esophagoscopy, flexible, transoral: with biopsy, single or multiple		Esophagoscopy, flexible, transoral: with biopsy, single or multiple		Esophagoscopy, flexible, transoral: with injection sclerosis of esophageal varices		Esophagoscopy, flexible, transoral: with injection sclerosis of esophageal varices			
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000
6	TOTAL CLINICAL LABOR TIME	L051A	RN	0	0	32	0	47	0	42	0	35	0	39	0	37	0	0	0	0	0
7	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	84	33	85	22	103	22	55	28	88	22	56	28	90	22	0	22	0	22
8	PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	18	30	9	19	9	19	9	19	9	19	9	19	9	19	0	19	0	19
9	SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	0	0	32	0	47	0	42	0	35	0	39	0	37	0	0	0	0	0
10	SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	66	0	73	0	91	0	43	6	76	0	47	6	78	0	0	0	0	0
11	POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	3	3	3	3	3	3	3	3	3	0	3	3	3	0	3	0	3
12	PRE-SERVICE																				
13	Start: Following visit when decision for surgery or procedure made																				
14	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	3	5	3	3	3	3	3	3	3	3	3	3	3	3		3	0	3
15	Coordinate pre-surgery services	L037D	RN/LPN/MTA	5	10	3	5	3	5	3	5	3	5	3	5	3	5		5	0	5
16	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0	5	0	3	0	3	0	3	0	3	0	3	0	3		3	0	3
17	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	7	7	0	5	0	5	0	5	0	5	0	5	0	5		5	0	5
18	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3	3	3	3	3	3	3	3	3	3	3	3	3	3		3	0	3
20	End: When patient enters office/facility for surgery/procedure																				
21	SERVICE PERIOD																				
22	Start: When patient enters office/facility for surgery/procedure:																				
23	Review charts [N/A in 2012]	L037D	RN/LPN/MTA	2		0		0		2		0		2		0					
24	Review history, systems, and meds [N/A in 2012]	L037D	RN/LPN/MTA	3		0		0		3		0		3		0					
25	Greet patient, provide gowning, ensure appropriate	L037D	RN/LPN/MTA	3		3		3		3		3		3		3					
26	Obtain vital signs	L037D	RN/LPN/MTA	3		5		5		3		5		3		5					
27	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	5		3		3		5		3		5		3					
28	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2		2		5		2		2		2		2					
29	Setup scope (non facility setting only)	L037D	RN/LPN/MTA			5		5				5				5					
30	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	2		2		2				2		2		2					
31	Sedate/apply anesthesia	L051A	RN	0		2		2		2		2		2		2					
32	Intra-service																				
33	Moderate sedation	L051A	RN	0		15		30		25		18		22		20					
34	Assist physician in performing procedure	L037D	RN/LPN/MTA	15		15		30		17		18		15		20					
35	Post-Service																				
36	Monitor pt. following service/check tubes, monitors,	L051A	RN			15		15		15		15		15		15					
37	Monitor pt. following service/check tubes, monitors,	L037D	RN/LPN/MTA	10																	
38	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	7		3		3		3		3		7		3					
39	Clean Scope	L037D	RN/LPN/MTA			30		30				30				30					
41	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA	2		2		2		2		2		2		2					
43	Check dressings & wound/ home care instructions	L037D	RN/LPN/MTA	3		3		3		3		3		3		3					
44	Other Clinical Activity - specify: phone call	L037D	RN/LPN/MTA	3																	
45	Other Clinical Activity - specify: CMS data entry error	L037D	RN/LPN/MTA	6																	
46	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)	L037D	RN/LPN/MTA								6				6						
47	Dischrg mgmt (1.0 x 99238) (enter 12 min)	L037D	RN/LPN/MTA																		
48	Dischrg mgmt (1.0 x 99239) (enter 15 min)	L037D	RN/LPN/MTA																		
49	End: Patient leaves office																				
50	POST-SERVICE Period																				
51	Start: Patient leaves office/facility																				
52	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	0	3	3	3	3	3	3	3	3	3	0	3	3	3		3	0	3
61	End: with last office visit before end of global period																				
62	MEDICAL SUPPLIES	CODE	UNIT																		
63	SCRUB, DRESS, DRAPE																				
64	pack, minimum multi-specialty visit	SA048	pack	1		1		1		1		1		1		1					
65	gown, staff, impervious	SB027	item	2		2		2				2		2		2					
66	cap, surgical	SB001	item	2		3		3		3		3		2		3					
67	mask, surgical, with face shield	SB034	item	2		3		3		3		3		2		3					
68	shoe covers, surgical	SB039	pair	2		3		3		3		3		2		3					
69	scrub brush (impregnated)	SM023	item	2		3		3		3		3		2		3					
70	drape, non-sterile, sheet 40in x 60in	SB006	item	1		1		1				1		1		1					



	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U
1				PEAC 2003		Recommendation		Recommendation		RUC 2002		Recommendation		PEAC 2003		Recommendation		PEAC 2003		Recommendation	
2				43200		43200		43206 NEW		43201		43201		43202		43202		43204		43204	
3	Meeting Date: October 2012 Tab: 10 Specialty: GI	CMS Code	Staff Type	Esophagoscopy, flexible, transoral: diagnostic, with or without collection of specimen(s) by brushing or washing (separate	Esophagoscopy, flexible, transoral: diagnostic, with or without collection of specimen(s) by brushing or washing (separate	Esophagoscopy, flexible, transoral: with optical endomicroscopy	Esophagoscopy, flexible, transoral: with directed submucosal injection(s), any substance	Esophagoscopy, flexible, transoral: with directed submucosal injection(s), any substance	Esophagoscopy, flexible, transoral: with biopsy, single or multiple	Esophagoscopy, flexible, transoral: with injection sclerosis of esophageal varices	Esophagoscopy, flexible, transoral: with injection sclerosis of esophageal varices										
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000
71	basin, emesis	SJ010	item	1		1		1		1		1		1		1					
72	denture cup	SJ016	item			1		1				1				1					
73	MODERATE SEDATION																				
74	pack, moderate sedation	SA044	pack			1		1		1		1		1		1					
75	electrode, ECG (single)	SD053	item							1		0									
76	nasal cannula	SD100	item							1		0		1		0					
77	bite block	SD006	item			1		1		1		1				1				0	
78	PROCEDURE INSTRUMENTS / SUPPLIES																				
79	Instrument pack basic (\$500 - \$1,499)	EQ137	pack																		
80	Pack, cleaning, surgical instruments	SA043	pack																		
81	endoscope anti-fog solution	SM014	ml	1		1		1				1		1		1					
82	endoscopic cytology brush	SD067	item	1		1		0						1		1					
83	endoscopic biopsy forceps	SD066	item													1					
84	endoscopic polypectomy snare (proxy for endoscopic grasping forceps)	SD068	item																		
85	endosheath (proxy for endoscopic hood)	SD070	item																		
86	endoscopic polypectomy snare	SD068	item																		
87	endoscopic clip	NEW	item																		
88	guidewire, STIFF (proxy for endoscopic guidewire)	SD090	item																		
89	sheath, endoscope ultrasound balloon (proxy for endoscopic balloon, dilation)	SD205	item																		
90	needle, endoscopic ultrasound, cytology	NEW	Item																		
91	needle, micropigmentation (tattoo)	SC079	item									1									
92	syringe 5-6ml	SC057	item							3		3									
93	cautery, patient ground pad with cord	SF021	item																		
94	cautery, bipolar cord	SF012	item																		
95	cautery, bipolar, probe, endoscopy	NEW	item																		
96	catheter, optical endomicroscopy	NEW	item					1													
97	kit, probe, radiofrequency, Xli-enhanced RF probe (proxy for catheter, RF ablation, endoscopic)	SA100	kit																		
98	canister, suction	SD009	item	1		2		2		1		2		1		2					
99	tubing, suction, non-latex (6ft uou)	SD132	item	1		1		1				1		1		1					
100	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item	1		1		1				1		1		1					
101	syringe 50-60ml	SC056	item	1		1		1				1		1		1					
102	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item			1		1				1				1					
103	gauze, non-sterile 4in x 4in	SG051	item	1		1		1				1		1		1					
104	cup, biopsy-specimen non-sterile 4oz	SL035	item	1		1		1				1		1		1					
105	paper, photo printing (8.5 x 11)	SK058	item			1		1				1				1					
106	skin marking ink (tattoo) (proxy for ink, endoscopy, tattoo)	SK073	ml									2									
107	applicator, cotton-tipped, non-sterile 6in	SG008	item	3		0		0						3		0					
108	lubricating jelly (K-Y) (5gm uou)	SJ032	item	4		4		4		2		4		4		4					
109	swab-pad, alcohol	SJ053	item	2		0		0						1		0					
110	SCOPE CLEANING																				
111	pack, cleaning and disinfecting, endoscope	SA042	pack			1		1				1				1					
112	gloves, non-sterile	SB022	pair	1		0		0		1		0		1		0					
113	basin, irrigation	SJ009	item	1		0		0		1		0		1		0					
114	cleaning brush, endoscope	SM010	item	1		0		0		1		0		1		0					
115	enzymatic detergent	SM015	oz	1		0		0						1		0					
116	glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)	SM018	oz	6		0		0						6		0					
117	glutaraldehyde test strips (Cidex, Metrex)	SM019	item	1		0		0						1		0					
118	EQUIPMENT	CODE																			
119	videoscope, gastroscopy	ES034		60		59		77		30		62		35		64					
120	videoscope, endoscopic ultrasound	NEW																			
121	stretcher	EF018				73		91		60		76		60		78					
122	IV infusion pump	EQ032				52		70		87		55		84		57					

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U
1				PEAC 2003		Recommendation		Recommendation		RUC 2002		Recommendation		PEAC 2003		Recommendation		PEAC 2003		Recommendation	
2				43200		43200		43206 NEW		43201		43201		43202		43202		43204		43204	
3	Meeting Date: October 2012 Tab: 10 Specialty: GI	CMS Code	Staff Type	Esophagoscopy, flexible, transoral: diagnostic, with or without collection of specimen(s) by brushing or washing (separate		Esophagoscopy, flexible, transoral: diagnostic, with or without collection of specimen(s) by brushing or washing (separate		Esophagoscopy, flexible, transoral: with optical endomicroscopy		Esophagoscopy, flexible, transoral: with directed submucosal injection(s), any substance		Esophagoscopy, flexible, transoral: with directed submucosal injection(s), any substance		Esophagoscopy, flexible, transoral: with biopsy, single or multiple		Esophagoscopy, flexible, transoral: with biopsy, single or multiple		Esophagoscopy, flexible, transoral: with injection sclerosis of esophageal varices		Esophagoscopy, flexible, transoral: with injection sclerosis of esophageal varices	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000
123	table, power	EF031		60		29		47		30		32		35		34					
124	video system, endoscopy (processor, digital capture, monitor, printer, cart)	ES031		60		29		47		30		32		35		34					
125	suction machine (Gomco)	EQ235		60		29		47				32		35		34					
126	table, instrument, mobile	EF027				29		47		87		32		84		34					
127	electrosurgical generator, gastrocautery	EQ113												35							
128	RF Ablation system NEW																				
129	endoscopic ultrasound processor unit system	NEW																			
130	optical endomicroscope processor unit system	NEW						77													
131	endoscope disinfectant, rigid or fiberoptic, w-cart	ES005		40		30		30				30		40		30					
132	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011				52		70		87		55		84		57					

	A	B	C	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM
1				PEAC 2003	Recommendation	PEAC 2003	Recommendation	PEAC 2004	Recommendation	PEAC 2003	Recommendation	PEAC 2003	Recommendation	PEAC 2003	Recommendation	PEAC 2003	Recommendation	PEAC 2003	Recommendation	PEAC 2003	Recommendation
2				43205	43205	43215	43215	43216	43216	43217	43217	43219	43219	43219	43219	43219	43219	43219	43219	43219	43219
3	Meeting Date: October 2012 Tab: 10 Specialty: GI	CMS Code	Staff Type	Esophagoscopy, flexible, transoral: with band ligation of esophageal varices	Esophagoscopy, flexible, transoral: with band ligation of esophageal varices	Esophagoscopy, flexible, transoral:with removal of foreign body	Esophagoscopy, flexible, transoral:with removal of foreign body	Esophagoscopy, flexible, transoral:with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar	Esophagoscopy, flexible, transoral:with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar	Esophagoscopy, flexible, transoral:with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	Esophagoscopy, flexible, transoral:with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	Esophagoscopy, flexible, transoral:with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	Esophagoscopy, flexible, transoral:with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	Esophagoscopy, flexible, transoral:with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	Esophagoscopy, flexible, transoral:with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	Esophagoscopy, flexible, transoral:with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	Esophagoscopy, flexible, transoral:with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	Esophagoscopy, flexible, transoral:with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	Esophagoscopy, flexible, transoral:with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	Esophagoscopy, flexible, transoral:with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	Esophagoscopy, flexible, transoral:with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000
6	TOTAL CLINICAL LABOR TIME	L051A	RN	0	0	0	0	0	0	37	0	50	0	39	0	46	0	47	0	0	0
7	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	22	0	22	0	22	90	22	95	25	92	22	60	22	100	22	0	33
8	PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	19	0	19	0	19	9	19	9	19	9	19	9	19	9	19	0	30
9	SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	0	0	0	0	0	0	37	0	50	0	39	0	46	0	47	0	0	0
10	SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	0	0	0	0	0	78	0	83	0	80	0	51	0	88	0	0	0
11	POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	3	0	3	0	3	3	3	3	6	3	3	0	3	3	3	0	3
12	PRE-SERVICE																				
13	Start: Following visit when decision for surgery or procedure made																				
14	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		3	0	3		3	3	3	3	3	3	3	3	3	3	3		5
15	Coordinate pre-surgery services	L037D	RN/LPN/MTA		5	0	5		5	3	5	3	5	3	5	3	5	3	5		10
16	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3	0	3		3	0	3	0	3	0	3	0	3	0	3		5
17	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5	0	5		5	0	5	0	5	0	5	0	5	0	5		7
18	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		3	0	3		3	3	3	3	3	3	3	3	3	3	3		3
20	End: When patient enters office/facility for surgery/procedure																				
21	SERVICE PERIOD																				
22	Start: When patient enters office/facility for surgery/procedure:																				
23	Review charts [N/A in 2012]	L037D	RN/LPN/MTA									2		0		2		0			
24	Review history, systems, and meds [N/A in 2012]	L037D	RN/LPN/MTA													3		0			
25	Greet patient, provide gowning, ensure appropriate	L037D	RN/LPN/MTA							3		3		3		3		3			
26	Obtain vital signs	L037D	RN/LPN/MTA							5		3		5		3		5			
27	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA							3		5		3		5		3			
28	Prepare room, equipment, supplies	L037D	RN/LPN/MTA							2		2		2		2		2			
29	Setup scope (non facility setting only)	L037D	RN/LPN/MTA							5		5		5		5		5			
30	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA							2		2		2		2		2			
31	Sedate/apply anesthesia	L051A	RN							2		2		2		2		2			
32	Intra-service																				
33	Moderate sedation	L051A	RN							20		33		22		29		30			
34	Assist physician in performing procedure	L037D	RN/LPN/MTA							20		22		22		19		30			
35	Post-Service																				
36	Monitor pt. following service/check tubes, monitors,	L051A	RN							15		15		15		15		15			
37	Monitor pt. following service/check tubes, monitors,	L037D	RN/LPN/MTA																		
38	Clean room/equipment by physician staff	L037D	RN/LPN/MTA							3		3		3		7		3			
39	Clean Scope	L037D	RN/LPN/MTA							30		30		30				30			
41	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA							2		3		2		2		2			
43	Check dressings & wound/ home care instructions	L037D	RN/LPN/MTA							3		3		3		3		3			
44	Other Clinical Activity - specify: phone call	L037D	RN/LPN/MTA																		
45	Other Clinical Activity - specify: CMS data entry error	L037D	RN/LPN/MTA																		
46	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)	L037D	RN/LPN/MTA																		
47	Dischrg mgmt (1.0 x 99238) (enter 12 min)	L037D	RN/LPN/MTA																		
48	Dischrg mgmt (1.0 x 99239) (enter 15 min)	L037D	RN/LPN/MTA																		
49	End: Patient leaves office																				
50	POST-SERVICE Period																				
51	Start: Patient leaves office/facility																				
52	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA		3	0	3		3	3	3	3	6	3	3	0	3	3	3		3
61	End: with last office visit before end of global period																				
62	MEDICAL SUPPLIES	CODE	UNIT																		
63	SCRUB, DRESS, DRAPE																				
64	pack, minimum multi-specialty visit	SA048	pack							1				1		1		1			
65	gown, staff, impervious	SB027	item							2				2		2		2			
66	cap, surgical	SB001	item							3				3		2		3			
67	mask, surgical, with face shield	SB034	item							3				3		2		3			
68	shoe covers, surgical	SB039	pair							3				3		2		3			
69	scrub brush (impregnated)	SM023	item							3				3		2		3			
70	drape, non-sterile, sheet 40in x 60in	SB006	item							1				1		1		1			

	A	B	C	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM
1				PEAC 2003		Recommendation		PEAC 2003		Recommendation		PEAC 2004		Recommendation		PEAC 2003		Recommendation		PEAC 2003	
2				43205		43205		43215		43215		43216		43216		43217		43217		43219	
3	Meeting Date: October 2012 Tab: 10 Specialty: GI	CMS Code	Staff Type	Esophagoscopy, flexible, transoral: with band ligation of esophageal varices		Esophagoscopy, flexible, transoral: with band ligation of esophageal varices		Esophagoscopy, flexible, transoral:with removal of foreign body		Esophagoscopy, flexible, transoral:with removal of foreign body		Esophagoscopy, flexible, transoral:with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar		Esophagoscopy, flexible, transoral:with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar		Esophagoscopy, flexible, transoral:with removal of tumor(s), polyp(s), or other lesion(s) by snare technique		Esophagoscopy, flexible, transoral:with removal of tumor(s), polyp(s), or other lesion(s) by snare technique		Esophagoscopy, flexible, transoral:with insertion of plastic tube or stent	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000
71	basin, emesis	SJ010	item							1				1		1		1			
72	denture cup	SJ016	item							1				1				1			
73	MODERATE SEDATION																				
74	pack, moderate sedation	SA044	pack							1				1		1		1			
75	electrode, ECG (single)	SD053	item																		
76	nasal cannula	SD100	item													1		0			
77	bite block	SD006	item			0				1				1				1			
78	PROCEDURE INSTRUMENTS / SUPPLIES																				
79	Instrument pack basic (\$500 - \$1,499)	EQ137	pack																		
80	Pack, cleaning, surgical instruments	SA043	pack																		
81	endoscope anti-fog solution	SM014	ml							1				1		1		1			
82	endoscopic cytology brush	SD067	item							1				1		1		1			
83	endoscopic biopsy forceps	SD066	item											1							
84	endoscopic polypectomy snare (proxy for endoscopic grasping forceps)	SD068	item							1								1			
85	endosheath (proxy for endoscopic hood)	SD070	item							1											
86	endoscopic polypectomy snare	SD068	item													1		1			
87	endoscopic clip	NEW	item																		
88	guidewire, STIFF (proxy for endoscopic guidewire)	SD090	item																		
89	sheath, endoscope ultrasound balloon (proxy for endoscopic balloon, dilation)	SD205	item																		
90	needle, endoscopic ultrasound, cytology	NEW	Item																		
91	needle, micropigmentation (tattoo)	SC079	item																		
92	syringe 5-6ml	SC057	item																		
93	cautery, patient ground pad with cord	SF021	item											1				1			
94	cautery, bipolar cord	SF012	item											1				1			
95	cautery, bipolar, probe, endoscopy	NEW	item															0			
96	catheter, optical endomicroscopy	NEW	item																		
97	kit, probe, radiofrequency, Xli-enhanced RF probe (proxy for catheter, RF ablation, endoscopic)	SA100	kit																		
98	canister, suction	SD009	item							2				2		1		2			
99	tubing, suction, non-latex (6ft uou)	SD132	item							1				1		1		1			
100	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item							1				1		1		1			
101	syringe 50-60ml	SC056	item							1				1		1		1			
102	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item							1				1				1			
103	gauze, non-sterile 4in x 4in	SG051	item							1				1		1		1			
104	cup, biopsy-specimen non-sterile 4oz	SL035	item							1				1		1		1			
105	paper, photo printing (8.5 x 11)	SK058	item							1				1				1			
106	skin marking ink (tattoo) (proxy for ink, endoscopy, tattoo)	SK073	ml																		
107	applicator, cotton-tipped, non-sterile 6in	SG008	item													1		0			
108	lubricating jelly (K-Y) (5gm uou)	SJ032	item							4				4		4		4			
109	swab-pad, alcohol	SJ053	item													2		0			
110	SCOPE CLEANING																				
111	pack, cleaning and disinfecting, endoscope	SA042	pack							1				1				1			
112	gloves, non-sterile	SB022	pair													1		0			
113	basin, irrigation	SJ009	item													1		0			
114	cleaning brush, endoscope	SM010	item													1		0			
115	enzymatic detergent	SM015	oz													1		0			
116	glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)	SM018	oz													6		0			
117	glutaraldehyde test strips (Cidex, Metrex)	SM019	item													1		0			
118	EQUIPMENT	CODE																			
119	videoscope, gastroscopy	ES034								64				66		42	42	74			
120	videoscope, endoscopic ultrasound	NEW																			
121	stretcher	EF018								78				80		60	60	88			
122	IV infusion pump	EQ032								57				59		91	91	67			



	A	B	C	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM
1				PEAC 2003		Recommendation		PEAC 2003		Recommendation		PEAC 2004		Recommendation		PEAC 2003		Recommendation		PEAC 2003	
2				43205		43205		43215		43215		43216		43216		43217		43217		43219	
3	Meeting Date: October 2012 Tab: 10 Specialty: GI	CMS Code	Staff Type	Esophagoscopy, flexible, transoral: with band ligation of esophageal varices		Esophagoscopy, flexible, transoral: with band ligation of esophageal varices		Esophagoscopy, flexible, transoral:with removal of foreign body		Esophagoscopy, flexible, transoral:with removal of foreign body		Esophagoscopy, flexible, transoral:with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar		Esophagoscopy, flexible, transoral:with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar		Esophagoscopy, flexible, transoral:with removal of tumor(s), polyp(s), or other lesion(s) by snare technique		Esophagoscopy, flexible, transoral:with removal of tumor(s), polyp(s), or other lesion(s) by snare technique		Esophagoscopy, flexible, transoral:with insertion of plastic tube or stent	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000
123	table, power	EF031								34				36		42	42	44			
124	video system, endoscopy (processor, digital capture, monitor, printer, cart)	ES031								34				36		42	42	44			
125	suction machine (Gomco)	EQ235								34				36		42	42	44			
126	table, instrument, mobile	EF027								34				36		91	91	44			
127	electrosurgical generator, gastrocautery	EQ113												36		42	42	44			
128	RF Ablation system	NEW																			
129	endoscopic ultrasound processor unit system	NEW																			
130	optical endomicroscope processor unit system	NEW																			
131	endoscope disinfecter, rigid or fiberoptic, w-cart	ES005								30				30		40	40	30			
132	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011								57				59		91	91	67			

	A	B	C	D	E	F	G
				Crosswalk Code from RUC 10/2012 FAC ONLY		Recommendation (x-walk 43217 RUC 10/12) FAC ONLY	
1				43205		43211 NEW	
2				ESOPH, with band ligation of esophageal varices		ESOPH, with endoscopic mucosal resection	
3	Meeting Date: January 2013 Tab: Esophagoscopy Specialty: GI Tab 9	CMS Code	Staff Type				
4	LOCATION			NF	FAC	NF	FAC
5	GLOBAL PERIOD			000	000	000	000
6	TOTAL CLINICAL LABOR TIME	L051A	RN	0	0	0	0
7	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	22	0	22
8	PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	19	0	19
9	SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	0	0	0	0
10	SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	0	0	0
11	POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	3	0	3
12	PRE-SERVICE						
13	Start: Following visit when decision for surgery or procedure made						
14	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		3		3
15	Coordinate pre-surgery services	L037D	RN/LPN/MTA		5		5
16	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3
17	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5
18	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		3		3
20	End: When patient enters office/facility for surgery/procedure						
21	SERVICE PERIOD						
22	Start: When patient enters office/facility for surgery/procedure:						
23	Greet patient, provide gowning, ensure appropriate	L037D	RN/LPN/MTA				
24	Obtain vital signs	L037D	RN/LPN/MTA				
25	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA				
26	Prepare room, equipment, supplies	L037D	RN/LPN/MTA				
27	Setup scope (non facility setting only)	L037D	RN/LPN/MTA				
28	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA				
29	Sedate/apply anesthesia	L051A	RN				
30	Intra-service						
31	Moderate sedation	L051A	RN				
32	Assist physician in performing procedure	L037D	RN/LPN/MTA				
33	Post-Service						
34	Monitor pt. following service/check tubes, monitors, drains	L051A	RN				
35	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MTA				
36	Clean room/equipment by physician staff	L037D	RN/LPN/MTA				
37	Clean Scope	L037D	RN/LPN/MTA				
38	Clean Surgical Instrument Package	L037D	RN/LPN/MTA				
39	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA				
40	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA				
41	Check dressings & wound/ home care instructions	L037D	RN/LPN/MTA				
45	End: Patient leaves office						
46	POST-SERVICE Period						
47	Start: Patient leaves office/facility						
48	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA		3		3
57	End: with last office visit before end of global period						
58	MEDICAL SUPPLIES	CODE	UNIT				
59	SCRUB, DRESS, DRAPE						
60	pack, minimum multi-specialty visit	SA048	pack				
61	gown, staff, impervious	SB027	item				
62	cap, surgical	SB001	item				
63	mask, surgical, with face shield	SB034	item				
64	shoe covers, surgical	SB039	pair				
65	scrub brush (impregnated)	SM023	item				
66	drape, non-sterile, sheet 40in x 60in	SB006	item				
67	basin, emesis	SJ010	item				
68	denture cup	SJ016	item				
69	MODERATE SEDATION						
70	pack, moderate sedation	SA044	pack				
71	electrode, ECG (single)	SD053	item				
72	nasal cannula	SD100	item				
73	bite block	SD006	item				
74	PROCEDURE INSTRUMENTS / SUPPLIES						
75	endoscope anti-fog solution	SM014	ml				
76	endoscopic cytology brush	SD067	item				
77	endoscopic biopsy forceps	SD066	item				
78	endoscopic polypectomy snare	SD068	item				
79	endosheath (proxy for endoscopic hood)	SD070	item				
80	endoscopic clip	NEW	item				
81	guidewire, STIFF	SD090	item				
82	endoscopic balloon, dilation	SD019	item				
83	needle, endoscopic ultrasound, cytology	NEW	item				
84	needle, micropigmentation (tattoo)	SC079	item				
85	skin marking ink (tattoo)	SK073	ml				
86	needle, variceal injection	SC044	item				
87	syringe 5-6ml	SC057	item				
88	cautery, patient ground pad with cord	SF021	item				
89	cautery, bipolar cord	SF012	item				
90	cautery, bipolar, probe, endoscopy	NEW	item				
91	kit, probe, radiofrequency, Xli-enhanced RF probe (proxy for catheter, RF ablation, endoscopic)	SA100	kit				
92	canister, suction	SD009	item				
93	tubing, suction, non-latex (6ft uou)	SD132	item				
94	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item				
95	syringe 50-60ml	SC056	item				
96	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item				
97	gauze, non-sterile 4in x 4in	SG051	item				
98	cup, biopsy-specimen non-sterile 4oz	SL035	item				
99	paper, photo printing (8.5 x 11)	SK058	item				
100	applicator, cotton-tipped, non-sterile 6in	SG008	item				
101	lubricating jelly (K-Y) (5gm uou)	SJ032	item				
102	swab-pad, alcohol	SJ053	item				
103	SCOPE CLEANING						
104	pack, cleaning and disinfecting, endoscope	SA042	pack				
105	gloves, non-sterile	SB022	pair				
106	basin, irrigation	SJ009	item				
107	cleaning brush, endoscope	SM010	item				
108	enzymatic detergent	SM015	oz				
109	glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)	SM018	oz				
110	glutaraldehyde test strips (Cidex, Metrex)	SM019	item				
111	EQUIPMENT	CODE					
112	videoscope, gastroscopy	ES034					
113	stretcher	EF018					
114	IV infusion pump	EQ032					
115	table, power	EF031					
116	video system, endoscopy (processor, digital capture, monitor, printer, cart)	ES031					
117	suction machine (Gomco)	EQ235					
118	table, instrument, mobile	EF027					
119	radiofrequency generator (NEURO)	EQ214					
120	electrosurgical generator, gastrocautery	EQ113					
121	endoscope disinfectant, rigid or fiberoptic, w-cart	ES005					
122	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011					



	A	B	C	H	I	J	K
				Crosswalk Code from RUC 10/2012		Recommendation (x-walk 43220, RUC 10/12)	
1							
2				43220		43213 <b>NEW</b>	
3	Meeting Date: January 2013 Tab: Esophagoscopy Specialty: GI Tab 9	CMS Code	Staff Type	ESOPH, with balloon dilation (less than 30 mm diameter)		ESOPH, with dilation of esophagus, by balloon or dilator, retrograde (includes fluoroscopic guidance, when	
4	LOCATION			NF	FAC	NF	FAC
5	GLOBAL PERIOD			000	000	000	000
6	TOTAL CLINICAL LABOR TIME	L051A	RN	37	0	62	0
7	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	90	22	115	22
8	PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	9	19	9	19
9	SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	37	0	62	0
10	SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	78	0	103	0
11	POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	3	3	3	3
12	PRE-SERVICE						
13	Start: Following visit when decision for surgery or procedure made						
14	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	3	3	3	3
15	Coordinate pre-surgery services	L037D	RN/LPN/MTA	3	5	3	5
16	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3
17	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5
18	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3	3	3	3
20	End: When patient enters office/facility for surgery/procedure						
21	SERVICE PERIOD						
22	Start: When patient enters office/facility for surgery/procedure:						
23	Greet patient, provide gowning, ensure appropriate	L037D	RN/LPN/MTA	3		3	
24	Obtain vital signs	L037D	RN/LPN/MTA	5		5	
25	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	3		3	
26	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2		2	
27	Setup scope (non facility setting only)	L037D	RN/LPN/MTA	5		5	
28	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	2		2	
29	Sedate/apply anesthesia	L051A	RN	2		2	
30	Intra-service						
31	Moderate sedation	L051A	RN	20		45	
32	Assist physician in performing procedure	L037D	RN/LPN/MTA	20		45	
33	Post-Service						
34	Monitor pt. following service/check tubes, monitors, drains	L051A	RN	15		15	
35	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MTA				
36	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	3		3	
37	Clean Scope	L037D	RN/LPN/MTA	30		30	
38	Clean Surgical Instrument Package	L037D	RN/LPN/MTA				
39	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA	2		2	
40	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA				
41	Check dressings & wound/ home care instructions	L037D	RN/LPN/MTA	3		3	
45	End: Patient leaves office						
46	POST-SERVICE Period						
47	Start: Patient leaves office/facility						
48	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	3	3	3	3
57	End: with last office visit before end of global period						
58	MEDICAL SUPPLIES	CODE	UNIT				
59	SCRUB, DRESS, DRAPE						
60	pack, minimum multi-specialty visit	SA048	pack	1		1	
61	gown, staff, impervious	SB027	item	2		2	
62	cap, surgical	SB001	item	3		3	
63	mask, surgical, with face shield	SB034	item	3		3	
64	shoe covers, surgical	SB039	pair	3		3	
65	scrub brush (impregnated)	SM023	item	3		3	
66	drape, non-sterile, sheet 40in x 60in	SB006	item	1		1	
67	basin, emesis	SJ010	item	1		1	
68	denture cup	SJ016	item	1		1	
69	MODERATE SEDATION						
70	pack, moderate sedation	SA044	pack	1		1	
71	electrode, ECG (single)	SD053	item				
72	nasal cannula	SD100	item				
73	bite block	SD006	item	1		1	
74	PROCEDURE INSTRUMENTS / SUPPLIES						
75	endoscope anti-fog solution	SM014	ml	1		1	
76	endoscopic cytology brush	SD067	item	1		1	
77	endoscopic biopsy forceps	SD066	item				
78	endoscopic polypectomy snare	SD068	item				
79	endosheath (proxy for endoscopic hood)	SD070	item				
80	endoscopic clip	NEW	item				
81	guidewire, STIFF	SD090	item	1		1	
82	endoscopic balloon, dilation	SD019	item	3		3	
83	needle, endoscopic ultrasound, cytology	NEW	item				
84	needle, micropigmentation (tattoo)	SC079	item				
85	skin marking ink (tattoo)	SK073	ml				
86	needle, variceal injection	SC044	item				
87	syringe 5-6ml	SC057	item				
88	cautery, patient ground pad with cord	SF021	item				
89	cautery, bipolar cord	SF012	item				
90	cautery, bipolar, probe, endoscopy	NEW	item				
91	kit, probe, radiofrequency, Xli-enhanced RF probe (proxy for catheter, RF ablation, endoscopic)	SA100	kit				
92	canister, suction	SD009	item	2		2	
93	tubing, suction, non-latex (6ft uou)	SD132	item	1		1	
94	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item	1		1	
95	syringe 50-60ml	SC056	item	1		1	
96	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item	1		1	
97	gauze, non-sterile 4in x 4in	SG051	item	1		1	
98	cup, biopsy-specimen non-sterile 4oz	SL035	item	1		1	
99	paper, photo printing (8.5 x 11)	SK058	item	1		1	
100	applicator, cotton-tipped, non-sterile 6in	SG008	item				
101	lubricating jelly (K-Y) (5gm uou)	SJ032	item	4		4	
102	swab-pad, alcohol	SJ053	item				
103	SCOPE CLEANING						
104	pack, cleaning and disinfecting, endoscope	SA042	pack	1		1	
105	gloves, non-sterile	SB022	pair				
106	basin, irrigation	SJ009	item				
107	cleaning brush, endoscope	SM010	item				
108	enzymatic detergent	SM015	oz				
109	glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)	SM018	oz				
110	glutaraldehyde test strips (Cidex, Metrex)	SM019	item				
111	EQUIPMENT	CODE					
112	videoscope, gastroscopy	ES034		64		100	
113	stretcher	EF018		78		0	
114	IV infusion pump	EQ032		57		107	
115	table, power	EF031		34		73	
116	video system, endoscopy (processor, digital capture, monitor, printer, cart)	ES031		34		73	
117	suction machine (Gomco)	EQ235		34		73	
118	table, instrument, mobile	EF027		34		107	
119	radiofrequency generator (NEURO)	EQ214					
120	electrosurgical generator, gastrocautery	EQ113					
121	endoscope disinfectant, rigid or fiberoptic, w-cart	ES005		30		30	
122	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011		57		107	

	A	B	C	L	M	N	O
				Crosswalk Code from RUC 10/2012 FAC ONLY		Recommendation (x-walk 43205, RUC 10/12) FAC ONLY	
1				43205		43214 NEW	
2				ESOPH, with band ligation of esophageal varices		ESOPH, with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance,	
3	Meeting Date: January 2013 Tab: Esophagoscopy Specialty: GI Tab 9	CMS Code	Staff Type				
4	LOCATION			NF	FAC	NF	FAC
5	GLOBAL PERIOD			000	000	000	000
6	TOTAL CLINICAL LABOR TIME	L051A	RN	0	0	0	0
7	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	22	0	22
8	PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	19	0	19
9	SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	0	0	0	0
10	SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	0	0	0
11	POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	3	0	3
12	PRE-SERVICE						
13	Start: Following visit when decision for surgery or procedure made						
14	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		3		3
15	Coordinate pre-surgery services	L037D	RN/LPN/MTA		5		5
16	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3
17	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5
18	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		3		3
20	End: When patient enters office/facility for surgery/procedure						
21	SERVICE PERIOD						
22	Start: When patient enters office/facility for surgery/procedure:						
23	Greet patient, provide gowning, ensure appropriate	L037D	RN/LPN/MTA				
24	Obtain vital signs	L037D	RN/LPN/MTA				
25	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA				
26	Prepare room, equipment, supplies	L037D	RN/LPN/MTA				
27	Setup scope (non facility setting only)	L037D	RN/LPN/MTA				
28	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA				
29	Sedate/apply anesthesia	L051A	RN				
30	Intra-service						
31	Moderate sedation	L051A	RN				
32	Assist physician in performing procedure	L037D	RN/LPN/MTA				
33	Post-Service						
34	Monitor pt. following service/check tubes, monitors, drains	L051A	RN				
35	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MTA				
36	Clean room/equipment by physician staff	L037D	RN/LPN/MTA				
37	Clean Scope	L037D	RN/LPN/MTA				
38	Clean Surgical Instrument Package	L037D	RN/LPN/MTA				
39	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA				
40	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA				
41	Check dressings & wound/ home care instructions	L037D	RN/LPN/MTA				
45	End: Patient leaves office						
46	POST-SERVICE Period						
47	Start: Patient leaves office/facility						
48	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA		3		3
57	End: with last office visit before end of global period						
58	MEDICAL SUPPLIES	CODE	UNIT				
59	SCRUB, DRESS, DRAPE						
60	pack, minimum multi-specialty visit	SA048	pack				
61	gown, staff, impervious	SB027	item				
62	cap, surgical	SB001	item				
63	mask, surgical, with face shield	SB034	item				
64	shoe covers, surgical	SB039	pair				
65	scrub brush (impregnated)	SM023	item				
66	drape, non-sterile, sheet 40in x 60in	SB006	item				
67	basin, emesis	SJ010	item				
68	denture cup	SJ016	item				
69	MODERATE SEDATION						
70	pack, moderate sedation	SA044	pack				
71	electrode, ECG (single)	SD053	item				
72	nasal cannula	SD100	item				
73	bite block	SD006	item				
74	PROCEDURE INSTRUMENTS / SUPPLIES						
75	endoscope anti-fog solution	SM014	ml				
76	endoscopic cytology brush	SD067	item				
77	endoscopic biopsy forceps	SD066	item				
78	endoscopic polypectomy snare	SD068	item				
79	endosheath (proxy for endoscopic hood)	SD070	item				
80	endoscopic clip	NEW	item				
81	guidewire, STIFF	SD090	item				
82	endoscopic balloon, dilation	SD019	item				
83	needle, endoscopic ultrasound, cytology	NEW	item				
84	needle, micropigmentation (tattoo)	SC079	item				
85	skin marking ink (tattoo)	SK073	ml				
86	needle, variceal injection	SC044	item				
87	syringe 5-6ml	SC057	item				
88	cautery, patient ground pad with cord	SF021	item				
89	cautery, bipolar cord	SF012	item				
90	cautery, bipolar, probe, endoscopy	NEW	item				
91	kit, probe, radiofrequency, Xli-enhanced RF probe (proxy for catheter, RF ablation, endoscopic)	SA100	kit				
92	canister, suction	SD009	item				
93	tubing, suction, non-latex (6ft uou)	SD132	item				
94	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item				
95	syringe 50-60ml	SC056	item				
96	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item				
97	gauze, non-sterile 4in x 4in	SG051	item				
98	cup, biopsy-specimen non-sterile 4oz	SL035	item				
99	paper, photo printing (8.5 x 11)	SK058	item				
100	applicator, cotton-tipped, non-sterile 6in	SG008	item				
101	lubricating jelly (K-Y) (5gm uou)	SJ032	item				
102	swab-pad, alcohol	SJ053	item				
103	SCOPE CLEANING						
104	pack, cleaning and disinfecting, endoscope	SA042	pack				
105	gloves, non-sterile	SB022	pair				
106	basin, irrigation	SJ009	item				
107	cleaning brush, endoscope	SM010	item				
108	enzymatic detergent	SM015	oz				
109	glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)	SM018	oz				
110	glutaraldehyde test strips (Cidex, Metrex)	SM019	item				
111	EQUIPMENT	CODE					
112	videoscope, gastroscopy	ES034					
113	stretcher	EF018					
114	IV infusion pump	EQ032					
115	table, power	EF031					
116	video system, endoscopy (processor, digital capture, monitor, printer, cart)	ES031					
117	suction machine (Gomco)	EQ235					
118	table, instrument, mobile	EF027					
119	radiofrequency generator (NEURO)	EQ214					
120	electrosurgical generator, gastrocautery	EQ113					
121	endoscope disinfectant, rigid or fiberoptic, w-cart	ES005					
122	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011					



	A	B	C	P	Q	R	S
				Crosswalk Code from RUC 10/2012 FAC ONLY		Recommendation (x-walk 43219, RUC 10/12) FAC ONLY	
1				43219		43212 NEW	
2	Meeting Date: January 2013 Tab: Esophagoscopy Specialty: GI Tab 9	CMS Code	Staff Type	ESOPH, with insertion of plastic tube or stent		ESOPH, with placement of endoscopic stent (includes pre- and post- dilation and guidewire passage, when	
3							
4	LOCATION			NF	FAC	NF	FAC
5	GLOBAL PERIOD			000	000	000	000
6	TOTAL CLINICAL LABOR TIME	L051A	RN	0	0	0	0
7	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	19	0	19
8	PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	19	0	19
9	SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	0	0	0	0
10	SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	0	0	0
11	POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	0	0	0
12	PRE-SERVICE						
13	Start: Following visit when decision for surgery or procedure made						
14	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		3		3
15	Coordinate pre-surgery services	L037D	RN/LPN/MTA		5		5
16	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3
17	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5
18	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		3		3
20	End: When patient enters office/facility for surgery/procedure						
21	SERVICE PERIOD						
22	Start: When patient enters office/facility for surgery/procedure:						
23	Greet patient, provide gowning, ensure appropriate	L037D	RN/LPN/MTA				
24	Obtain vital signs	L037D	RN/LPN/MTA				
25	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA				
26	Prepare room, equipment, supplies	L037D	RN/LPN/MTA				
27	Setup scope (non facility setting only)	L037D	RN/LPN/MTA				
28	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA				
29	Sedate/apply anesthesia	L051A	RN				
30	Intra-service						
31	Moderate sedation	L051A	RN				
32	Assist physician in performing procedure	L037D	RN/LPN/MTA				
33	Post-Service						
34	Monitor pt. following service/check tubes, monitors, drains	L051A	RN				
35	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MTA				
36	Clean room/equipment by physician staff	L037D	RN/LPN/MTA				
37	Clean Scope	L037D	RN/LPN/MTA				
38	Clean Surgical Instrument Package	L037D	RN/LPN/MTA				
39	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA				
40	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA				
41	Check dressings & wound/ home care instructions	L037D	RN/LPN/MTA				
45	End: Patient leaves office						
46	POST-SERVICE Period						
47	Start: Patient leaves office/facility						
48	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA				0
57	End: with last office visit before end of global period						
58	MEDICAL SUPPLIES	CODE	UNIT				
59	SCRUB, DRESS, DRAPE						
60	pack, minimum multi-specialty visit	SA048	pack				
61	gown, staff, impervious	SB027	item				
62	cap, surgical	SB001	item				
63	mask, surgical, with face shield	SB034	item				
64	shoe covers, surgical	SB039	pair				
65	scrub brush (impregnated)	SM023	item				
66	drape, non-sterile, sheet 40in x 60in	SB006	item				
67	basin, emesis	SJ010	item				
68	denture cup	SJ016	item				
69	MODERATE SEDATION						
70	pack, moderate sedation	SA044	pack				
71	electrode, ECG (single)	SD053	item				
72	nasal cannula	SD100	item				
73	bite block	SD006	item				
74	PROCEDURE INSTRUMENTS / SUPPLIES						
75	endoscope anti-fog solution	SM014	ml				
76	endoscopic cytology brush	SD067	item				
77	endoscopic biopsy forceps	SD066	item				
78	endoscopic polypectomy snare	SD068	item				
79	endosheath (proxy for endoscopic hood)	SD070	item				
80	endoscopic clip	NEW	item				
81	guidewire, STIFF	SD090	item				
82	endoscopic balloon, dilation	SD019	item				
83	needle, endoscopic ultrasound, cytology	NEW	item				
84	needle, micropigmentation (tattoo)	SC079	item				
85	skin marking ink (tattoo)	SK073	ml				
86	needle, variceal injection	SC044	item				
87	syringe 5-6ml	SC057	item				
88	cautery, patient ground pad with cord	SF021	item				
89	cautery, bipolar cord	SF012	item				
90	cautery, bipolar, probe, endoscopy	NEW	item				
91	kit, probe, radiofrequency, Xli-enhanced RF probe (proxy for catheter, RF ablation, endoscopic)	SA100	kit				
92	canister, suction	SD009	item				
93	tubing, suction, non-latex (6ft uou)	SD132	item				
94	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item				
95	syringe 50-60ml	SC056	item				
96	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item				
97	gauze, non-sterile 4in x 4in	SG051	item				
98	cup, biopsy-specimen non-sterile 4oz	SL035	item				
99	paper, photo printing (8.5 x 11)	SK058	item				
100	applicator, cotton-tipped, non-sterile 6in	SG008	item				
101	lubricating jelly (K-Y) (5gm uou)	SJ032	item				
102	swab-pad, alcohol	SJ053	item				
103	SCOPE CLEANING						
104	pack, cleaning and disinfecting, endoscope	SA042	pack				
105	gloves, non-sterile	SB022	pair				
106	basin, irrigation	SJ009	item				
107	cleaning brush, endoscope	SM010	item				
108	enzymatic detergent	SM015	oz				
109	glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)	SM018	oz				
110	glutaraldehyde test strips (Cidex, Metrex)	SM019	item				
111	EQUIPMENT	CODE					
112	videoscope, gastroscopy	ES034					
113	stretcher	EF018					
114	IV infusion pump	EQ032					
115	table, power	EF031					
116	video system, endoscopy (processor, digital capture, monitor, printer, cart)	ES031					
117	suction machine (Gomco)	EQ235					
118	table, instrument, mobile	EF027					
119	radiofrequency generator (NEURO)	EQ214					
120	electrosurgical generator, gastrocautery	EQ113					
121	endoscope disinfectant, rigid or fiberoptic, w-cart	ES005					
122	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011					

	A	B	C	T	U	V	W
				Crosswalk Code from RUC 10/2012		Recommendation (x-walk 43228, RUC 10/12)	
1							
2				43228		43229 <b>NEW</b>	
3	Meeting Date: January 2013 Tab: Esophagoscopy Specialty: GI Tab 9	CMS Code	Staff Type	Esophagoscopy, flexible, transoral: with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by		ESOPH, with ablation of tumor(s), polyp(s), or other lesion(s), (includes pre- and post-dilation and guidewire passage,	
4	LOCATION			NF	FAC	NF	FAC
5	GLOBAL PERIOD			000	000	000	000
6	TOTAL CLINICAL LABOR TIME	L051A	RN	52	0	62	0
7	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	105	22	115	22
8	PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	9	19	9	19
9	SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	52	0	62	0
10	SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	93	0	103	0
11	POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	3	3	3	3
12	PRE-SERVICE						
13	Start: Following visit when decision for surgery or procedure made						
14	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	3	3	3	3
15	Coordinate pre-surgery services	L037D	RN/LPN/MTA	3	5	3	5
16	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3
17	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5
18	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3	3	3	3
20	End: When patient enters office/facility for surgery/procedure						
21	SERVICE PERIOD						
22	Start: When patient enters office/facility for surgery/procedure:						
23	Greet patient, provide gowning, ensure appropriate	L037D	RN/LPN/MTA	3		3	
24	Obtain vital signs	L037D	RN/LPN/MTA	5		5	
25	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	3		3	
26	Prepare room, equipment, supplies	L037D	RN/LPN/MTA			2	
27	Setup scope (non facility setting only)	L037D	RN/LPN/MTA	5		5	
28	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	2		2	
29	Sedate/apply anesthesia	L051A	RN	2		2	
30	Intra-service						
31	Moderate sedation	L051A	RN	35		45	
32	Assist physician in performing procedure	L037D	RN/LPN/MTA	35		45	
33	Post-Service						
34	Monitor pt. following service/check tubes, monitors, drains	L051A	RN	15		15	
35	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MTA				
36	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	3		3	
37	Clean Scope	L037D	RN/LPN/MTA	30		30	
38	Clean Surgical Instrument Package	L037D	RN/LPN/MTA				
39	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA	2		2	
40	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA				
41	Check dressings & wound/ home care instructions	L037D	RN/LPN/MTA	3		3	
45	End: Patient leaves office						
46	POST-SERVICE Period						
47	Start: Patient leaves office/facility						
48	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	3	3	3	3
57	End: with last office visit before end of global period						
58	MEDICAL SUPPLIES	CODE	UNIT				
59	SCRUB, DRESS, DRAPE						
60	pack, minimum multi-specialty visit	SA048	pack	1		1	
61	gown, staff, impervious	SB027	item	2		2	
62	cap, surgical	SB001	item	3		3	
63	mask, surgical, with face shield	SB034	item	3		3	
64	shoe covers, surgical	SB039	pair	3		3	
65	scrub brush (impregnated)	SM023	item	3		3	
66	drape, non-sterile, sheet 40in x 60in	SB006	item	1		1	
67	basin, emesis	SJ010	item	1		1	
68	denture cup	SJ016	item	1		1	
69	MODERATE SEDATION						
70	pack, moderate sedation	SA044	pack	1		1	
71	electrode, ECG (single)	SD053	item				
72	nasal cannula	SD100	item				
73	bite block	SD006	item	1		1	
74	PROCEDURE INSTRUMENTS / SUPPLIES						
75	endoscope anti-fog solution	SM014	ml	1		1	
76	endoscopic cytology brush	SD067	item	1		1	
77	endoscopic biopsy forceps	SD066	item				
78	endoscopic polypectomy snare	SD068	item				
79	endosheath (proxy for endoscopic hood)	SD070	item				
80	endoscopic clip	NEW	item				
81	guidewire, STIFF	SD090	item	1		1	
82	endoscopic balloon, dilation	SD019	item	1		1	
83	needle, endoscopic ultrasound, cytology	NEW	item				
84	needle, micropigmentation (tattoo)	SC079	item				
85	skin marking ink (tattoo)	SK073	ml				
86	needle, variceal injection	SC044	item				
87	syringe 5-6ml	SC057	item				
88	cautery, patient ground pad with cord	SF021	item				
89	cautery, bipolar cord	SF012	item				
90	cautery, bipolar, probe, endoscopy	NEW	item				
91	kit, probe, radiofrequency, Xli-enhanced RF probe (proxy for catheter, RF ablation, endoscopic)	SA100	kit	1		0	
92	canister, suction	SD009	item	2		2	
93	tubing, suction, non-latex (6ft uou)	SD132	item	1		1	
94	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item	1		1	
95	syringe 50-60ml	SC056	item	1		1	
96	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item	1		1	
97	gauze, non-sterile 4in x 4in	SG051	item	1		1	
98	cup, biopsy-specimen non-sterile 4oz	SL035	item	1		1	
99	paper, photo printing (8.5 x 11)	SK058	item	1		1	
100	applicator, cotton-tipped, non-sterile 6in	SG008	item				
101	lubricating jelly (K-Y) (5gm uou)	SJ032	item	4		4	
102	swab-pad, alcohol	SJ053	item				
103	SCOPE CLEANING						
104	pack, cleaning and disinfecting, endoscope	SA042	pack	1		1	
105	gloves, non-sterile	SB022	pair				
106	basin, irrigation	SJ009	item				
107	cleaning brush, endoscope	SM010	item				
108	enzymatic detergent	SM015	oz				
109	glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)	SM018	oz				
110	glutaraldehyde test strips (Cidex, Metrex)	SM019	item				
111	EQUIPMENT	CODE					
112	videoscope, gastroscopy	ES034		79		100	
113	stretcher	EF018		93		0	
114	IV infusion pump	EQ032		72		107	
115	table, power	EF031		49		73	
116	video system, endoscopy (processor, digital capture, monitor, printer, cart)	ES031		49		73	
117	suction machine (Gomco)	EQ235		49		73	
118	table, instrument, mobile	EF027		49		107	
119	radiofrequency generator (NEURO)	EQ214		49		73	
120	electrosurgical generator, gastrocautery	EQ113		49		73	
121	endoscope disinfectant, rigid or fiberoptic, w-cart	ES005		30		30	
122	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011		72		107	

AMA/Specialty Society RVS Update Committee Summary of Recommendations  
*MPC List Screen*

January 2013/April 2013

**Esophagoscopy Gastroscopy Duodenoscopy (EGD)**

Several Esophagogastroduodenoscopy (EGD) codes were identified through CMS and RUC screens as potentially misvalued, including: MPC list screen; high expenditures screen; and fastest growing screen. The specialties agreed to survey the entire family of codes (43235-43259). In review of this family of codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were necessary to describe current practice. In October 2012, the CPT Editorial Panel approved revised guidelines along with revision, addition, and deletion of codes within the EGD code set. In the Panel Action memo from the October CPT Editorial Panel meeting CPT requested clarifications from the involved specialty societies regarding instructions affecting the EGD codes (43235-43259). A specific request was made for the societies to provide clarification regarding the reporting of reduced service modifiers and an EGD service. After discussions with CPT and RUC staff it was determined that the CPT Editorial Panel's request for clarification will require a material change to codes 43237 and 43238 requiring approval by the CPT Editorial Panel. Therefore, the RUC approved the specialty societies' request to refer these services back to CPT and requested that they be surveyed for presentation at the April 2013 RUC meeting. Additionally, 43246 and 43251 were re-surveyed for April 2013 as the survey median times presented at the January 2013 meeting were anomalous.

After survey of the procedures for April, the specialty societies noted that the EGD with EUS procedures (43237-8, 43240, 43242, 43259 and 43253) are not inherently performed with moderate sedation by the same physician. However, due to CMS' consistent position, at the April meeting and in multiple Medicare Physician Payment Rules, that the Agency is looking for larger bundling of services, not unbundling of services, the moderate sedation for these services will remain bundled. Therefore, the EGD with EUS family of services will remain on Appendix G in the CPT codebook.

Prior to valuing this series of EGD codes, the RUC discussed the difference in survey methodologies between this series and the previously RUC recommended series of esophagoscopy codes in October 2012. The esophagoscopy codes surveyed for the October 2012 RUC meeting were conducted under a mini-survey format in which only the base code 43200 was fully surveyed and the rest of the family was only surveyed for the work value and intra-service time. Given that only one survey existed for pre and post-service times, this resulted in standardized time components. Following the October 2012 meeting, the specialty societies requested and received approval from the Research Subcommittee to fully survey all elements of the codes moving forward. The RUC agreed with the specialty societies that in order to accurately value each procedure, the surveyed times should be used rather than arbitrarily deriving times from a previous survey.



To maintain relativity with this family of services and the esophagoscopy services, the RUC and specialty societies agreed on a standardized set of methodologies to arrive at appropriate work values. The RUC administered three primary methodologies to value these services:

1. If a corresponding esophagoscopy code exists, and the previously billed codes are in the same endoscopic family, the RUC applied the Endoscopy Rule incremental approach.
2. If a corresponding esophagoscopy code exists and the additional codes were part of a different family of endoscopic procedure, the RUC applied the appropriate multiple procedure reduction.
3. If a corresponding esophagoscopy code did NOT exist, either the current value or the survey 25<sup>th</sup> percentile was recommended, whichever was lower.

***43235 Esophagogastroduodenoscopy, flexible, transoral; diagnostic, with collection of specimen(s) by brushing or washing, when performed***

The RUC reviewed the survey results from 315 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 27 minutes, intra-service time= 15 minutes and post-service time= 12 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the survey's estimated work RVU and agreed that respondents overestimated the work value, with a 25<sup>th</sup> percentile (work RVU= 2.59) above the current value. Furthermore, the RUC noted that because the survey's median intra-service time is 5 minutes less compared to the current time, the current work RVU of 2.39 was also overvalued. To determine an appropriate work RVU, the RUC reviewed analogous CPT code 31579 *Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy* (work RVU= 2.26) and agreed that with identical intra-service time, 15 minutes, and similar total time, the two services should have identical work values. Therefore, 43235 should be valued at 2.26 work RVUs. To validate this RVU, the RUC reviewed MPC codes 64479 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level* (work RVU= 2.29) and 52000 *Cystourethroscopy* (work RVU= 2.23) and agreed that the services, with identical intra-service times, should all be valued similarly. **The RUC recommends a work RVU of 2.26 for CPT code 43235.**

***43236 Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal injection(s), any substance***

The RUC reviewed the survey results from 78 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 27 minutes, intra-service time= 20 minutes and post-service time= 15 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this code. In addition, since the median intra-service time was less than the current time, the current value of 2.92 was deemed too high as well. Consistent with the previously approved esophagoscopy recommendations in October 2012, the RUC noted that the identical increment between the esophagoscopy

base code, 43200 (recommended work RVU= 1.59), and the submucosal injection code, 43201 (recommended work RVU= 1.90), should be maintained in this family of EGD services. Therefore, the established increment of 0.31 work RVUs was added to the base EGD diagnostic code, 43235 (recommended work RVU= 2.26), for a recommended work RVU of 2.57 for 43236. To validate a work RVU of 2.57, the RUC compared the surveyed code to CPT code 32556 *Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance* (work RVU= 2.50) and agreed that with identical intra-service time, 20 minutes, and similar total time, the two services should be valued similarly. Code 43236 was also compared to MPC code 51102 *Aspiration of bladder; with insertion of suprapubic catheter* (work RVU= 2.70) and it was agreed that while both services have identical intra-service time, the reference code is slightly more intense and should therefore be valued higher. **The RUC recommends a work RVU of 2.57 for CPT code 43236.**

***43237 Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination limited to the esophagus***

The RUC reviewed the survey results from 37 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 38 minutes, intra-service time= 35 minutes and post-service time= 20 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the current work value of 3.98 for this procedure is too high. The RUC noted that while the surveyed intra-service time is 10 minutes less than the current time, the previous survey valued this procedure with moderate sedation inherent in the intra-service time. With the subsequent establishment of pre-service time packages, moderate sedation is now considered pre-service time. Removing 10 minutes of intra-service time, accounting for the moderate sedation, from the previous survey, provides a reasonable comparison to the new survey, and suggests that the recommended intra-service time of 35 minutes is accurate. The RUC agreed with the specialty societies that the survey 25<sup>th</sup> percentile work RVU of 3.85 accurately reflects the physician work involved in 43237. To validate this work value, the RUC compared the surveyed code to the key reference service 31625 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites* (work RVU= 3.36) and noted that 43237 should be valued higher due to greater intra-service time compared to the reference code, 35 minutes and 30 minutes, respectively. In addition, the RUC reviewed CPT code 32550 *Insertion of indwelling tunneled pleural catheter with cuff* (work RVU= 4.17) and agreed while 43237 has 5 additional minutes of intra-service time, the reference code is more intense and should be valued higher. **The RUC recommends a work RVU of 3.85 for CPT code 43237.**

***43238 Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), esophagus (includes endoscopic ultrasound examination limited to the esophagus)***

The RUC reviewed the survey results from 33 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 38 minutes, intra-service time= 45 minutes and post-service time= 20 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the current work value of 5.02 for this procedure is too high. The RUC noted that while the surveyed intra-service time is less than the current time, the previous survey valued this procedure with moderate sedation inherent in the intra-service time. With the subsequent establishment of pre-service time packages, moderate sedation is now considered pre-service time. However, even removing intra-service time, accounting for the moderate sedation, from the previous survey, the survey intra-service time of 45 minutes is still lower. Therefore, the RUC agreed with the specialty societies that the survey 25<sup>th</sup> percentile work RVU of 4.50 accurately values the physician work of 43238. To justify this work value, the RUC compared the surveyed code to the key reference service 31638 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required)* (work RVU= 4.88, intra time= 60 minutes) and agreed that while 43238 has less intra-service time compared to the reference code, the survey respondents indicated the EGD code is a more intense procedure. Given this, the RUC agreed that the recommended value, 4.50, slightly less than the reference code, is appropriate. The RUC also reviewed CPT code 20902 *Bone graft, any donor area; major or large* (work RVU= 4.58) and agreed that since both codes have identical intra-service time, the codes should be valued similarly. **The RUC recommends a work RVU of 4.50 for CPT code 43238.**

#### **43239 Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple**

The RUC reviewed the survey results from 310 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 27 minutes, intra-service time= 15 minutes and post-service time= 12 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this code. To ensure relativity within the family of services, it was also agreed upon that the current work RVU of 2.87 was too high. Consistent with the previously approved esophagoscopy recommendations in October 2012, the RUC noted that the identical increment between the esophagoscopy base code, 43200 (recommended work RVU= 1.59), and the biopsy code, 43202 (recommended work RVU= 1.89), should be maintained in this family of EGD services. Therefore, the established increment of 0.30 work RVUs was added to the base EGD diagnostic code, 43235 (recommended work RVU= 2.26), for a recommended work RVU of 2.56 for 43239. To validate a work RVU of 2.56, the RUC compared the surveyed code to MPC code 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older* (work RVU= 2.50) and CPT code 55700 *Biopsy, prostate; needle or punch, single or multiple, any approach* (work RVU= 2.58) and determined that with identical intra-service time, 15 minutes, the recommended work value is relative to other similar reference codes in the RBRVS. Finally, the RUC compared 43239 to 43236 and agreed that while the intra-service times are slightly different, the work values should be almost identical to maintain relativity within the family of EGD and esophagoscopy codes. **The RUC recommends a work RVU of 2.56 for CPT code 43239.**

**43240 Esophagogastroduodenoscopy, flexible, transoral; with transmural drainage of pseudocyst (includes placement of transmural drainage catheter[s]/stent[s], when performed, and endoscopic ultrasound, when performed)**

The RUC reviewed the survey results from 33 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 70 minutes and post-service time= 30 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

Prior to valuing this procedure, the specialty societies presented compelling evidence that the current work value of 6.85 for CPT code 43240 may be misvalued. First, there has been a change in technique and patient population since the last valuation. When this service was last valued by the RUC in 2000, the standard method for pancreatic pseudocyst marsupialization was surgical cyst-enterostomy. Endoscopic drainage was utilized primarily for the simpler cases. Management of pancreatic pseudocysts has evolved over the past decade: today endoscopic drainage is the standard first line therapy, with surgical drainage largely reserved for those who have failed endoscopic treatment or are not candidates. Finally, new treatment guidelines by the GI endoscopy authorities, based on recent natural history data, now recommend non-drainage treatment of simple unilocular pseudocysts in healthy asymptomatic patients. Thus, those patients who typically had endoscopic drainage in 2000 are now rarely drained at all, while the sicker patients with more complex and technically demanding pseudocysts previously treated surgically are currently being managed with endoscopic therapy. Secondly, flawed assumptions were used in the previous valuation. The RUC originally valued this procedure based off a crosswalk to an endoscopic code outside the EGD family CPT code 43262 *Endoscopic retrograde cholangio-pancreatography (ERCP); with sphincterotomy/papilotomy*, which was Harvard valued at the time. Furthermore, this comparison for 43240 was derived from survey data from only 6 respondents, for what was then a new procedure. Given these arguments, the RUC accepted that there is compelling evidence that this procedure is currently misvalued.

The RUC agreed with the specialty society that the survey 25<sup>th</sup> percentile work RVU of 7.25, slightly above the current work value of 6.85, is appropriate. To justify this value, the RUC compared the surveyed code to CPT code 20555 *Placement of needles or catheters into muscle and/or soft tissue for subsequent interstitial radioelement application (at the time of or subsequent to the procedure)* (work RVU= 6.00) and agreed that while both services have identical intra-service time, 70 minutes, 43240 is a more intense procedure and should be valued higher than the reference code. The RUC also reviewed CPT code 31276 *Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus* (work RVU= 8.84) and agreed since the reference code has 5 minutes more intra-service time, the recommended work RVU is appropriately valued less than this reference code. Finally, the RUC reviewed the incremental approach to ensure the recommendation is relative to other codes in the family. The RUC noted that 43240 contains the work of an upper diagnostic endoscopy with fine needle aspiration (CPT code 43242, RUC recommended work RVU= 5.39) and the approved incremental value of 2.14 for placement of an endoscopic stent. Added together, the resultant work value of 7.53 is comparable to the recommended value. **The RUC recommends a work RVU of 7.25 for CPT code 43240.**

***43241 Esophagogastroduodenoscopy, flexible, transoral; with insertion of intraluminal tube, or catheter***

The RUC reviewed the survey results from 39 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 33 minutes, intra-service time= 30 minutes and post-service time= 15 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents greatly overestimated the value of this code, with a 25<sup>th</sup> percentile value of 3.50. The RUC noted that since there is no equivalent esophagoscopy code to compare, the current work RVU of 2.59 is appropriate. The RUC compared the surveyed code to CPT code 52005 *Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service* (work RVU= 2.37) and agreed that while both codes have identical intra-service time, 30 minutes, and nearly identical total time, 43241 is a more intense procedure and should be valued slightly higher. Additionally, the RUC reviewed CPT code 57156 *Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy* (work RVU= 2.69) and agreed that since both this code and the surveyed code have identical intra-service time and comparable physician work, the recommended value for 43241 is appropriate. **The RUC recommends a work RVU of 2.59 for CPT code 43241.**

***43242 Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)***

The RUC reviewed the survey results from 36 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 50 minutes and post-service time= 23 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this code. To ensure relativity within the family of services, it was also agreed that the current work RVU of 7.30 was too high. Consistent with recently RUC reviewed fine needle aspiration recommendations, the RUC noted that the identical increment between the fine needle aspiration code, 43238 (RUC recommended work RVU= 4.50), and the endoscopic ultrasound (limited to esophagus) code, 43237 (RUC recommended work RVU= 3.85), should be maintained in this family of EGD services. Therefore, the established increment of 0.65 work RVUs was added to the base EGD with endoscopic ultrasound code, 43259 (recommended work RVU= 4.74), for a recommended work RVU of 5.39 for 43242. To justify this value, the RUC compared the surveyed code to CPT codes 36251 *Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when*



*performed; unilateral* (work RVU= 5.35, intra time= 45 minutes) and code 52282 *Cystourethroscopy, with insertion of permanent urethral stent* (work RVU= 6.39, intra time= 50 minutes) and noted that both reference codes have almost identical physician time components as the surveyed code and comparable physician work. Therefore, the RUC agreed that the recommended work value of 5.39 for 43242 is accurately valued between these two reference codes. **The RUC recommends a work RVU of 5.39 for CPT code 43242.**

**43243 *Esophagogastroduodenoscopy, flexible, transoral; with injection sclerosis of esophageal / gastric varices***

The RUC reviewed the survey results from 58 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 30 minutes and post-service time= 20 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC agreed with the specialty societies that the current work RVU of 4.56 was too high relative to the RUC recommendations in this family of services. Since no equivalent esophagoscopy code exists to compare, the survey's 25<sup>th</sup> percentile work RVU of 4.37 was deemed appropriate. To validate this recommended work value, the RUC compared the surveyed code to CPT code 32550 *Insertion of indwelling tunneled pleural catheter with cuff* (work RVU= 4.17) and agreed since the two services have identical intra-service time, 30 minutes, both should be valued analogously. In addition, CPT code 52234 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 up to 2.0 cm)* (work RVU= 4.62, intra time= 30 minutes) was compared to 43243 and the RUC agreed that the reference code should be valued slightly higher than the surveyed code due to greater intensity and complexity. **The RUC recommends a work RVU of 4.37 for CPT code 43243.**

**43244 *Esophagogastroduodenoscopy, flexible, transoral; with band ligation of esophageal / gastric varices***

The RUC reviewed the survey results from 69 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 30 minutes and post-service time= 20 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC agreed with the specialty societies that the current work RVU of 5.04 was too high relative to the RUC recommendations in this family of services. Since no equivalent esophagoscopy code exists to compare, the survey's 25<sup>th</sup> percentile work RVU of 4.50 was deemed appropriate. To validate this recommended work value, the RUC compared the surveyed code to CPT code 32550 *Insertion of indwelling tunneled pleural catheter with cuff* (work RVU= 4.17) and agreed that while the two services have identical intra-service time, 30 minutes, 43244 should be valued higher as it is a more intense service. In addition, the RUC reviewed CPT code 37191 *Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging*

*guidance (ultrasound and fluoroscopy), when performed* (work RVU= 4.71) and noted that the two services, with identical intra-service time and analogous total time, should be valued similarly. Finally, the RUC compared 43244 to 43243 and agreed that while both codes have identical physician time, 43244 is a more intense procedure and is accurately valued slightly higher than 43243. **The RUC recommends a work RVU of 4.50 for CPT code 43244.**

***43245 Esophagogastroduodenoscopy, flexible, transoral; with dilation of gastric / duodenal stricture(s) (eg, balloon, bougie)***

The RUC reviewed the survey results from 56 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 33 minutes, intra-service time= 23 minutes and post-service time= 15 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this code, with a 25<sup>th</sup> percentile value of 3.58. The RUC noted that since there is no equivalent esophagoscopy code to compare, the current work RVU of 3.18 is appropriate. The RUC compared the surveyed code to CPT code 58555 *Hysteroscopy, diagnostic* (work RVU= 3.33) and agreed that the reference code, with slightly greater intra-service time compared to the surveyed code, 25 minutes and 23 minutes, respectively, should be valued higher. Additionally, CPT code 43245 was compared to CPT code 52287 *Cystourethroscopy, with injection(s) for chemodenervation of the bladder* (work RVU= 3.20) and it was agreed that while the surveyed code has two additional minutes of intra-service time, both services should be valued similarly. **The RUC recommends a work RVU of 3.18 for CPT code 43245.**

***43246 Esophagogastroduodenoscopy, flexible, transoral; with directed placement of percutaneous gastrostomy tube***

The RUC reviewed the survey results from 57 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 30 minutes and post-service time= 15 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

Prior to valuing this service, the RUC noted that this service was previously surveyed for the January 2013 meeting. The RUC and specialty societies agreed that the survey median intra-service time of 23 minutes grossly underestimated the time it takes to perform this procedure. The RUC agreed with the specialty societies that the surveyed intra-service time of 30 minutes for this meeting is a much better representation of the physician work for this procedure for two reasons. First, during the last valuation of this service, in 2005, the RUC approved imputed intra-service time, 38 minutes, greater than the median time from the survey, 30 minutes. Second, since moderate sedation was included as intra-service time during the previous valuation, and is now included as pre-service time, reducing the current time by 10 minutes, to 28 minutes, provides a comparison that matches up well with the surveyed time of 30 minutes. Given this, the RUC agreed with the specialty societies that the physician work has not changed and the current work RVU of 4.32 is appropriate for 43246. To justify this value, the RUC compared the surveyed code to CPT codes 32550 *Insertion of indwelling tunneled pleural catheter with cuff* (work RVU= 4.17, intra time= 30 minutes) and 37191 *Insertion of intravascular vena cava filter*,

*endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed* (work RVU= 4.71, intra time= 30 minutes) and noted that both reference codes have identical physician time components as the surveyed code and comparable physician work. Therefore, the RUC agreed that the recommended work value of 4.32 for 43246 is accurately valued between these two reference codes. **The RUC recommends a work RVU of 4.32 for CPT code 43246.**

***43247 Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body***

The RUC reviewed the survey results from 68 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 23 minutes, intra-service time= 30 minutes and post-service time= 15 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this code. To ensure relativity within the family of services, it was also agreed upon that the current work RVU of 3.38 was too high. Consistent with the previously approved esophagoscopy recommendations in October 2012, the RUC noted that the identical increment between the esophagoscopy base code, 43200 (recommended work RVU= 1.59), and the removal of foreign body code, 43215 (recommended work RVU= 2.60), should be maintained in this family of EGD services. Therefore, the established increment of 1.01 work RVUs was added to the base EGD diagnostic code, 43235 (recommended work RVU= 2.26), for a recommended work RVU of 3.27 for 43247. To validate a work RVU of 3.27, the RUC compared the surveyed code to 36200 *Introduction of catheter, aorta* (work RVU= 3.02) and agreed that while both services have identical intra-service time, 30 minutes, the surveyed code should be valued higher due to greater intensity and complexity. Additionally, the RUC reviewed CPT code 50386 *Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation* (work RVU= 3.30) and agreed that with identical times and analogous intensity, this reference code and 43247 should be valued similarly. **The RUC recommends and work RVU of 3.27 for CPT code 43247.**

***43248 Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by dilation of passage of dilator(s) through esophagus over guide wire***

The RUC reviewed the survey results from 50 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 27 minutes, intra-service time= 20 minutes and post-service time= 15 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this code. To ensure relativity within the family of services, it was also agreed upon the current work RVU of 3.15 was too high. Consistent with the previously approved esophagoscopy recommendations in October 2012, the RUC noted that the identical increment between the esophagoscopy base

code, 43200 (recommended work RVU= 1.59), and the insertion of guide wire with dilation code, 43226 (recommended work RVU= 2.34), should be maintained in this family of EGD services. Therefore, the established increment of 0.75 work RVUs was added to the base EGD diagnostic code, 43235 (recommended work RVU= 2.26), for a recommended work RVU of 3.01 for 43248. To validate a work RVU of 3.01, the RUC compared the surveyed code to 31295 *Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa* (work RVU= 2.70) and agreed that while the two services have identical intra-service time, 20 minutes, the surveyed code should be valued higher, as it is a more intense procedure. In addition, the RUC reviewed CPT code 32551 *Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open* (work RVU= 3.29) and agreed that while this reference code has the same intra-service time as the surveyed code, the reference code has greater total time and should thus be valued higher. **The RUC recommends a work RVU of 3.01 for CPT code 43248.**

**43249 Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)**

The RUC reviewed the survey results from 56 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 27 minutes, intra-service time= 20 minutes and post-service time= 15 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this code. To ensure relativity within the family of services, it was also agreed upon the current work RVU of 2.90 was too high. Consistent with the previously approved esophagoscopy recommendations in October 2012, the RUC noted that the identical increment between the esophagoscopy base code, 43200 (recommended work RVU= 1.59), and the balloon dilation code, 43220 (recommended work RVU= 2.10), should be maintained in this family of EGD services. Therefore, the established increment of 0.51 work RVUs was added to the base EGD diagnostic code, 43235 (recommended work RVU= 2.26), for a recommended work RVU of 2.77 for 43249. To validate a work RVU of 2.77, the RUC compared the surveyed code to 31295 *Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa* (work RVU= 2.70) and agreed that with identical intra-service time, 20 minutes, and analogous intensity and complexity, the two services should be valued similarly. In addition, the RUC also reviewed CPT code 32551 *Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open* (work RVU= 3.29) and agreed that while this reference code and the surveyed code have identical intra-service time, the reference code has greater total time, 83 minutes compared to 62 minutes, and should be valued higher. Finally, the RUC compared this service to 43248 and noted that while both services have identical physician time components, 43249 is appropriately valued lower than 43248, as it is a less intense procedure. **The RUC recommends a work RVU of 2.77 for CPT code 43249.**

***43233 Esophagogastroduodenoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)***

The RUC reviewed the survey results from 35 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 38 minutes, intra-service time= 30 minutes and post-service time= 20 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work value from the survey for this new code and agreed with the specialty societies that the 25<sup>th</sup> percentile work RVU of 4.45 accurately values this service. To validate this work value, the RUC compared the surveyed code to CPT code 32550 *Insertion of indwelling tunneled pleural catheter with cuff* (work RVU= 4.17) and noted that while both codes have identical intra-service time, 30 minutes, the surveyed code should be valued higher because it is a more intense and complex to perform. The RUC also reviewed CPT code 93452 *Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed* (work RVU= 4.75) and agreed that since the reference code has greater total time compared to 43233, 108 minutes and 88 minutes, respectively, it is appropriately valued higher. **The RUC recommends a work RVU of 4.45 for CPT code 43233.**

***43250 Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery***

The RUC reviewed the survey results from 59 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 24 minutes, intra-service time= 20 minutes and post-service time= 14 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this code. To ensure relativity within the family of services, it was also agreed upon the current work RVU of 3.20 was too high. Consistent with the previously approved esophagoscopy recommendations in October 2012, the RUC noted that the identical increment between the esophagoscopy base code, 43200 (recommended work RVU= 1.59), and the removal of tumor by biopsy forceps code, 43216 (recommended work RVU= 2.40), should be maintained in this family of EGD services. Therefore, the established increment of 0.81 work RVUs was added to the base EGD diagnostic code, 43235 (recommended work RVU= 2.26), for a recommended work RVU of 3.07 for 43250. To validate a work RVU of 3.07, the RUC compared the surveyed code to 31295 *Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa* (work RVU= 2.70) and agreed that while the two service have identical intra-service time, 20 minutes, the surveyed code should be valued higher, as it is a more intense procedure. In addition, the RUC reviewed CPT code 32551 *Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open* (work RVU= 3.29) and agreed that while this reference code has the same intra-service time as the surveyed code, the

reference code has greater total time and should thus be valued higher. Finally, the RUC reviewed 43250 in comparison to 43248 and 43249 and agreed that all three codes have identical intra-service time and are appropriately valued similarly. **The RUC recommends a work RVU of 3.07 for CPT code 43250.**

***43251 Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique***

The RUC reviewed the survey results from 39 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 33 minutes, intra-service time= 20 minutes and post-service time= 10 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

Prior to valuing this service, the RUC noted that this service was previously surveyed for the January 2013 meeting. The RUC and specialty societies agreed that the survey median intra-service time of 20 minutes grossly underestimated the time it takes to perform this procedure. A five minute time differential between the base code 43235, 15 minutes, and 43251, 20 minutes, does not accurately account for the additional work in removing a lesion by snare technique. The specialty societies resurveyed code 43251 and the RUC reviewed the survey results in April 2013, . The RUC noted that the median intra-service time was 20 minutes. The RUC remains convinced that the time is anomalous, especially considering that the analogous code for esophageal snare polypectomy, 43217, has an incremental intra-service time above the base code 43200, both surveyed in 2012, of 15 minutes.

Following discussion of the survey time data, the RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this code. Consistent with the recently approved esophagoscopy removal of lesion by snare technique recommendations, the RUC noted that the identical increment between the removal of lesion by snare technique code, 43217 (RUC recommended work RVU= 2.90), and the base esophagoscopy code, 43200 (RUC recommended work RVU= 1.59), should be maintained in this family of EGD services. Therefore, the established increment of 1.31 work RVUs was added to the base diagnostic EGD code, 43235 (RUC recommended work RVU= 2.26), for a recommended work RVU of 3.57 for 43251. This recommendation is lower than the current value. To justify this value, the RUC compared the surveyed code to CPT 32551 *Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open (separate procedure)* (work RVU= 3.29) and noted that while both services have identical intra-service time, 20 minutes, 43251 is a more intense procedure and should be valued higher. Additionally, the RUC reviewed CPT code 16035 *Escharotomy; initial incision* (work RVU= 3.74, intra time= 20 minutes) and agreed that since the reference code has greater total time compared to 43251, 70 minutes and 63 minutes, respectively, it is appropriately valued slightly higher than the surveyed code. **The RUC recommends a work RVU of 3.57 for CPT code 43251.**

***43252 Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy***

The RUC reviewed the survey results from 26 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 27 minutes, intra-service time= 30 minutes and post-service time= 20 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this code. To ensure relativity within the family of services, the RUC compared this new service to the newly created esophagoscopy optical endomicroscopy code 43206. To ensure consistency, the RUC maintained the identical increment between the esophagoscopy base code, 43200 (recommended work RVU= 1.59), and the optical endomicroscopy code, 43206 (recommended work RVU= 2.39). Therefore, the established increment of 0.80 work RVUs was added to the base EGD diagnostic code, 43235 (recommended work RVU= 2.26), for a recommended work RVU of 3.07 for 43250. To validate a work RVU of 3.06, the RUC compared the surveyed code to 36200 *Introduction of catheter, aorta* (work RVU= 3.02) and agreed that since both codes have identical intra-service time, 30 minutes, and comparable physician work, the two services should be valued similarly. In addition, the RUC reviewed CPT code 50386 *Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation* (work RVU= 3.30) and noted that while the two services have identical intra-service time, the reference code has greater total time compared to the surveyed code, 90 minutes and 77 minutes, respectively. Therefore, the 43252 is appropriately valued less than 50386. **The RUC recommends and work RVU of 3.06 for CPT code 43252.**

***43253 Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance(s) (eg, anesthetic, neurolytic agent) or fiducial marker(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)***

The RUC reviewed the survey results from 34 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 40 minutes and post-service time= 23 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this code at the median level. Consistent with the recently approved EGD fine needle aspiration recommendations, the RUC noted that the identical increment between the fine needle aspiration code, 43238 (RUC recommended work RVU= 4.50), and the endoscopic ultrasound (limited to esophagus) code, 43237 (RUC recommended work RVU= 3.85), should be maintained in this family of EGD services. Therefore, the established increment of 0.65 work RVUs was added to the base EGD with endoscopic ultrasound code, 43259 (RUC recommended work RVU= 4.74), for a recommended work RVU of 5.39 for 43253, lower than the survey median work RVU (5.77). To justify a work RVU of 5.39, the RUC compared the surveyed code to CPT codes 52315 *Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); complicated* (work RVU= 5.20, intra time= 45 minutes) and 36222 *Selective catheter placement, common carotid or innominate artery, unilateral,*

*any approach, with angiography of the ipsilateral extracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed* (work RVU= 5.53, intra time= 40 minutes) and noted that both reference codes have similar intra-service and total time compared to the surveyed code. Therefore, the RUC agreed that a work value of 5.39 for 43253 accurately places this service between these two reference codes. **The RUC recommends a work RVU of 5.39 for CPT code 43253.**

***43254 Esophagogastroduodenoscopy, flexible, transoral; with endoscopic mucosal resection***

The RUC reviewed the survey results from 43 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 38 minutes, intra-service time= 45 minutes and post-service time= 20 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work value from the survey and agreed with the specialty societies that the 25<sup>th</sup> percentile work RVU of 5.25 accurately values this service. To validate this work value, the RUC noted that this service contains three additional services from the base code: removal of lesion by snare, band ligation, and submucosal injection. The consistent increment approach was applied to sum the incremental differences between the equivalent esophagoscopy codes and the base code, 43200 (recommended work RVU= 1.59): 43217 (recommended work RVU= 2.90), increment difference= 1.31; 43205 (recommended work RVU= 3.00), incremental difference= 1.41; and 43201 (recommended work RVU= 1.90), incremental difference= 0.31). Adding the work RVU differences, 3.03, to the base EGD code 43235 (recommended work RVU= 2.26) arrives at a work RVU of 5.29, slightly higher than the recommended work value of 5.25. The RUC compared the surveyed code to CPT code 52315 *Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); complicated* (work RVU= 5.20) and agreed that since these two codes have identical intra-service time, 45 minutes, and comparable physician work, they should be valued similarly. Finally, the RUC reviewed CPT code 36251 *Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral* (work RVU= 5.35) and noted that while both services have identical intra-service time, the reference code has greater total time compared to 43254, 116 minutes and 103 minutes, respectively. Therefore, the reference code is accurately valued higher than the surveyed code. **The RUC recommends a work RVU of 5.25 for CPT code 43254.**

***43255 Esophagogastroduodenoscopy, flexible, transoral; with control of bleeding, any method***

The RUC reviewed the survey results from 82 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 30 minutes and post-service time= 20 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.



The RUC agreed with the specialty societies that the current work RVU of 4.81 was too high relative to the RUC recommendations in this family of services. Since no equivalent esophagoscopy code exists to compare, the survey's 25<sup>th</sup> percentile work RVU of 4.20 was deemed appropriate. To validate this recommended work value, the RUC compared the surveyed code to CPT code 32550 *Insertion of indwelling tunneled pleural catheter with cuff* (work RVU= 4.17) and agreed that since both codes have identical intra-service time (30 minutes), and analogous total time, the two services should be valued similarly. Additionally, the RUC reviewed CPT code 37191 *Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed* (work RVU= 4.71) and noted that while the reference code has identical intra-service time compared to 43255, 37191 should be valued greater because it is a more intense and complex service. **The RUC recommends a work RVU of 4.20 for CPT code 43255.**

***43266 Esophagogastroduodenoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)***

The RUC reviewed the survey results from 51 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 40 minutes and post-service time= 20 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work value from the survey for this new code and agreed with the specialty societies that the 25<sup>th</sup> percentile work RVU of 4.40 accurately values this service. To validate this work value, the RUC compared the surveyed code to CPT code 49418 *Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous* (work RVU= 4.21) and noted that since both codes have identical intra-service time, 40 minutes, and analogous physician work, the two services should be valued similarly. The RUC also reviewed CPT code 58558 *Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C* (work RVU= 4.74) and agreed that the reference code should be valued higher since it is a more intense procedure than 43266. Finally, the RUC compared 43266 to 43233 (recommended work RVU= 4.45) and agreed that while 43266 has 10 minutes more intra-service time, placement of an endoscopic stent is a more intense procedure than balloon dilation of the esophagus, therefore, both services should be valued similarly. **The RUC recommends a work RVU of 4.40 for CPT code 43266.**

***43257 Esophagogastroduodenoscopy, flexible, transoral; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease***

The RUC reviewed the survey results from 25 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 45 minutes and post-service time= 15 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC agreed with the specialty societies that the current work RVU of 5.50 was too high relative to the RUC recommendations in this family of services. Since no equivalent esophagoscopy code exists to compare, the survey's 25<sup>th</sup> percentile work RVU of 4.25 was deemed appropriate. To validate this recommended work value, the RUC compared the surveyed code to CPT code 31648 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), initial lobe* (work RVU= 4.20) and agreed that since both services have identical intra-service time, 45 minutes, and analogous intensity, they should both be valued similarly. The RUC also reviewed CPT code 20902 *Bone graft, any donor area; major or large* (work RVU= 4.58) and noted that while both services have identical intra-service time, the reference code has much greater total time compared to the surveyed code and should thus be valued higher. **The RUC recommends a work RVU of 4.25 for CPT code 43257.**

***43270 Esophagogastroduodenoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)***

The RUC reviewed the survey results from 49 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 45 minutes and post-service time= 15 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work value from the survey for this new code and agreed with the specialty societies that the 25<sup>th</sup> percentile work RVU of 4.39 accurately values this service. To validate this work value, the RUC compared the surveyed code to CPT code 11044 *Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less* (work RVU= 4.10) and agreed that while both codes have identical intra-service time, 45 minutes, 43270 is a more intense and complex service and should be valued higher than the reference code. The RUC also reviewed CPT code 20902 *Bone graft, any donor area; major or large* (work RVU= 4.58) and noted that with greater total time compared to the surveyed code, 123 minutes and 101 minutes, respectively, the reference code is accurately valued higher than 43270. **The RUC recommends a work RVU of 4.39 for CPT code 43270.**

***43259 Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)***

The RUC reviewed the survey results from 36 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 45 minutes and post-service time= 20 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this code at the median level, a work RVU of 5.45. The RUC also noted that the surveyed intra-service time is lower than the current time of 69 minutes. However, since moderate sedation was included as intra-service time during the previous valuation, and is now included as pre-service time, reducing the current time by 10 minutes, to 59 minutes, provides a comparison between the surveys. Considering the surveyed time is still lower, the RUC agreed with the specialty societies that the current work RVU of 5.19 is too high and accepted the survey 25<sup>th</sup> percentile work RVU of 4.74. To justify this value, the RUC compared the surveyed code to CPT codes 20902 *Bone graft, any donor area; major or large* (work RVU= 4.58, intra time= 45 minutes) and 36251 *Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral* (work RVU= 5.35, intra time= 45 minutes) and noted that both reference codes have identical intra-service time as the surveyed code. Therefore, the RUC agreed that the current work value of 4.74 for 43259 is accurately valued between these two reference codes. Finally, the specialty societies explained that 43259 needs to be valued greater than 43237 *EGD with EUS limited to the esophagus* (RUC recommended work RVU= 3.85) because there is more to examine (stomach and either duodenum or surgically altered stomach) in the surveyed code. **The RUC recommends a work RVU of 4.74 for CPT code 43259.**

#### **Practice Expense:**

The practice expense for these services was a direct crosswalk to the approved practice expense for the related esophagoscopy codes approved at the October 2012 RUC meeting. At the January 2013 RUC meeting the Practice Expense Subcommittee recommended and the RUC approved the following changes to the practice expense for esophagogastroduodenoscopy and the specialty requests that the changes be applied to the esophagoscopy codes that were previously approved at the October 2012 RUC meeting.

- Addition of 3 minutes to “Prepare room, equipment, supplies” (L037D) for code 43252 (*Esophagogastroduodenoscopy; with optical endomicroscopy*) for the technician to turn on the optical endomicroscope processor unit system added to its esophagoscopy counterpart, 43206 (*Esophagoscopy, flexible, transoral; with optical endomicroscopy*)
- At the last meeting the Practice Expense Subcommittee used equipment practice expense input EQ322 *Radiofrequency generator (Angiodynamics), liver RFA* as a proxy. The specialty will identify a more appropriate RF ablation system for 43270 (*Esophagogastroduodenoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)*) and provide an invoice for this equipment. It should also be added to its esophagoscopy counterpart 4320X5 (*Esophagoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)*) which replaced 43228
- Addition of “Instrument pack basic (\$500 - \$1,499)” (EQ137) for 43248 (*Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by dilation of passage of dilator(s) through esophagus over guide wire*) added to its esophagoscopy counterpart 43226 (*Esophagoscopy, flexible, transoral; with insertion of guide wire followed by dilation over guide wire*)

- Addition of “Pack, cleaning, surgical instruments” (SA043) for 43248 (*Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by dilation of passage of dilator(s) through esophagus over guide wire*) for cleaning the dilators added to its counterpart 43226 (*Esophagoscopy, flexible, transoral; with insertion of guide wire followed by dilation over guide wire*)

In April 2013, the RUC recommended the direct practice expense inputs for CPT codes 43237-8, 43240, 43242, 43259 and 43253 and submitted by the specialty societies and approved by the Practice Expense Subcommittee.

#### Work Neutrality:

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

#### RUC Database Flag:

The RUC agreed that the low IWPOT for CPT code 43241 was anomalous in comparison to the entire family of EGD services. Additionally, the RUC agreed that CPT code 43251 has anomalous intra-service time. A 5 minute time differential between the base code 43235, 15 minutes, and 43251, 20 minutes, does not accurately account for the additional work in removing a lesion by snare technique. Therefore, a flag will be added to the database to indicate that these codes should not be used for valuation comparisons.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		<p><u>(For examination of the esophagus from the cricopharyngeus muscle [upper esophageal sphincter] to and including the gastroesophageal junction, including examination of the proximal region of the stomach via retroflexion when performed, see 43197, 43198, 43200, 43201, 43202, 43204, 43205, 43206, 43211, 43213, 43214, 43212, 43229, 43215, 43216, 43217, 43212, 43220, 43226, 43227, 43231, 43232)</u></p> <p><u>(Use 43235, 43236, 43237, 43238, 43239, 43253, 43233, 43266, 43270 for examination of a surgically altered stomach where the jejunum is examined distal to the anastomosis [eg, gastric bypass, gastroenterostomy {Billroth II}])</u></p> <p><u>(To report esophagogastrosocopy where the duodenum is deliberately not examined (eg judged clinically not pertinent), or because significant situations preclude such exam (eg significant gastric retention precludes safe exam of duodenum), append modifier 52 if repeat examination is not planned, or modifier 53 if repeat examination is planned.)</u></p>		

◎ ▲ 43235	I1	<del>Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate</del> Esophagogastroduodenoscopy, flexible, transoral; diagnostic, with <del>or without</del> collection of specimen(s) by brushing or washing, <u>when performed (separate procedure)</u>	000	2.26
◎ ▲ 43236	I2	with directed submucosal injection(s), any substance (For injection sclerosis of esophageal and/or gastric varices, use 43243) <u>(Do not report 43236 in conjunction with 43254, 43243, 43255)</u>	000	2.57
◎ ▲ 43237	I3	with endoscopic ultrasound examination limited to the esophagus <u>(Do not report 43237 in conjunction with 76942, 76975)</u>	000	3.85
◎ ▲ 43238	I4	with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), esophagus (includes endoscopic ultrasound examination limited to the esophagus) <u>(Do not report 43238 in conjunction with 43237, 76942, <del>or</del> 76975)</u>	000	4.50
◎ ▲ 43239	I5	with biopsy, single or multiple	000	2.56
◎ ▲ 43240	I6	with transmural drainage of pseudocyst <u>(includes placement of transmural drainage catheter[s]/stent[s], when performed, and endoscopic ultrasound, when performed)</u> <u>(Do not report 43240 in conjunction with 43242, 43266, 43259)</u> <u>(For endoscopic pancreatic necrosectomy, use 48999)</u>	000	7.25

◎ ▲ 43241	I7	<p>with <del>transendoscopic</del> insertion of intraluminal tube or catheter placement</p> <p><u>(Do not report 43241 in conjunction with 43266)</u></p> <p><u>(For naso- or oro-gastric tube placement requiring physician or other qualified healthcare professional's skill and fluoroscopic guidance, use 43752)</u></p> <p><u>(For enteric tube placement, see 44500, 74340)</u></p>	000	2.59 (No Change)
◎ ▲ 43242	I8	<p>with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum <del>and/or jejunum as appropriate</del>) <u>or a surgically altered stomach where the jejunum is examined distal to the anastomosis</u></p> <p><u>(Do not report 43242 in conjunction with 43240, 43259, 76942, 76975)</u></p> <p><u>(For transendoscopic ultrasound-guided transmural fine needle aspiration/biopsy limited to esophagus, use 43238)</u></p> <p><u>(For interpretation of specimen, see 88172-88173)</u></p>	000	5.39
◎ ▲ 43243	I9	<p>with injection sclerosis of esophageal/<del>and/or</del> gastric varices</p> <p><u>(Do not report 43243 in conjunction with 43236, 43255)</u></p>	000	4.37
◎ ▲ 43244	I10	<p>with band ligation of esophageal/<del>and/or</del> gastric varices</p> <p><u>(Do not report 43244 in conjunction with 43254, 43255)</u></p>	000	4.50

◎▲43245	I11	with dilation of gastric outlet/duodenal stricture(s) for obstruction(eg, balloon, guide wire,bougie) (Do not report 43245 in conjunction with 43256,43266) (For radiological supervision and interpretation, use 74360)	000	3.18 (No Change)
◎▲43246	I12	with directed placement of percutaneous gastrostomy tube (For nonendoscopic percutaneous placement of gastrostomy tube, see 49440)	000	4.32 (No Change)
◎▲43247	I13	with removal of foreign body (For radiological supervision and interpretation, use 74235)	000	3.27
◎▲43248	I14	with insertion of guide wire followed by dilation of passage of dilator(s) through esophagus over guide wire (Do not report 43248 in conjunction with 43266, 43270) (If imaging guidance is performed, use 74360)	000	3.01
◎▲43249	I15	with transendoscopic balloon dilation of esophagus (less than 30 mm diameter) (Do not report 43249 in conjunction with 43266, 43270) (If imaging guidance is performed, use 74360)	000	2.77
#◎●43233	I16	with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed) (Do not report 43233 in conjunction with 74360, 76000, 76001)	000	4.45
◎▲43250	I17	with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	000	3.07

◎▲43251	I18	<p>with removal of tumor(s), polyp(s), or other lesion(s) by snare technique</p> <p><u>(Do not report 43251 in conjunction with 43254)</u></p> <p><u>(For endoscopic mucosal resection, use 43254)</u></p>	000	3.57
◎▲43252	I19	<p>with optical endomicroscopy</p> <p>(Report supply of contrast agent separately)</p> <p>(Do not report 43252 in conjunction with 88375)</p> <p><u>(For biopsy specimen pathology, use 88305)</u></p>	000	3.06
◎●43253	I20	<p>with transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance(s) (eg, anesthetic, neurolytic agent) or fiducial marker(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)</p> <p><u>(Do not report 43253 in conjunction with 43237, 43238, 43240, 43242, 43259, 76942, 76975)</u></p> <p><u>(For transendoscopic ultrasound-guided transmural fine needle aspiration/biopsy limited to esophagus, use 43238)</u></p> <p><u>(For interpretation of specimen, see 88172, 88173)</u></p>	000	5.39



◎●43254	I21	with endoscopic mucosal resection  (Do not report 43254 in conjunction with 43236, 43244, 43251)  (Endoscopic mucosal resection includes biopsy of the same lesion, when performed)	000	5.25
◎▲43255	I22	with control of bleeding, any method  (Do not report 43255 in conjunction with 43243, 43244)	000	4.20
D◎43256		<del>with transendoscopic stent placement (includes predilation)</del> (For radiological supervision and interpretation, use 74360) (43256 has been deleted. To report, use 43266)	000	N/A
#◎●43266	I23	with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)  (Do not report 43266 in conjunction with 43240, 43241, 43245, 43248, 43249)		4.40
◎▲43257	I24	with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease	000	4.25
D◎43258		<del>with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique</del> (For injection sclerotherapy of esophageal varices, use 43204, 43243) (43258 has been deleted. To report, use 43270)	000	N/A

#●●43270	I25	with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed) <u>(For injection sclerosis of esophageal varices, use 43204,43243)</u> <u>(Do not report 43270 in conjunction with 43248, 43249)</u>	000	4.39
◎▲43259	I26	with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum <del>and/or jejunum as appropriate</del> <u>or a surgically altered stomach where the jejunum is examined distal to the anastomosis)</u>  (Do not report 43259 in conjunction with <u>43240, 76975</u> )	000	4.74
Laparoscopy				
43281	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh			
43282	with implantation of mesh  (To report transabdominalparaesophageal hiatal hernia repair, see 43332, 43333. To report transthoracic diaphragmatic hernia repair, see 43334, 43335)  (Do not report <u>43213, 43214, 43220, 43249, 43233, 43281, 43282</u> in conjunction with <u>43280, 43450, 43453, 43456, 43458, 49568</u> )			
Manipulation				
◎43453	Dilation of esophagus, over guide wire  (For dilation with direct visualization, use 43220)  (For dilation of esophagus, by balloon or dilator, see 43220, <del>43458, 43214, 43233 and 74360</del> )			
D◎43456		<del>Dilation of esophagus, by balloon or dilator, retrograde</del> <u>(43456 has been deleted. To report, use 43213)</u>	000	N/A

D●43458		<p><del>Dilation of esophagus with balloon (30 mm diameter or larger) for achalasia</del></p> <p><del>(43458 has been deleted. To report, use 43214, 43233)</del></p> <p><del>(For endoscopic dilation of esophagus with balloon less than 30 mm diameter, see 43195, 43220, 43249)</del></p> <p><del>(For endoscopic dilation of esophagus with balloon 30mm diameter or greater, see 43214, 43233)</del></p> <p><del>(For direct endoscopic guidance, see 43200, 43235)</del></p> <p><del>(For radiological supervision and interpretation, use 74360)</del></p>	000	N/A
<p><b>Endoscopy, Small Intestine and Stomal</b></p> <p>Surgical endoscopy always includes diagnostic endoscopy.</p> <p>(For upper gastrointestinal endoscopy, see 43235-43257, 43270<del>43258</del>)</p> <p>●44360 Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)</p>				
<p><b>Nervous System</b></p> <p><b>Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System</b></p>				
<p><b>Introduction/Injection of Anesthetic Agent (Nerve Block), Diagnostic or Therapeutic Autonomic Nerves</b></p> <p>64505 Injection, anesthetic agent; sphenopalatine ganglion</p> <p>64530 celiac plexus, with or without radiologic monitoring</p> <p>(For transendoscopic ultrasound-guided transmural injection, <del>[eg, anesthetic, neurolytic agent]</del> celiac plexus, use 43253)</p>				

<b>Destruction by Neurolytic Agent (eg, Chemical, Thermal, Electrical or Radiofrequency), Chemodenervation Sympathetic Nerves</b>	
64680	Destruction by neurolytic agent, with or without radiologic monitoring; celiac plexus  (For transendoscopic ultrasound-guided transmural injection, <del>eg, anesthetic, neurolytic agent</del> , celiac plexus, use 43253)
<b>Radiology Diagnostic Radiology (Diagnostic Imaging) Gastrointestinal Tract</b>	
74360	Intraluminal dilation of strictures and/or obstructions (eg, esophagus), radiological supervision and interpretation (Do not report 74360 in conjunction with 4320X2, 4320X3, 43233)
<b>Medicine Gastroenterology</b>	
<del>(For duodenal intubation and aspiration, see 43756, 43757)</del> <del>(For gastrointestinal radiologic procedures, see 74210-74363)</del> <del>(For esophagoscopy procedures, see 43200-43227, 43228; upper GI endoscopy 43235-43259; endoscopy, small intestine and stomal 44360-44393; proctosigmoidoscopy 45300-45321; sigmoidoscopy 45330-45339; colonoscopy 45355-45385; anoscopy 46600-46615)</del> (91000 has been deleted)	
91010	Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report;
91040	Esophageal balloon distension provocation study

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43235	Tracking Number II	Original Specialty Recommended RVU: <b>2.39</b>
		Presented Recommended RVU: <b>2.39</b>
Global Period: 000		RUC Recommended RVU: <b>2.26</b>

CPT Descriptor: Esophagogastroduodenoscopy, flexible, transoral; diagnostic, with collection of specimen(s) by brushing or washing, when performed

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 67-year-old patient with dyspepsia and weight loss refractory to pharmacological therapy is referred for diagnostic esophagogastroduodenoscopy and collection of specimens by brushings.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 81%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 67%

Description of Pre-Service Work: Review with the patient any symptoms including dysphagia and sleep apnea. The patient's history is reviewed to assess past problems with sedation and the need for pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays and other diagnostic tests are reviewed. The pre-service review is documented. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained. The physician verifies all endoscopic equipment is available and operational and appropriate computer entries are made. The patient is positioned on the examination table. The endoscopic and moderate sedation monitoring equipment is positioned to provide access for the procedure. A time out is performed. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide when indicated, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat. A bite block is placed in the mouth.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible upper endoscope is inserted through the mouth into the oropharynx and advanced through the esophagus into the proximal stomach. The stomach is insufflated with air after suctioning liquid contents. Examination of the entire stomach in the forward and retroflexed positions is performed. The endoscope is advanced through the pylorus into the duodenal bulb. Circumferential inspection of the duodenum is performed after air insufflation. The endoscope is slowly withdrawn re-inspecting the stomach and duodenum. After suctioning air to deflate the stomach, the endoscope is withdrawn into the esophagus, allowing measurement of the squamocolumnar and gastro-esophageal junction from the incisors, assessment for presence of a hiatal hernia, and examination of the esophageal mucosa. When indicated, brushings or washings are

obtained of suspicious abnormalities. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. Supervision of the level of sedation and vital signs is performed during the procedure with additional measures taken to maintain an appropriate level of sedation, vital signs, airway and oxygenation as indicated. At the conclusion of the procedure, the endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. Post procedure orders are completed. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to referral source and other appropriate parties. Data is entered into procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others. Necessary prescriptions, follow-up tests and appointments are provided to the patient.

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)		01/2013				
Presenter(s):	Drs. Brill, Nickl, Bentley, and Selzer					
Specialty(s):	AGA, ASGE, SAGES					
CPT Code:	43235					
Sample Size:	7554	Resp N:	315	Response: 4.1 %		
Description of Sample:	The AGA and ASGE conducted an enhanced random sample of member gastroenterologists as approved by the Research Subcommittee. The methodology consisted of a random sample with the addition of an expert panel consisting of physicians from industry, members of ASGE Special Interest Groups (SIG) who perform specific procedures (e.g. endoscopic ultrasound, optical endomicroscopy, stent placement, etc.) and survey volunteers who responded to educational articles and identified themselves as performers of therapeutic endoscopic services. SAGES conducted a random sample of their members.					
		Low	25 <sup>th</sup> pctl	Median*	75 <sup>th</sup> pctl	High
Service Performance Rate		0.00	87.00	200.00	400.00	1500.00
Survey RVW:		0.70	2.59	3.00	3.50	8.95
Pre-Service Evaluation Time:				20.00		
Pre-Service Positioning Time:				5.00		
Pre-Service Scrub, Dress, Wait Time:				5.00		
Intra-Service Time:		5.00	10.00	15.00	20.00	60.00
Immediate Post Service-Time:	12.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00		
Discharge Day Mgmt:	0.00	99238x 0.00	99239x 0.00	99217x 0.00		
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00	15x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00	
Sub Obs Care:	0.00	99224x 0.00	99225x 0.00	99226x 0.00		

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1b-FAC Straightforw Pat Procedure(w sedate/anes)

CPT Code:	43235	Recommended Physician Work RVU: 2.26				
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time		
Pre-Service Evaluation Time:		19.00	19.00	0.00		
Pre-Service Positioning Time:		3.00	1.00	2.00		
Pre-Service Scrub, Dress, Wait Time:		5.00	5.00	0.00		
Intra-Service Time:		15.00				
Immediate Post Service-Time:	<u>12.00</u>					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00			
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00		

<b>Discharge Day Mgmt:</b>	<u><b>0.00</b></u>	99238x <b>0.0</b>	99239x <b>0.0</b>	99217x <b>0.00</b>
<b>Office time/visit(s):</b>	<u><b>0.00</b></u>	99211x <b>0.00</b>	12x <b>0.00</b>	13x <b>0.00</b> 14x <b>0.00</b> 15x <b>0.00</b>
<b>Prolonged Services:</b>	<u><b>0.00</b></u>	99354x <b>0.00</b>	55x <b>0.00</b>	56x <b>0.00</b> 57x <b>0.00</b>
<b>Sub Obs Care:</b>	<u><b>0.00</b></u>	99224x <b>0.00</b>	99225x <b>0.00</b>	99226x <b>0.00</b>

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31622	000	2.78	RUC Time

CPT Descriptor BRONCHOSCOPY, RIGID OR FLEXIBLE, WITH OR WITHOUT FLUOROSCOPIC GUIDANCE; DIAGNOSTIC, WITH OR WITHOUT CELL WASHING (SEPARATE PROCEDURE)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
64479	000	2.29	RUC Time	42,670

CPT Descriptor 1 Injection, anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
36556	000	2.50	RUC Time	499,921

CPT Descriptor 2 Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
52000	000	2.23	RUC Time

CPT Descriptor Cystourethroscopy (separate procedure)

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 98      % of respondents: 31.1 %**

**TIME ESTIMATES (Median)**

	<u>CPT Code:</u> 43235	<u>Key Reference CPT Code:</u> 31622	<u>Source of Time</u> RUC Time
Median Pre-Service Time	27.00	20.00	
Median Intra-Service Time	15.00	30.00	
Median Immediate Post-service Time	12.00	15.00	
Median Critical Care Time	0.0	0.00	



Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>54.00</b>	<b>65.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.67	3.45
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.52	3.39
Urgency of medical decision making	3.43	3.23

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.72	3.42
Physical effort required	3.26	3.02

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.36	3.14
Outcome depends on the skill and judgment of physician	3.68	3.47
Estimated risk of malpractice suit with poor outcome	3.65	3.39

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.08	2.92
Intra-Service intensity/complexity	3.51	3.37
Post-Service intensity/complexity	3.12	2.93

---

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

## Background

Several EGD codes were identified through CMS and RUC screens as potentially misvalued, including: MPC list screen; high expenditures screen; and fastest growing screen. The specialties agreed to survey the entire family of codes (43235-43259). In review of this family of codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In October 2012, the CPT Editorial Panel approved revised guidelines along with revision, addition, and deletion of codes within the EGD code set.

## Overview of EGD Family RVW Recommendations

The specialty consensus panel spent a significant amount of time reviewing the survey data for the current set of EGD codes, comparing the data and values with the esophagoscopy codes (43200-43228) that were approved by the RUC at the October 2012 RUC meeting. The compelling arguments from the esophagoscopy review are the same as for the EGD codes, with the additional fact that the times for codes built on increments from the base code (43235) would require adjustment.

After reviewing the survey data, the consensus panel determined that for the EGD codeset, the incremental value above the base code for EGD (43235) should be similar where possible to the analogous incremental value above the esophagoscopy base code (43200) previously approved. For the existing codes, the RVW recommendations are based on the lower of the current value or the EGD base+increment from the esophagoscopy pair (ie, valuing the increment). Where there was no exact match for existing codes, the RVW recommendation is the lower of the current RVW or the 25<sup>th</sup> percentile RVW. For all new codes that bundle multiple codes and/or deleted codes, the RVW recommendation is based on endoscopy multiple procedure payment policy or surgical multiple procedure payment policy, as applicable. For this last set of codes, all but two recommendations are less than the survey 25<sup>th</sup> percentile. For the two exceptions, the recommendation is between the 25<sup>th</sup> and median survey RVW.

## 43235 – Discussion and Recommendation

Code 43235 *Esophagogastroduodenoscopy, flexible, transoral; diagnostic, with collection of specimen(s) by brushing or washing, when performed* was identified through the MPC List / CMS High Expenditure screens. This service has been reviewed by the RUC four times, most recently in 2005 during the third 5YR. The AGA, ASGE, and SAGES conducted a RUC survey and received 315 responses. The consensus panel agrees that physician work for this service has not changed since the prior RUC review in 2005. The survey intra-time is consistent with the prior review after the shift in reporting moderate sedation from intra-service to pre-service is considered.

**We recommend maintaining the current RVW of 2.39.** This value is less than the survey 25<sup>th</sup> percentile and maintains the base code increment established by Harvard and maintained by the RUC and CMS.

**Pre-time Package 1b** is appropriate for 43235, with an additional 2 minutes for positioning the patient, endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

### Comparison to Key Ref 31622

Key Reference code 31622 was surveyed and presented to the RUC in 2005 prior to the discussion of pre-time packages and moderate sedation work. The RUC did not accept the specialty survey results and recommendations and did not accept the survey pre-time. In addition, the intra-service work description includes initiation of moderate sedation. Noting that none of the 106+ endoscopy codes being surveyed during 2012-2014 could be included on the RSL, while code 31622 may not be a good comparator to 43235, it was likely chosen by survey respondents because of the similarity in service description.

### Comparison to Esophagoscopy Base Code 43200

*Estimating time in 5 minute increments.* As discussed in the compelling evidence, respondents for the EGD surveys reported intra-time in increments of 5 minutes. The median of 15 minutes for both 43200 and 43235 masks slight differences of +/- a few minutes that would be shown using time and motion studies.

*Establishment of base code increments.* Harvard conducted an extensive review of the endoscopy families prior to the publication of the first PFS. The increments established between the base codes were key to developing values for each

family. In 1992, the Harvard-based RVW for 43200 (esophagoscopy base) was 1.68 and the Harvard-based RVW for 43235 (EGD base) was 2.52. This resulted in an RVW increment of 0.84. In 1995, the RUC reviewed both 43200 and 43235 and recommended maintaining the current RVW for each code (1.59 and 2.39, respectively). These RVWs were less than the 1992 values due to budget neutrality RVW adjustments that CMS made to all codes in the early years of the fee schedule. In 2005, the RUC reviewed 43235 and determined there was no change in work and recommended maintaining the current RVW of 2.39, which also maintain the incremental RVW difference in work of 0.80 between 43200 and 43235. In 2012, the RUC reviewed 43200 and determined there was no change in work and recommended maintaining the current RVW of 1.59.

*Physician work relates to both time and intensity/complexity.* Total physician work is not dependent solely on time. Consideration for intensity and complexity components are also important. There are many examples throughout the fee schedule of similar codes with the same intra-time that have different RVWs, such as the comparison of lesion removal from the back versus lesion removal from the eyelid (11400 vs 11440) or arthrocentesis of a small joint versus arthrocentesis of a large joint (20600 vs 20610).

#### Comparison to MPC and Other RUC-Reviewed Codes with 15 Minutes Intra-Service Time

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
MPC 2005	<b>52000</b>	Cystoscopy	2.23	0.113	42	10	2	5	<b>15</b>	10
2011	<b>92960</b>	Cardioversion external	2.25	0.101	51	15	1	5	<b>15</b>	15
2005	<b>31579</b>	Diagnostic laryngoscopy	2.26	0.106	45	10	5		<b>15</b>	15
MPC 2009	<b>64479</b>	Inj foramen epidural c/t	2.29	0.108	49	13	5	6	<b>15</b>	10
	<b>43235</b>	EGD base	2.26	0.106	54	19	3	5	<b>15</b>	12
MPC 2003	<b>36556</b>	Insert non-tunnel cv cath	2.50	0.119	50	15	5	5	<b>15</b>	10
2005	<b>55700</b>	Biopsy of prostate	2.58	0.102	65	20	5	5	<b>15</b>	20

### SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

### FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43235

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology

How often? Commonly

Specialty GI Surgery                      How often? Sometimes

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1185000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare database for 2011 is approximately 395,000. 395,000 times 3 considering commercial patients is 1,185,000

Specialty Gastroenterology	Frequency 948000	Percentage 80.00 %
----------------------------	------------------	--------------------

Specialty GI Surgery	Frequency 118500	Percentage 10.00 %
----------------------	------------------	--------------------

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

397,520 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare database for 2011 is 397520.

Specialty Gastroenterology	Frequency 316000	Percentage 80.00 %
----------------------------	------------------	--------------------

Specialty GI Surgery	Frequency 39500	Percentage 10.00 %
----------------------	-----------------	--------------------

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43235

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43236	Tracking Number I2	Original Specialty Recommended RVU: <b>2.69</b>
		Presented Recommended RVU: <b>2.69</b>
Global Period: 000		RUC Recommended RVU: <b>2.57</b>

CPT Descriptor: Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal injection(s), any substance

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 60-year-old patient with weight loss and difficulty swallowing is referred for evaluation after imaging studies revealed a markedly dilated esophagus with a “bird’s beak” tapering near the gastroesophageal junction consistent with a diagnosis of achalasia. The patient is referred for therapeutic esophagogastroduodenoscopy with injection of botulinum toxin into the distal esophagus, and evaluation of the upper GI tract.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 81%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 72%

Description of Pre-Service Work: Review with the patient any symptoms including dysphagia and sleep apnea. The patient's history is reviewed to assess past problems with sedation and the need for pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays and other diagnostic tests are reviewed. The pre-service review is documented. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained. The physician verifies all endoscopic equipment is available and operational and appropriate computer entries are made. The patient is positioned on the examination table. The endoscopic and moderate sedation monitoring equipment is positioned to provide access for the procedure. A time out is performed. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide when indicated, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat. A bite block is placed in the mouth.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible upper endoscope is inserted through the mouth into the oropharynx and advanced through the esophagus into the proximal stomach. The stomach is insufflated with air after suctioning liquid contents. Examination of the entire stomach in the forward and retroflexed positions is performed. The endoscope is advanced through the pylorus into the duodenal bulb. Circumferential inspection of the duodenum is performed after air insufflation. The endoscope is slowly withdrawn re-inspecting the stomach and duodenum. After suctioning air to deflate the stomach, the endoscope is withdrawn into the esophagus, allowing measurement of the squamocolumnar and gastro-esophageal junction from the incisors, assessment

for presence of a hiatal hernia, and examination of the esophageal mucosa. When indicated, brushings or washings are obtained of suspicious abnormalities. The lower esophageal sphincter is identified. The endoscope is withdrawn to that level and Botulinum toxin A solution is injected submucosally at four quadrants under endoscopic direction. Photodocumentation of the exam findings including measurements of the lesion, labeling of the identified structures and magnified images of the abnormality are obtained and sent to a hard copy device. After observation to confirm the absence of bleeding, the endoscope is then withdrawn. Supervision of the level of sedation and vital signs is performed during the procedure with additional measures taken to maintain an appropriate level of sedation, vital signs, airway and oxygenation as indicated.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. Post procedure orders are completed. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to referral source and other appropriate parties. Data is entered into procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others. Necessary prescriptions, follow-up tests and appointments are provided to the patient.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	01/2013				
<b>Presenter(s):</b>	Drs. Brill, Nickl, Bentley, and Selzer				
<b>Specialty(s):</b>	AGA, ASGE, SAGES				
<b>CPT Code:</b>	43236				
<b>Sample Size:</b>	1926	<b>Resp N:</b>	78	<b>Response:</b> 4.0 %	
<b>Description of Sample:</b>	The AGA and ASGE conducted a random sample of member gastroenterologists as approved by the Research Subcommittee. The sampling methodology was a random sample with the addition of survey volunteers who responded to educational articles and identified themselves as performers of therapeutic endoscopic services. SAGES conducted a random sample of their members.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	5.00	<b>10.00</b>	24.00	400.00
<b>Survey RVW:</b>	1.50	3.21	<b>3.62</b>	4.35	7.17
<b>Pre-Service Evaluation Time:</b>			<b>25.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>5.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>5.00</b>		
<b>Intra-Service Time:</b>	12.00	18.00	<b>20.00</b>	30.00	60.00
<b>Immediate Post Service-Time:</b>	<b>15.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 1b-FAC Straightforw Pat Procedure(w sedate/anes)

<b>CPT Code:</b>	43236	<b>Recommended Physician Work RVU: 2.57</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>19.00</b>	<b>19.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>3.00</b>	<b>1.00</b>	<b>2.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>5.00</b>	<b>5.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>20.00</b>		
<b>Immediate Post Service-Time:</b>	<b>15.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00

<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31625	000	3.36	RUC Time

CPT Descriptor BRONCHOSCOPY, RIGID OR FLEXIBLE, WITH OR WITHOUT FLUOROSCOPIC GUIDANCE; WITH BRONCHIAL OR ENDOBRONCHIAL BIOPSY(S), SINGLE OR MULTIPLE SITES

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
51102	000	2.70	RUC Time	14,057

CPT Descriptor 1 Aspiration of bladder; with insertion of suprapubic catheter

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
15002	000	3.65	RUC Time	15,981

CPT Descriptor 2 Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
---------------------------------	---------------	-----------------	--------------------

CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 25      % of respondents: 32.0 %**

**TIME ESTIMATES (Median)**

	<b>CPT Code: 43236</b>	<b>Key Reference CPT Code: 31625</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	27.00	25.00	
Median Intra-Service Time	20.00	30.00	
Median Immediate Post-service Time	15.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	



Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>62.00</b>	<b>70.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.78	3.54
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.05	3.58
--	------	------

Urgency of medical decision making	3.53	3.41
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.13	3.59
--------------------------	------	------

Physical effort required	3.47	3.18
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.81	3.42
---	------	------

Outcome depends on the skill and judgment of physician	4.01	3.74
--	------	------

Estimated risk of malpractice suit with poor outcome	3.76	3.54
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.38	3.21
----------------------------------	------	------

Intra-Service intensity/complexity	4.01	3.79
------------------------------------	------	------

Post-Service intensity/complexity	3.38	3.27
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

## Background

Several EGD codes were identified through CMS and RUC screens as potentially misvalued, including: MPC list screen; high expenditures screen; and fastest growing screen. The specialties agreed to survey the entire family of codes (43235-43259). In review of this family of codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In October 2012, the CPT Editorial Panel approved revised guidelines along with revision, addition, and deletion of codes within the EGD code set.

## Overview of EGD Family RVW Recommendations

The specialty consensus panel spent a significant amount of time reviewing the survey data for the current set of EGD codes, comparing the data and values with the esophagoscopy codes (43200-43228) that were approved by the RUC at the October 2012 RUC meeting. The compelling arguments from the esophagoscopy review are the same as for the EGD codes, with the additional fact that the times for codes built on increments from the base code (43235) would require adjustment.

After reviewing the survey data, the consensus panel determined that for the EGD code set, the incremental value above the base code for EGD (43235) should be similar where possible to the analogous incremental value above the esophagoscopy base code (43200) previously approved. For the existing codes, the RVW recommendations are based on the lower of the current value or the EGD base+increment from the esophagoscopy pair (ie, valuing the increment). Where there was no exact match for existing codes, the RVW recommendation is the lower of the current RVW or the 25<sup>th</sup> percentile RVW. For all new codes that bundle multiple codes and/or deleted codes, the RVW recommendation is based on endoscopy multiple procedure payment policy or surgical multiple procedure payment policy, as applicable. For this last set of codes, all but two recommendations are less than the survey 25<sup>th</sup> percentile. For the two exceptions, the recommendation is between the 25<sup>th</sup> and median survey RVW.

## 43236 – Discussion and Recommendation

Code 43236 *Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal injection(s), any substance* was identified through the MPC List / CMS Fastest Growing screens. This service was a new code added to CPT in 2003 and reviewed by the RUC in 2002 prior to the discussion of pre-time packages and moderate sedation work. The RUC did not accept the specialty's initial RVW and time recommendations and instead developed recommendations through facilitation, utilizing a review of incremental work compared with the base code. The AGA, ASGE, and SAGES conducted a RUC survey and received 315 responses. The consensus panel agrees that physician work for this service has not changed since the prior RUC review in 2002; however, the panel believes the increment of 0.31 established by the RUC in October 2012 for the esophagoscopy code pair 43200/43201 should apply to the EGD code pair 43235/43236.

**We recommend reducing the RVW to 2.69.** This value is less than the current RVW and less than the survey 25<sup>th</sup> percentile. This value is equal to the EGD base 43235 plus an increment of 0.30 (43201-43200) (ie, valuing the increment) approved by the RUC in October 2012.

**Pre-time Package 1b** is appropriate for 43236, with an additional 2 minutes for positioning the patient, endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

### Comparison to Key Ref 31625

Key Reference code 31625 was surveyed and presented to the RUC in 2003 prior to the discussion of pre-time packages and moderate sedation work. The RUC agreed that the CPT change was editorial and that work had not changed. The RVW was maintained and the survey data was accepted. The recommended RVW of 2.69 for 43236 compares favorably with the RVW for 31625.

### Comparison to EGD Base Code 43235

*Estimating time in 5 minute increments.* As discussed in the compelling evidence, respondents for the EGD surveys reported intra-time in increments of 5 minutes. The median of 15 minutes for 43235 and 20 minutes for 43236 masks slight differences of +/- a few minutes that would be shown using time and motion studies.

*Establishment of increments.* Harvard conducted an extensive review of the endoscopy families prior to the publication of the first PFS. The increments established between and within families were key to maintaining relativity. The consensus panel reviewing this family of codes believes the increment of 0.30 established for the esophagoscopy pair 43200/43201 is correct for the similar EGD pair 43235/43236.

## Comparison to MPC and Other RUC-Reviewed Codes with 20 Minutes Intra-Service Time

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2012	<b>32556</b>	Insert cath pleura w/o image	2.50	0.084	60	13	3	6	<b>20</b>	18
2010	<b>90870</b>	Electroconvulsive therapy	2.50	0.107	36	10	1		<b>20</b>	5
2003	<b>36555</b>	Insert non-tunnel cv cath	2.68	0.093	60	20	5	5	<b>20</b>	10
	<b>43236</b>	EGD with injection	2.57	0.091	62	19	3	5	<b>20</b>	15
<b>MPC 2008</b>	<b>51102</b>	Drain bl w/cath insertion	2.70	0.094	60	19	1	5	<b>20</b>	15
2010	<b>52281</b>	Cystoscopy and treatment	2.75	0.112	46	10	1	5	<b>20</b>	10
2008	<b>49452</b>	Replace g-j tube perc	2.86	0.102	60	20	5	5	<b>20</b>	10
2012	<b>32551</b>	Insertion of chest tube	3.29	0.101	83	30	3	10	<b>20</b>	20
2011	<b>15273</b>	Skin sub grft t/arm/lg child	3.50	0.093	100	40	10	10	<b>20</b>	20
<b>MPC 2006</b>	<b>15002</b>	Wound prep trk/arm/leg	3.65	0.087	115	45	15	15	<b>20</b>	20

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43236

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology How often? Commonly

Specialty GI Surgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 43200

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare database for 2011 is approximately 14,400. 14,400 times 3 considering commercial patients is 43,200

Specialty Gastroenterology	Frequency 38880	Percentage 90.00 %
Specialty GI Surgery	Frequency 432	Percentage 1.00 %
Specialty	Frequency 0	Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?  
 14,788 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.  
 Please explain the rationale for this estimate. Medicare database for 2011 is 14,788.

Specialty Gastroenterology	Frequency 12960	Percentage 90.00 %
Specialty GI Surgery	Frequency 144	Percentage 1.00 %
Specialty	Frequency 0	Percentage 0.00 %

Do many physicians perform this service across the United States? No

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43236

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43237	Tracking Number I3	Original Specialty Recommended RVU: <b>3.85</b>
		Presented Recommended RVU: <b>3.85</b>
Global Period: 000		RUC Recommended RVU: <b>3.85</b>

CPT Descriptor: Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination limited to the esophagus

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 66 year-old patient with recent onset dysphagia is found to have an exophytic mass lesion in the mid- esophagus which on prior biopsy was proven to be an adenocarcinoma. Imaging studies demonstrate thickening of the mid-esophagus without evidence of distant metastases. Diagnostic esophagogastroduodenoscopy of the upper GI tract is performed, then endoscopic ultrasound of the esophagus is performed to evaluate and stage the lesion.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 60%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 33%

Description of Pre-Service Work: Review with the patient any symptoms including dysphagia and sleep apnea. The patient's history is reviewed to assess past problems with sedation and the need for and timing of pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's imaging studies and other diagnostic tests are reviewed. The pre-service review is documented. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained. The physician verifies all endoscopic and echoendoscopy imaging and image capture equipment is available, operational and appropriate imaging settings and computer entries are made, with special attention to the transducer balloon sheath. A time out is performed. The patient is positioned on the procedure table. The endoscopic, imaging and moderate sedation monitoring equipment is positioned to provide access for the procedure. Appropriate protective attire is applied and verification that all others in the suite are properly protected including the patient. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide when indicated, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat. A bite block is placed in the mouth.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard upper endoscope is inserted into the mouth and the oropharynx and advanced through the esophagus into the stomach. Residual fluid is removed from the stomach. The endoscope is advanced through the pylorus into the duodenal bulb, and then

around the bulb apex to the second portion of the duodenum. Examination is conducted of the duodenum, the entire stomach including the gastric cardia in a retroflexed scope position, and the entire esophagus, noting the abnormal area(s) to be evaluated by echoendoscopy and location as well as any other abnormalities present. The standard upper endoscope is withdrawn; the radial-view echoendoscope is inserted into the mouth and the oropharynx and advanced through the esophagus into the proximal stomach. Echoendoscopic evaluation is conducted of all abnormalities identified, correlating the endoscopic and ultrasonographic images. The locations of the findings are noted, as is the relationship of abnormalities to adjoining normal and abnormal structures including the esophageal wall as well as vascular and other structures of the mediastinum. Multiple transducer frequencies are utilized as needed to fully visualize the area of interest. Doppler imaging of appropriate areas is completed when indicated. A determination of risk and benefit to sample (e.g. biopsy) the lesion is performed. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. Supervision of the level of sedation and vital signs is performed during the procedure with additional measures taken to maintain an appropriate level of sedation, vital signs, airway and oxygenation as indicated. At the conclusion of the procedure, the endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. The patient is assessed for physical signs and symptoms suggestive of complications, including abdominal pain, nausea/vomiting, respiratory distress, and bleeding. Post procedure orders are completed and discussed with staff. Photographs are reviewed and labeled. Radiographic images are reviewed with the technologist for entry into the image storing system. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to the referral source and other appropriate parties. Data is entered into the procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others including a discussion regarding potential procedure complications and follow-up plans or further treatments. Restrictions, prescriptions, follow-up tests, instructions and appointments are provided to the patient and pertinent others.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Bruce Cameron, MD (ACG), Joel Brill, MD (AGE), Shivan Mehta, MD (AGA), Nicholas Nickl, MD (ASGE), Edward Bentley, MD (ASGE)				
<b>Specialty(s):</b>	ACG, AGA, ASGE				
<b>CPT Code:</b>	43237				
<b>Sample Size:</b>	981	<b>Resp N:</b>	37	<b>Response:</b> 3.7 %	
<b>Description of Sample:</b>	The ACG, AGA and ASGE conducted an enhanced random sample as approved by the Research Subcommittee. The sampling methodology was a random sample of member gastroenterologists with the addition of ASGE Special Interest Group physicians identified as performers of EUS procedures and survey volunteers who responded to educational articles and identified themselves as EUS performers.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	10.00	<b>23.00</b>	50.00	400.00
<b>Survey RVW:</b>	2.20	3.85	<b>4.20</b>	5.00	13.00
<b>Pre-Service Evaluation Time:</b>			<b>30.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>5.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>5.00</b>		
<b>Intra-Service Time:</b>	15.00	25.00	<b>35.00</b>	45.00	90.00
<b>Immediate Post Service-Time:</b>	<b>20.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	43237	<b>Recommended Physician Work RVU: 3.85</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>30.00</b>	<b>33.00</b>	<b>-3.00</b>
<b>Pre-Service Positioning Time:</b>		<b>3.00</b>	<b>1.00</b>	<b>2.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>5.00</b>	<b>5.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>35.00</b>		
<b>Immediate Post Service-Time:</b>	<b>20.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		

<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31625	000	3.36	RUC Time

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

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 8      % of respondents: 21.6 %**

**TIME ESTIMATES (Median)**

	<u>CPT Code:</u> 43237	<u>Key Reference CPT Code:</u> 31625	<u>Source of Time</u> RUC Time
Median Pre-Service Time	38.00	25.00	
Median Intra-Service Time	35.00	30.00	
Median Immediate Post-service Time	20.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	



Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>93.00</b>	<b>70.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.50	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.38	3.13
Urgency of medical decision making	3.63	3.38

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.75	3.38
Physical effort required	3.13	2.88

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.75	3.50
Outcome depends on the skill and judgment of physician	3.75	3.50
Estimated risk of malpractice suit with poor outcome	3.63	3.25

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.50	3.38
Intra-Service intensity/complexity	3.50	3.50
Post-Service intensity/complexity	3.25	3.13

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**

Several EGD codes were identified through CMS and RUC screens as potentially misvalued, including: MPC list screen; high expenditures screen; and fastest growing screen. The specialties agreed to survey the entire family of codes (43235-43259). In review of this family of codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In October 2012, the CPT Editorial Panel approved revised guidelines along with revision, addition, and deletion of codes within the EGD code set.

### 43237 – Discussion and Recommendation

Code 43237 *Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination limited to the esophagus* was identified as a family code through the MPC List screen. This service was reviewed by the RUC as a new code in 2003, with 27 survey respondents. To maintain proper rank order, the RUC utilized valuing the increment by adding the incremental RVW assigned to code 43231 Esophagoscopy, EUS and subtracting the RVW of code 43200 Esophagoscopy, which results in an RVW increment of 1.60. This incremental work value represents the intra-service work only of esophageal EUS. Adding 1.60 to the RVW of 2.39 for base EGD code resulted in a sum of 3.99. The current value for code 43237 is 3.98. A survey was conducted and 37 responses were received, with almost all respondents familiar with the procedure.

**We recommend the 25<sup>th</sup> percentile RVW of 3.85 which is less than the current value.** We note that the code pair 43231/43237 compares to code pair 43200/43235 in that the incremental work for each pair represents the incremental work of full EGD vs. esophagoscopy alone. Recent RUC valuation of 43200 and 43235 results in an increment of 0.67 RVU between them; adding this amount to the value of 3.19 for 43231 results in a sum of 3.86 which is comparable to the recommendation of 3.85 for this code.

### Comparison to Key Ref 31625

Key Reference code 31625 was surveyed and presented to the RUC in 2003 prior to the discussion of pre-time packages and moderate sedation work. The RUC agreed that the CPT change was editorial and that work had not changed. The RVW was maintained and the survey data was accepted. The recommended RVW of 3.85 for 43237 compares favorably with the RVW for 31625.

### 43237 Comparison To Other RUC-Reviewed Codes with 30-35 Minutes Intra-Service Time

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2011	<b>36200</b>	Place catheter in aorta	3.02	0.058	91	33	3	5	<b>30</b>	20
2012	<b>32557</b>	Insert cath pleura w/ image	3.12	0.079	67	13	3	6	<b>30</b>	15
2010	<b>31296</b>	Sinus endo w/balloon dil	3.29	0.071	88	30	3	10	<b>30</b>	15
2012	<b>52214</b>	Cystoscopy and treatment	3.50	0.082	79	19	5	5	<b>30</b>	20
	<b>43237</b>	EGD; EUS limited to esoph	<b>3.85</b>	<b>0.075</b>	<b>93</b>	<b>30</b>	<b>3</b>	<b>5</b>	<b>35</b>	<b>20</b>
2007	<b>20660</b>	Apply rem fixation device	4.00	0.093	90	20		10	<b>30</b>	30
2012	<b>52224</b>	Cystoscopy and treatment	4.05	0.101	79	19	5	5	<b>30</b>	20
2012	<b>52234</b>	Cystoscopy and treatment	4.62	0.120	79	19	5	5	<b>30</b>	20
2011	<b>37191</b>	Ins endovas vena cava filtr	4.71	0.120	83	30	3	5	<b>30</b>	15

### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43237

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology                      How often? Rarely

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 2550

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2011 ~ 850 ( $3 \times 850 = 2250$ )

Specialty Gastroenterology                      Frequency 2142                      Percentage 84.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 850

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2011 ~ 850

Specialty Gastroenterology                      Frequency 714                      Percentage 84.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? No

## Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43237

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43238	Tracking Number I4	Original Specialty Recommended RVU: <b>4.50</b>
		Presented Recommended RVU: <b>4.50</b>
Global Period: 000		RUC Recommended RVU: <b>4.50</b>

CPT Descriptor: Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), esophagus (includes endoscopic ultrasound examination limited to the esophagus)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 66 year-old patient with long-standing tobacco use, weight loss and abdominal discomfort is found to have mediastinal lymphadenopathy on imaging studies. Esophagogastroduodenoscopy of the upper GI tract is performed, with endoscopic ultrasound for staging of suspected cancer and trans-endoscopic fine needle aspiration biopsy of the lymphadenopathy for cytologic evaluation.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 63%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 37%

Description of Pre-Service Work: Review with the patient any symptoms including dysphagia and sleep apnea. The patient's history is reviewed to assess past problems with sedation and the need for and timing of pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's imaging studies and other diagnostic tests are reviewed. The pre-service review is documented. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained. The physician verifies all endoscopic and echoendoscopy imaging and image capture equipment is available, operational and appropriate imaging settings and computer entries are made, with special attention to the transducer balloon sheath. A time out is performed. The patient is positioned on the procedure table. The endoscopic, imaging and moderate sedation monitoring equipment is positioned to provide access for the procedure. Appropriate protective attire is applied and verification that all others in the suite are properly protected including the patient. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide when indicated, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat. A bite block is placed in the mouth.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard upper endoscope is inserted into the mouth and the oropharynx and advanced through the esophagus into the stomach. Residual

fluid is removed from the stomach. The endoscope is advanced through the pylorus into the duodenal bulb, and then around the bulb apex to the second portion of the duodenum. Examination is conducted of the duodenum, the entire stomach including the gastric cardia in a retroflexed scope position, and the entire esophagus, noting the abnormal area(s) to be evaluated by echoendoscopy and location as well as any other abnormalities present. The standard upper endoscope is withdrawn; the radial-view echoendoscope is inserted into the mouth and the oropharynx and advanced through the esophagus into the proximal stomach. Echoendoscopic evaluation is conducted of all abnormalities identified, correlating the endoscopic and ultrasonographic images. The locations of the findings are noted, as is the relationship of abnormalities to adjoining normal and abnormal structures including the esophageal wall as well as vascular and other structures of the mediastinum. Multiple transducer frequencies are utilized as needed to fully visualize the area of interest. Doppler imaging of appropriate areas is completed when indicated including identification of vascular structures in the anticipated track of the biopsy needle. A determination of risk and benefit to sample (e.g. biopsy) the lesion is performed. The radial-view echoendoscope is withdrawn; the linear-view biopsy echoendoscope is inserted into the mouth and the oropharynx and advanced through the esophagus into the proximal stomach. The area of interest is re-imaged and fully characterized, noting the correlation of the sagittal/coronal image to the transverse image previously obtained. The fine needle aspiration (FNA) device is inserted into the endoscope. Under continuous endoscopic and ultrasound guidance the FNA needle tip is advanced intramurally or transmurally into the location to be biopsied, taking care to avoid vascular structures and using Doppler imaging as needed to identify such structures. The FNA needle is inserted into the area to be biopsied, the stylette is withdrawn, and suction is applied. The needle is thrust in and out of the region to be biopsied, taking care that the correct needle position is maintained. The needle is withdrawn and the contents of the needle are expressed on to microscope slides and/or into appropriate cytological fixative. Cytology slides are smeared and fixed. The biopsy procedure is repeated until a cytopathologist confirms that adequate tissue has been obtained; or, in the absence of immediate cytopathological evaluation, until 4-8 biopsies are obtained. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. Supervision of the level of sedation and vital signs is performed during the procedure with additional measures taken to maintain an appropriate level of sedation, vital signs, airway and oxygenation as indicated. At the conclusion of the procedure, the endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. The patient is assessed for physical signs and symptoms suggestive of complications, including abdominal pain, nausea/vomiting, respiratory distress, and bleeding. Radiographic images are reviewed with the technologist for entry into the image storing system. Post procedure orders are completed and discussed with staff. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to the referral source and other appropriate parties. Data is entered into the procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others including a discussion regarding potential procedure complications. Restrictions, prescriptions, follow-up tests, instructions and appointments are provided to the patient and pertinent others.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Bruce Cameron, MD (ACG), Joel Brill, MD (AGA), Shivan Mehta, MD (AGA), Nicholas Nickl, MD (ASGE), Edward Bentley, MD (ASGE)				
<b>Specialty(s):</b>	ACG, AGA, ASGE				
<b>CPT Code:</b>	43238				
<b>Sample Size:</b>	980	<b>Resp N:</b>	33	<b>Response:</b> 3.3 %	
<b>Description of Sample:</b>	The ACG, AGA and ASGE conducted an enhanced random sample as approved by the Research Subcommittee. The sampling methodology was a random sample of member gastroenterologists with the addition of ASGE Special Interest Group physicians identified as performers of EUS procedures and survey volunteers who responded to educational articles and identified themselves as EUS performers.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	10.00	<b>25.00</b>	50.00	400.00
<b>Survey RVW:</b>	2.30	4.50	<b>5.03</b>	5.75	14.00
<b>Pre-Service Evaluation Time:</b>			<b>30.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>5.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>6.00</b>		
<b>Intra-Service Time:</b>	20.00	40.00	<b>45.00</b>	60.00	135.00
<b>Immediate Post Service-Time:</b>	<b>20.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	43238	<b>Recommended Physician Work RVU: 4.50</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>30.00</b>	<b>33.00</b>	<b>-3.00</b>
<b>Pre-Service Positioning Time:</b>		<b>3.00</b>	<b>1.00</b>	<b>2.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>5.00</b>	<b>5.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>45.00</b>		
<b>Immediate Post Service-Time:</b>	<b>20.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		

<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31638	000	4.88	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
11044	000	4.10	RUC Time	57,022
<u>CPT Descriptor 1</u> Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
15004	000	4.58	RUC Time	20,050

CPT Descriptor 2 Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 5      % of respondents: 15.1 %

**TIME ESTIMATES (Median)**

	<u>CPT Code:</u> 43238	<u>Key Reference CPT Code:</u> 31638	<u>Source of Time</u> RUC Time
Median Pre-Service Time	38.00	50.00	
Median Intra-Service Time	45.00	60.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	



Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>103.00</b>	<b>140.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.40	4.20
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.60	4.00
--	------	------

Urgency of medical decision making	4.20	4.00
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.80	4.40
--------------------------	------	------

Physical effort required	4.40	4.00
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.60	4.60
---	------	------

Outcome depends on the skill and judgment of physician	4.60	4.20
--	------	------

Estimated risk of malpractice suit with poor outcome	4.60	4.40
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.80	4.00
----------------------------------	------	------

Intra-Service intensity/complexity	4.60	4.00
------------------------------------	------	------

Post-Service intensity/complexity	4.20	4.00
-----------------------------------	------	------

---

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

### 43238 – Discussion and Recommendation

Code 43238 Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), esophagus (includes endoscopic ultrasound examination limited to the esophagus) was identified as a family code through the MPC List screen. This service was reviewed by the RUC as a new code in 2003. The RUC did not use a building block approach for this code since it would have produced a rank order anomaly. Therefore this code was cross walked to code 31641 Bronchoscopy, (rigid or flexible); with destruction of tumor or relief of stenosis by any method other than excision (eg, laser therapy, cryotherapy) (work RVU = 5.03).

**We recommend the 25<sup>th</sup> percentile RVW of 4.50 which is less than the current value.** We note that code pair 43238/43237 compares to pair 43231/43232 in that the incremental work between each pair, esophageal FNA, is the same. The recommended value for this code establishes the incremental work above 43237 at 0.65 which is comparable to the recommended increment for code pair 43231/43232 of 0.67. This value is supported by a comparison to other codes representing needle aspiration or needle biopsy (see table)

Code	Descriptor	RUC review	RVW	IS time
10021	FNA w/o image guidance	1995	1.27	17
10022	FNA w/ imaging	1995	1.27	20
19100	Breast Bx, no image guidance	1993	1.27	30
19102	Breast Bx, w/ image guidance	2000	2.00	30
32405	Lung Bx, percutaneous needle	2010	1.93	30
38505	Needle BX, lymph node		1.14	28
49082	Abd paracentesis wo/ image guidance	2010	1.24	10
49083	Abd paracentesis w/ image guidance	2010	2.00	25
49180	Needle Bx, percutaneous mass	1995	1.73	22
55700	Prostate Bx	2005	2.58	15
60100	Thyroid Bx, percutaneous needle	2000	1.56	25
60300	Thyroid cyst, aspiration	1995	0.97	15
64530	Celiac plexus block		1.58	30
76937	UTZ guidance, vascular access	2003	0.30	10
76942	UTZ guidance, needle placement		0.67	30
76946	UTZ guidance, amniocentesis		0.38	15
76975	GI endoscopic UTZ, S+I	1993	0.81	34
93306	Cardiac echo with 2D, m-mode, color flow and spectral Doppler	2007	1.30	20
93307	Cardiac echo with 2D, m-mode, no Doppler	2009	0.92	18
93312	TEE, including probe placement, S+I	1996	2.20	13
93313	TEE, probe placement	1996	0.95	25
93314	TEE, S+I only	1996	1.25	25

### Comparison to Key Ref 31638

Key Reference code 31638 requires lower intensity fluoroscopic guidance which increases the intra-service time. The difference in RVW compared with 43238 accounts for longer total time, but at lower intensity.

**43238 Comparison To MPC and Other RUC-Reviewed Codes with 45 Minutes Intra-Service Time**

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
MPC 2010	<b>11044</b>	Deb bone 20 sq cm/<	4.10	0.061	116	33	3	15	<b>45</b>	20
2009	<b>31626</b>	Bronchoscopy w/markers	4.16	0.074	85	19	1	5	<b>45</b>	15
2012	<b>31648</b>	Bronchial valve addl insert	4.20	0.068	100	19	1	5	<b>45</b>	30
	<b>43238</b>	EGD; US FNA, esophagus	4.50	0.073	104	30	3	6	<b>45</b>	20
MPC 2006	<b>15004</b>	Wound prep f/n/hf/g	4.58	0.054	150	45	15	15	<b>45</b>	30
2011	<b>36246</b>	Ins cath abd/l-ext art 2nd	5.27	0.088	106	33	3	5	<b>45</b>	20
2008	<b>52341</b>	Cysto w/ureter stricture tx	5.35	0.079	135	45	10	15	<b>45</b>	20

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43238

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 2100

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2011 ~ 700. (700 \* 3 = 2100)

Specialty Gastroenterology Frequency 1600 Percentage 76.19 %

Specialty Frequency 0 Percentage 0.00 %

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 700  
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2011 ~ 700

Specialty Gastroenterology	Frequency 540	Percentage 77.14 %
----------------------------	---------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? No

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43238

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43239	Tracking Number I5	Original Specialty Recommended RVU: <b>2.69</b>
		Presented Recommended RVU: <b>2.69</b>
Global Period: 000		RUC Recommended RVU: <b>2.56</b>

CPT Descriptor: Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 63 year old patient with abdominal pain and persistent dyspepsia undergoes esophagogastroduodenoscopy. Evaluation of the upper GI tract is performed, and multiple biopsies are taken for histology and H. pylori rapid urease test.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 81%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 67%

Description of Pre-Service Work: Review with the patient any symptoms including dysphagia and sleep apnea. The patient's history is reviewed to assess past problems with sedation and the need for pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays and other diagnostic tests are reviewed. The pre-service review is documented. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained. The physician verifies all endoscopic equipment is available and operational and appropriate computer entries are made. The patient is positioned on the examination table. The endoscopic and moderate sedation monitoring equipment is positioned to provide access for the procedure. A time out is performed. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide when indicated, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat. A bite block is placed in the mouth.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible upper endoscope is inserted through the mouth into the oropharynx and advanced through the esophagus into the proximal stomach. The stomach is insufflated with air after suctioning liquid contents. Examination of the entire stomach in the forward and retroflexed positions is performed. The endoscope is advanced through the pylorus into the duodenal bulb. Circumferential inspection of the duodenum is performed after air insufflation. The endoscope is slowly withdrawn re-inspecting the stomach and duodenum. Endoscopically directed biopsies are taken of abnormal tissue. After observation to confirm the absence of bleeding, the endoscope is then withdrawn into the esophagus suctioning air to deflate the stomach, allowing measurement of the squamocolumnar and gastro-esophageal junction from the incisors, assessment for presence

of a hiatal hernia, and examination of the esophageal mucosa. When indicated, brushings or washings are obtained of suspicious abnormalities. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. Supervision of the level of sedation and vital signs is performed during the procedure with additional measures taken to maintain an appropriate level of sedation, vital signs, airway and oxygenation as indicated. At the conclusion of the procedure, the endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. Post procedure orders are completed. Pathology forms are completed; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to referral source and other appropriate parties. Data is entered into procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others. Necessary prescriptions, follow-up tests and appointments are provided to the patient.

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)		01/2013				
Presenter(s):	Drs. Brill, Nickl, Bentley, and Selzer					
Specialty(s):	AGA, ASGE, SAGES					
CPT Code:	43239					
Sample Size:	7558	Resp N:	310	Response: 4.1 %		
Description of Sample:	The AGA and ASGE conducted an enhanced random sample of member gastroenterologists as approved by the Research Subcommittee. The methodology consisted of a random sample with the addition of an expert panel consisting of physicians from industry, members of ASGE Special Interest Groups (SIG) who perform specific procedures (e.g. endoscopic ultrasound, optical endomicroscopy, stent placement, etc.) and survey volunteers who responded to educational articles and identified themselves as performers of therapeutic endoscopic services. SAGES conducted a random sample of their members.					
		Low	25 <sup>th</sup> pctl	Median*	75 <sup>th</sup> pctl	High
Service Performance Rate		0.00	200.00	300.00	500.00	1600.00
Survey RVW:		0.80	3.00	3.36	3.90	10.35
Pre-Service Evaluation Time:				20.00		
Pre-Service Positioning Time:				5.00		
Pre-Service Scrub, Dress, Wait Time:				5.00		
Intra-Service Time:		5.00	12.00	15.00	20.00	60.00
Immediate Post Service-Time:	12.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00		
Discharge Day Mgmt:	0.00	99238x 0.00	99239x 0.00	99217x 0.00		
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00	15x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00	
Sub Obs Care:	0.00	99224x 0.00	99225x 0.00	99226x 0.00		

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1b-FAC Straightforw Pat Procedure(w sedate/anes)

CPT Code:	43239	Recommended Physician Work RVU: 2.56			
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:		19.00	19.00	0.00	
Pre-Service Positioning Time:		3.00	1.00	2.00	
Pre-Service Scrub, Dress, Wait Time:		5.00	5.00	0.00	
Intra-Service Time:		15.00			
Immediate Post Service-Time:	<u>12.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	

<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31625	000	3.36	RUC Time

CPT Descriptor BRONCHOSCOPY, RIGID OR FLEXIBLE, WITH OR WITHOUT FLUOROSCOPIC GUIDANCE; WITH BRONCHIAL OR ENDOBRONCHIAL BIOPSY(S), SINGLE OR MULTIPLE SITES

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
52000	000	2.23	RUC Time	925,004

CPT Descriptor 1 Cystourethroscopy (separate procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
51102	000	2.70	RUC Time	14,057

CPT Descriptor 2 Aspiration of bladder; with insertion of suprapubic catheter

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
36556	000	2.50	RUC Time

CPT Descriptor Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 144 % of respondents: 46.4 %

**TIME ESTIMATES (Median)**

	<u>CPT Code:</u> 43239	<u>Key Reference CPT Code:</u> 31625	<u>Source of Time</u> RUC Time
Median Pre-Service Time	27.00	25.00	
Median Intra-Service Time	15.00	30.00	
Median Immediate Post-service Time	12.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	



Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>54.00</b>	<b>70.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.74	3.54
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.56	3.46
--	------	------

Urgency of medical decision making	3.40	3.26
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.78	3.43
--------------------------	------	------

Physical effort required	3.32	3.05
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.47	3.24
---	------	------

Outcome depends on the skill and judgment of physician	3.76	3.55
--	------	------

Estimated risk of malpractice suit with poor outcome	3.65	3.38
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.20	3.07
----------------------------------	------	------

Intra-Service intensity/complexity	3.67	3.52
------------------------------------	------	------

Post-Service intensity/complexity	3.24	3.13
-----------------------------------	------	------

---

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

### Background

Several EGD codes were identified through CMS and RUC screens as potentially misvalued, including: MPC list screen; high expenditures screen; and fastest growing screen. The specialties agreed to survey the entire family of codes (43235-43259). In review of this family of codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In October 2012, the CPT Editorial Panel approved revised guidelines along with revision, addition, and deletion of codes within the EGD codeset.

### Overview of EGD Family RVW Recommendations

The specialty consensus panel spent a significant amount of time reviewing the survey data for the current set of EGD codes, comparing the data and values with the esophagoscopy codes (43200-43228) that were approved by the RUC at the October 2012 RUC meeting. The compelling arguments from the esophagoscopy review are the same as for the EGD codes, with the additional fact that the times for codes built on increments from the base code (43235) would require adjustment.

After reviewing the survey data, the consensus panel determined that for the EGD codeset, the incremental value above the base code for EGD (43235) should be similar where possible to the analogous incremental value above the esophagoscopy base code (43200) previously approved. For the existing codes, the RVW recommendations are based on the lower of the current value or the EGD base+increment from the esophagoscopy pair (ie, valuing the increment). Where there was no exact match for existing codes, the RVW recommendation is the lower of the current RVW or the 25<sup>th</sup> percentile RVW. For all new codes that bundle multiple codes and/or deleted codes, the RVW recommendation is based on endoscopy multiple procedure payment policy or surgical multiple procedure payment policy, as applicable. For this last set of codes, all but two recommendations are less than the survey 25<sup>th</sup> percentile. For the two exceptions, the recommendation is between the 25<sup>th</sup> and median survey RVW.

### 43239 – Discussion and Recommendation

Code 43239 *Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple* was identified as a family code through the MPC List screen. This service has been reviewed by the RUC three times, most recently in 2000 during the second 5YR. The AGA, ASGE, and SAGES conducted a RUC survey and received 310 responses. The consensus panel agrees that physician work for this service has not changed since the prior RUC review in 2000, however, the panel believes the increment of 0.30 established by the RUC in October 2012 for the esophagoscopy code pair 43200/43202 should apply to the EGD code pair 43235/43239.

**We recommend reducing the RVW to 2.69.** This value is less than the current RVW and less than the survey 25<sup>th</sup> percentile. This value is equal to the base code 43235 plus an increment of 0.30 (43202-43200) (ie, valuing the increment) approved by the RUC in October 2012.

**Pre-time Package 1b** is appropriate for 43239, with an additional 2 minutes for positioning the patient, endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

### Comparison to Key Ref 31625

Key Reference code 31625 was surveyed and presented to the RUC in 2003 prior to the discussion of pre-time packages and moderate sedation work. The RUC agreed that the CPT change was editorial and that work had not changed. The RVW was maintained and the survey data was accepted.

### Comparison to EGD Base Code 43235

*Estimating time in 5 minute increments.* As discussed in the compelling evidence, respondents for the EGD surveys reported intra-time in increments of 5 minutes. The median of 15 minutes for both 43235 and 43239 masks slight differences of +/- a few minutes that would be shown using time and motion studies. We do not believe that the intra-service time for 43239 is identical to 43235 and the survey median of 15 minutes is an artifact of estimating time in 5 minute increments.

*Establishment of increments.* Harvard conducted an extensive review of the endoscopy families prior to the publication of the first PFS. The increments established between and within families were key to maintaining relativity across the fee schedule. In 1992, the Harvard-based RVW for 43235 (EGD base) was 2.52 and the Harvard-based RVW for 43239

(EGD biopsy) was 2.83. This resulted in an RVW increment of 0.31. In 1995, the RUC reviewed both 43235 and 43239 and recommended maintaining the current RVW for each code (2.39 and 2.69, respectively). These RVWs were less than the 1992 values due to budget neutrality RVW adjustments that CMS made to all codes in the early years of the fee schedule. In 2000, the RUC reviewed 43239 and determined there was a change in work and recommended increasing the RVW to 2.87. The consensus panel reviewing this family of codes and the current survey data believe the increment of 0.30 established for the esophagoscopy pair 43200/43202 is correct for the similar EGD pair 43235/43239.

#### Comparison to MPC and Other RUC-Reviewed Codes with 15-20 Minutes Intra-Service Time

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
MPC 2005	<b>52000</b>	Cystoscopy	2.23	0.113	<b>42</b>	10	2	5	<b>15</b>	10
MPC 2003	<b>36556</b>	Insert non-tunnel cv cath	2.50	0.119	<b>50</b>	15	5	5	<b>15</b>	10
2010	<b>90870</b>	Electroconvulsive therapy	2.50	0.107	<b>36</b>	10	1		<b>20</b>	5
1995	<b>31520</b>	Dx laryngoscopy newborn	2.56	0.121	<b>58</b>	14		15	<b>15</b>	14
2005	<b>55700</b>	Biopsy of prostate	2.58	0.102	<b>65</b>	20	5	5	<b>15</b>	20
2003	<b>36555</b>	Insert non-tunnel cv cath	2.68	0.093	<b>60</b>	20	5	5	<b>20</b>	10
	<b>43239</b>	EGD with biopsy	2.56	0.126	<b>54</b>	19	3	5	<b>15</b>	12
MPC 2008	<b>51102</b>	Drain bl w/cath insertion	2.70	0.094	<b>60</b>	19	1	5	<b>20</b>	15
2010	<b>52281</b>	Cystoscopy and treatment	2.75	0.112	<b>46</b>	10	1	5	<b>20</b>	10
2008	<b>49452</b>	Replace g-j tube perc	2.86	0.102	<b>60</b>	20	5	5	<b>20</b>	10
2007	<b>93503</b>	Insert/place heart catheter	2.91	0.166	<b>37</b>	5	2	5	<b>15</b>	10
2012	<b>32551</b>	Insertion of chest tube	3.29	0.101	<b>83</b>	30	3	10	<b>20</b>	20
2005	<b>67221</b>	Ocular photodynamic ther	3.45	0.208	<b>30</b>	10			<b>15</b>	5
2008	<b>27250</b>	Treat hip dislocation	3.82	0.203	<b>53</b>	15	5	5	<b>15</b>	13

#### SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.  
☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.  
☐ Multiple codes allow flexibility to describe exactly what components the procedure included.  
☐ Multiple codes are used to maintain consistency with similar codes.  
☐ Historical precedents.  
☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

#### FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43239

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology

How often? Commonly

Specialty GI Surgery                      How often? Sometimes

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 4425000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare database for 2011 is approximately 1,475,000. 1,475,000 times 3 considering commercial patients is 4,425,000

Specialty Gastroenterology                      Frequency 3628500                      Percentage 82.00 %

Specialty GI Surgery                      Frequency 354000                      Percentage 8.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,475,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare database for 2011 is approximately 1,475,000.

Specialty Gastroenterology                      Frequency 1209500                      Percentage 82.00 %

Specialty GI Surgery                      Frequency 118000                      Percentage 8.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43239

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43240	Tracking Number I6	Original Specialty Recommended RVU: <b>7.25</b>
		Presented Recommended RVU: <b>7.25</b>
Global Period: 000		RUC Recommended RVU: <b>7.25</b>

CPT Descriptor: Esophagogastroduodenoscopy, flexible, transoral; with transmural drainage of pseudocyst (includes placement of transmural drainage catheter[s]/stent[s], when performed, and endoscopic ultrasound, when performed)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 68-year-old patient with a history of acute pancreatitis has developed a symptomatic pancreatic pseudocyst that has failed to resolve despite conservative measures. Esophagogastroduodenoscopy with evaluation of the upper GI tract, transmural drainage of the pseudocyst under endoscopic ultrasound guidance, and placement of stents to maintain drainage of the pseudocyst into the stomach is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 53%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 13%

Description of Pre-Service Work: Review with the patient any symptoms including dysphagia and sleep apnea. The patient's history is reviewed to assess past problems with sedation and the need for and timing of pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's imaging studies and other diagnostic tests are reviewed. The pre-service review is documented. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for procedure is obtained. The physician verifies all endoscopic and echoendoscopy imaging and image capture equipment is available, operational and appropriate imaging settings and computer entries are made, with special attention to the transducer balloon sheath. The devices to be used to accomplish pseudocyst drainage are reviewed. A time out is performed. The patient is positioned on the procedure table. The endoscopic, imaging and moderate sedation monitoring equipment is positioned to provide access for the procedure. Appropriate protective attire is applied and verification that all others in the suite are properly protected including the patient. A bite block is placed in the mouth.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard upper endoscope is inserted into the mouth and the oropharynx and advanced through the esophagus into the stomach. Residual fluid is removed from the stomach. The endoscope is advanced through the pylorus into the duodenal bulb, and then around the bulb apex to the second portion of the duodenum. Examination is conducted of the duodenum, the entire stomach including the gastric cardia in a retroflexed scope position, and the entire esophagus, noting the abnormal area(s) to be evaluated by echoendoscopy and location as well as any other abnormalities present. The standard upper endoscope is withdrawn; the linear-view echoendoscope is inserted into the mouth and the oropharynx and advanced through the

esophagus into the stomach and to the duodenum or jejunum. Echoendoscopic evaluation is conducted of the pseudocyst(s), correlating the endoscopic and ultrasonographic images. The locations of the pseudocyst(s) are noted, as is the relationship of abnormalities to adjoining normal and abnormal structures including vascular and other structures of the mediastinum or abdomen/retroperitoneum. Multiple transducer frequencies are utilized as needed to fully visualize the pseudocyst(s). Doppler imaging of appropriate areas is completed when indicated including identification of vascular structures in the anticipated track of the pseudocyst drainage. A determination of risk and benefit to drain the pseudocyst is performed. The needle aspiration (FNA) device is inserted into the endoscope. Under continuous endoscopic and ultrasonographic guidance, the needle tip is advanced transmurally into the pseudocyst, taking care to avoid vascular structures and using Doppler imaging as needed to identify such structures. Pseudocyst fluid is aspirated through the FNA needle to confirm the correct position. A guidewire is inserted through the needle into the pseudocyst, and the needle is withdrawn over the guidewire. An electrocautery accessory such as a sphincterotome is advanced over the guidewire and electrocautery is used to open a stoma into the pseudocyst. Fluid which drains into the stomach is aspirated. The stoma is enlarged to the appropriate size using further cautery. The electrocautery accessory is removed over the guidewire; balloon dilators may be passed over the guidewire to further dilate the stoma. An enteral stent is advanced over the guidewire using the appropriate positioning device system and is deployed into the appropriate position straddling the stoma. The guidewire and deployment system is removed. When clinically indicated, the guidewire may be re-placed into the pseudocyst for enlargement of the stoma, creation of additional stoma(s), or placement of additional stents using the same technique. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. At the conclusion of the procedure, the endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. The patient is assessed for physical signs and symptoms suggestive of complications, including abdominal pain, nausea/vomiting, respiratory distress, and bleeding. A focused abdominal exam is conducted to evaluate for evidence of pseudocyst leakage or bleeding, and for effective cyst decompression. Post procedure orders are completed and discussed with staff. Photographs are reviewed and labeled. Radiographic images are reviewed with the technologist for entry into the image storing system. Cytology and/or pathology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. A procedure report is generated and forwarded to the referral source and other appropriate parties. Data is entered into the procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others including a discussion regarding potential procedure complications and follow-up plans or further treatments, specifically including stent removal plans. Restrictions, prescriptions, follow-up tests, instructions and appointments are provided to the patient and pertinent others.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Bruce Cameron, MD (ACG), Joel Brill, MD (AGA), Nicholas Nickl, MD (ASGE), Edward Bentley, MD (ASGE)				
<b>Specialty(s):</b>	ACG, AGA, ASGE				
<b>CPT Code:</b>	43240				
<b>Sample Size:</b>	985	<b>Resp N:</b>	33	<b>Response:</b> 3.3 %	
<b>Description of Sample:</b>	The ACG, AGA and ASGE conducted an enhanced random sample as approved by the Research Subcommittee. The sampling methodology was a random sample of member gastroenterologists with the addition of ASGE Special Interest Group physicians identified as performers of EUS procedures and survey volunteers who responded to educational articles and identified themselves as EUS performers.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	0.00	<b>5.00</b>	10.00	50.00
<b>Survey RVW:</b>	4.65	7.25	<b>8.50</b>	10.00	13.00
<b>Pre-Service Evaluation Time:</b>			<b>50.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>10.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>10.00</b>		
<b>Intra-Service Time:</b>	40.00	60.00	<b>70.00</b>	90.00	120.00
<b>Immediate Post Service-Time:</b>	<b>30.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	43240	<b>Recommended Physician Work RVU: 7.25</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>33.00</b>	<b>33.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>3.00</b>	<b>1.00</b>	<b>2.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>5.00</b>	<b>5.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>70.00</b>		
<b>Immediate Post Service-Time:</b>	<b>30.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		

<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31600	000	7.17	RUC Time

CPT Descriptor Tracheostomy, planned (separate procedure)**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.****Number of respondents who choose Key Reference Code: 6      % of respondents: 18.1 %****TIME ESTIMATES (Median)**

	<b>CPT Code:</b> 43240	<b>Key Reference CPT Code:</b> 31600	<b>Source of Time</b> RUC Time
Median Pre-Service Time	41.00	50.00	
Median Intra-Service Time	70.00	40.00	
Median Immediate Post-service Time	30.00	66.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	



Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>141.00</b>	<b>156.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.33	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.83	3.83
Urgency of medical decision making	5.00	4.00

**Technical Skill/Physical Effort (Mean)**

Technical skill required	5.00	4.33
Physical effort required	4.67	4.00

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	5.00	4.33
Outcome depends on the skill and judgment of physician	5.00	4.33
Estimated risk of malpractice suit with poor outcome	4.67	4.33

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.50	4.00
Intra-Service intensity/complexity	5.00	4.17
Post-Service intensity/complexity	4.33	3.67

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUR analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**

Several EGD codes were identified through CMS and RUC screens as potentially misvalued, including: MPC list screen; high expenditures screen; and fastest growing screen. The specialties agreed to survey the entire family of codes (43235-43259). In review of this family of codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In October 2012, the CPT Editorial Panel approved revised guidelines along with revision, addition, and deletion of codes within the EGD codeset.

### Compelling Evidence - 43240

The expert panel reviewed the prior valuation history of this service as well as changes in practice pattern since the last valuation, and concluded that there were reasons to present compelling evidence for re-valuation of the code.

#### Change in patient:

Code 43240 *Esophagogastroduodenoscopy, flexible, transoral; with transmural drainage of pseudocyst (includes placement of transmural drainage catheter[s]/stent[s], when performed, and endoscopic ultrasound, when performed)* was new for CPT 2000. When this service was last valued by the RUC in 2000, the standard method for pancreatic pseudocyst marsupialization was surgical cyst-enterostomy. Endoscopic drainage was utilized primarily for the simpler cases: pseudocysts < 6 cm without internal debris or infection and which are unilocular without septations, in patients who are otherwise healthy. Management of pancreatic pseudocysts has evolved over the past decade: today endoscopic drainage is the standard first line therapy, with surgical drainage largely reserved for those who have failed endoscopic treatment or are not candidates. Endoscopic treatment is now performed on giant pseudocysts > 10 cm, multiloculated and septated pseudocysts, pseudocysts containing solid and necrotic debris, and infected pseudocysts (pancreatic abscesses). Additionally, because it is less invasive than surgery, endoscopic treatment is preferred for sicker patients, particularly those who are poor surgical candidates due to severe malnutrition associated with the pancreatic disease. Finally, new treatment guidelines by the GI endoscopy authorities (ASGE 2005, Varadarajulu 2011), based on recent natural history data, now recommend non-drainage treatment of simple unilocular pseudocysts in healthy asymptomatic patients. Thus those patients who typically had endoscopic drainage in 2000 are now rarely drained at all, while the more sick patients with more complex and technically demanding pseudocysts previously treated surgically are currently being managed with endoscopic therapy. This represents a major shift in the clinical practice pattern since the last valuation. We note that the Medicare frequency has grown from 89 (2001) to 314 (2011). This infrequently performed procedure is still largely confined to tertiary care centers. In addition, pancreatitis with pseudocysts is more common in younger populations, so that a preponderance of claims are in Medicaid and commercial patients. The 10 year trend in this procedure represents both a slow growth in volume in addition to the dramatic shift in the clinical profile as described.

#### Flawed methodology:

Code 43240 was reviewed by the RUC as a new code in 2000. Because there were only six survey responses, the RUC recommended an RVW equivalent to code 43262 *Endoscopic retrograde cholangio-pancreatography (ERCP); with sphincterotomy/papilotomy* (work RVU = 7.39) based on a comparison of total survey time (from 6 responses). When created, this new code was very infrequently performed, resulting in the low survey response rate. Although the survey median RVW was 10.00, the RUC crosswalked the value to another code based on time. Subsequent to the RUC review, CMS reduced the RVW to 6.86 as part of refinement after the second five-year-review. We do not believe the current RVW is survey based and we do not believe the current value correctly reflects the relative work compared with other codes, including those in the EGD family of codes.

---

### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43240

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology                      How often? Rarely

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 900

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2011 ~ 300

Specialty Gastroenterology                      Frequency 801                      Percentage 89.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 300

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2011 ~300

Specialty Gastroenterology                      Frequency 267                      Percentage 89.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? No

## Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43240

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

# American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



141 Northwest Point Blvd  
Elk Grove Village, IL 60007-1019  
Phone: 847/434-4000  
Fax: 847/434-8000  
E-mail: [kidsdocs@aap.org](mailto:kidsdocs@aap.org)  
[www.aap.org](http://www.aap.org)

January 2, 2013

## Executive Committee

### President

Thomas K. McInerney, MD, FAAP

### President-Elect

James M. Perrin, MD, FAAP

### Immediate Past President

Robert W. Block, MD, FAAP

### Executive Director/CEO

Errol R. Alden, MD, FAAP

## Board of Directors

### District I

Carole E. Allen, MD, FAAP  
Arlington, MA

### District II

Danielle Laraque, MD, FAAP  
Brooklyn, NY

### District III

David I. Bromberg, MD, FAAP  
Frederick, MD

### District IV

Francis E. Rushton, Jr, MD, FAAP  
Beaufort, SC

### District V

Marilyn J. Bull, MD, FAAP  
Indianapolis, IN

### District VI

Pamela K. Shaw, MD, FAAP  
Kansas City, KS

### District VII

Kenneth E. Matthews, MD, FAAP  
College Station, TX

### District VIII

Kyle Yasuda, MD, FAAP  
Seattle, WA

### District IX

Stuart A. Cohen, MD, MPH, FAAP  
San Diego, CA

### District X

Sara H. Goza, MD, FAAP  
Fayetteville, GA

Barbara Levy, MD

Chair, AMA/Specialty Society RVS Update Committee  
American Medical Association

Department of Physician Payment Policy and Systems  
515 North State Street  
Chicago, IL 60610

Re: Direct Practice Expense Inputs for Neonatal Hypothermia Services (99481-99482;  
Tracking Codes K1-K2; Tab 18)

Dear Dr Levy:

Codes 99481-99482 (*Total body systemic/selective head hypothermia in a critically ill neonate per day*) are among the codes being considered during the January 2013 RUC meeting.

The American Academy of Pediatrics (AAP) has conducted physician work surveys for codes 99481-99482 and developed work RVU recommendations based on the survey results.

However, we recommend no direct practice expense inputs for codes 99481-99482.

If you have any questions, please contact Linda Walsh, AAP staff, at 800/433-9016 ext 7931 or [lwalsh@aap.org](mailto:lwalsh@aap.org). Thank you.

Sincerely,

A handwritten signature in black ink, appearing to read "Steve Krug".

Steven E. Krug, MD, FAAP  
AAP RUC Advisor



**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:43242	Tracking Number I8	Original Specialty Recommended RVU: <b>5.39</b>
		Presented Recommended RVU: <b>5.39</b>
Global Period: 000		RUC Recommended RVU: <b>5.39</b>

CPT Descriptor: Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 69 year old patient with weight loss and painless jaundice is found to have a tumor in the head of the pancreas on imaging studies. The patient is referred for diagnostic esophagogastroduodenoscopy with evaluation of the upper GI tract, then endoscopic ultrasound staging of the tumor of the pancreatic head is performed with transendoscopic fine needle aspiration biopsy of the pancreatic head for cytologic evaluation.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 56%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 13%

Description of Pre-Service Work: Review with the patient any symptoms including dysphagia and sleep apnea. The patient's history is reviewed to assess past problems with sedation and the need for and timing of pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's imaging studies and other diagnostic tests are reviewed. The pre-service review is documented. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained. The physician verifies all endoscopic and echoendoscopy imaging and image capture equipment is available, operational and appropriate imaging settings and computer entries are made, with special attention to the transducer balloon sheath. A time out is performed. The patient is positioned on the procedure table. The endoscopic, imaging and moderate sedation monitoring equipment is positioned to provide access for the procedure. Appropriate protective attire is applied and verification that all others in the suite are properly protected including the patient. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide when indicated, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat. A bite block is placed in the mouth.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard upper endoscope is inserted into the mouth and the oropharynx and advanced through the esophagus into the stomach. Residual

fluid is removed from the stomach. The endoscope is advanced through the pylorus into the duodenal bulb, and then around the bulb apex to the second portion of the duodenum. Examination is conducted of the duodenum, the entire stomach including the gastric cardia in a retroflexed scope position, and the entire esophagus, noting the abnormal area(s) to be evaluated by echoendoscopy and location as well as any other abnormalities present. The standard upper endoscope is withdrawn; the radial-view or linear-view echoendoscope is inserted into the mouth and the oropharynx and advanced through the esophagus into the stomach and to the duodenum or jejunum. Echoendoscopic evaluation is conducted of all abnormalities identified, correlating the endoscopic and ultrasonographic images. The locations of the findings are noted, as is the relationship of abnormalities to adjoining normal and abnormal structures including the GI tract wall as well as vascular and other structures of the mediastinum or abdomen/retroperitoneum. Multiple transducer frequencies are utilized as needed to fully visualize the area of interest. Doppler imaging of appropriate areas is completed when indicated including identification of vascular structures in the anticipated track of the biopsy needle. A determination of risk and benefit to sample (e.g. biopsy) the lesion is performed. The radial-view echoendoscope is withdrawn (if used); the linear-view biopsy echoendoscope is inserted into the mouth and the oropharynx and advanced through the esophagus to the area to be biopsied. The area of interest is re-imaged and fully characterized, noting the correlation of the sagittal/coronal image to the transverse image previously obtained. The fine needle aspiration (FNA) device is inserted into the endoscope. Under continuous endoscopic and ultrasound guidance the FNA needle tip is advanced intramurally or transmurally into the location to be biopsied, taking care to avoid vascular structures and using Doppler imaging as needed to identify such structures. The FNA needle is inserted into the area to be biopsied, the stylette is withdrawn, and suction is applied. The needle is thrust in and out of the region to be biopsied, taking care that the correct needle position is maintained. The needle is withdrawn and the contents of the needle are expressed on to microscope slides and/or into appropriate cytological fixative. Cytology slides are smeared and fixed. The biopsy procedure is repeated until a cytopathologist confirms that adequate tissue has been obtained; or, in the absence of immediate cytopathological evaluation, until 4-8 biopsies are obtained. A determination of risk and benefit to sample (e.g. biopsy) the lesion is performed. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. Supervision of the level of sedation and vital signs is performed during the procedure with additional measures taken to maintain an appropriate level of sedation, vital signs, airway and oxygenation as indicated. At the conclusion of the procedure, the endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. The patient is assessed for physical signs and symptoms suggestive of complications, including abdominal pain, nausea/vomiting, respiratory distress, and bleeding. Radiographic images are reviewed with the technologist for entry into the image storing system. Post procedure orders are completed and discussed with staff. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to the referral source and other appropriate parties. Data is entered into the procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others including a discussion regarding potential procedure complications. Restrictions, prescriptions, follow-up tests, instructions and appointments are provided to the patient and pertinent others.



**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Bruce Cameron, MD (ACG), Joel Brill, MD (AGA), Shivan Mehta, MD (AGA), Nicholas Nickl, MD (ASGE)				
<b>Specialty(s):</b>	ACG, AGA, ASGE				
<b>CPT Code:</b>	43242				
<b>Sample Size:</b>	979	<b>Resp N:</b>	36	<b>Response:</b> 3.6 %	
<b>Description of Sample:</b>	The ACG, AGA and ASGE conducted an enhanced random sample as approved by the Research Subcommittee. The sampling methodology was a random sample of member gastroenterologists with the addition of ASGE Special Interest Group physicians identified as performers of EUS procedures and survey volunteers who responded to educational articles and identified themselves as EUS performers.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	24.00	<b>60.00</b>	100.00	300.00
<b>Survey RVW:</b>	3.00	5.04	<b>6.65</b>	8.00	14.00
<b>Pre-Service Evaluation Time:</b>			<b>38.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>10.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>10.00</b>		
<b>Intra-Service Time:</b>	25.00	45.00	<b>50.00</b>	66.00	160.00
<b>Immediate Post Service-Time:</b>	<b>23.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	43242	<b>Recommended Physician Work RVU: 5.39</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>33.00</b>	<b>33.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>3.00</b>	<b>1.00</b>	<b>2.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>5.00</b>	<b>5.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>50.00</b>		
<b>Immediate Post Service-Time:</b>	<b>23.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		

<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31600	000	7.17	RUC Time

CPT Descriptor Tracheostomy, planned (separate procedure)**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.****Number of respondents who choose Key Reference Code: 5      % of respondents: 13.8 %****TIME ESTIMATES (Median)**

	<b>CPT Code:</b> 43242	<b>Key Reference CPT Code:</b> 31600	<b>Source of Time</b> RUC Time
Median Pre-Service Time	41.00	50.00	
Median Intra-Service Time	50.00	40.00	
Median Immediate Post-service Time	23.00	66.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>114.00</b>	<b>156.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.60	3.60
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.40	3.60
--	------	------

Urgency of medical decision making	4.60	3.80
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.60	4.00
--------------------------	------	------

Physical effort required	4.00	3.60
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.20	4.20
---	------	------

Outcome depends on the skill and judgment of physician	4.60	3.80
--	------	------

Estimated risk of malpractice suit with poor outcome	4.20	4.00
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.40	3.80
----------------------------------	------	------

Intra-Service intensity/complexity	4.60	4.00
------------------------------------	------	------

Post-Service intensity/complexity	4.40	3.60
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUR analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**43242 – Discussion and Recommendation**

Code 43242 *Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)* was identified as a family code through the MPC List screen. This service was reviewed by the RUC as a new code in 2000. Because there were only eight survey responses, the RUC recommended 5.51 based on valuing the increment of biopsy to 43259. The biopsy increment was based on a blend between 19291 (0.63) and the increment between 31629 and 31622. CMS accepted the RUC recommendation for 2001, however, after the second 5-year-review that included other EGD codes, CMS refinement increased 43242 to 7.31 to maintain rank order. The RUC again reviewed 43242 as part of a family of new and revised codes in 2003 and determined that the RVW of 7.31 correctly valued this service.

The panel noted that the median survey RVW was 6.65 which is less than the current value of the code. The panel observed that the code pair 43259/43242 compares to code pairs 43231/43232 and 43237/43238 in that the incremental work for each pair represents performance of FNA biopsy under ultrasound guidance. For the 43231/43232 and 43237/43238 code pairs this interval was, respectively 0.67 and 0.65 RVUs, which was consistent with other needle aspiration biopsy codes. The panel noted that both median and 25th percentile RVWs provide inconsistent increments for this work. The panel determined that, to maintain internal consistency and relativity within and outside the code set, 43242 is most appropriately valued as the sum of code 43259, 4.74 RVUs, plus 0.65 RVUs for FNA under ultrasound guidance, yielding 5.39. This value is between the 25th percentile and the median.

**We recommend a value of 5.39 RVU, which is less than the current value.**

This value is supported by a comparison to other codes representing needle aspiration or needle biopsy (see table)

Code	Descriptor	RUC review	RVW	IS time
10021	FNA w/o image guidance	1995	1.27	17
10022	FNA w/ imaging	1995	1.27	20
19100	Breast Bx, no image guidance	1993	1.27	30
19102	Breast Bx, w/ image guidance	2000	2.00	30
32405	Lung Bx, percutaneous needle	2010	1.93	30
38505	Needle BX, lymph node		1.14	28
49082	Abd paracentesis wo/ image guidance	2010	1.24	10
49083	Abd paracentesis w/ image guidance	2010	2.00	25
49180	Needle Bx, percutaneous mass	1995	1.73	22
55700	Prostate Bx	2005	2.58	15
60100	Thyroid Bx, percutaneous needle	2000	1.56	25
60300	Thyroid cyst, aspiration	1995	0.97	15
64530	Celiac plexus block		1.58	30
76937	UTZ guidance, vascular access	2003	0.30	10
76942	UTZ guidance, needle placement		0.67	30
76946	UTZ guidance, amniocentesis		0.38	15
76975	GI endoscopic UTZ, S+I	1993	0.81	34
93306	Cardiac echo with 2D, m-mode, color flow and spectral Doppler	2007	1.30	20
93307	Cardiac echo with 2D, m-mode, no Doppler	2009	0.92	18

CPT Code: 43242				
93312	TEE, including probe placement, S+I	1996	2.20	13
93313	TEE, probe placement	1996	0.95	25
93314	TEE, S+I only	1996	1.25	25

### Comparison to Key Ref 31600

The intra-time and relative intensity of 43242 compares well with key reference code 31600.

### 43242 Comparison To Other RUC-Reviewed Codes with 40-60 Minutes Intra-Service Time

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2005	<b>50384</b>	Remove ureter stent percut	5.00	0.070	112	25	7	10	55	15
2011	<b>52315</b>	Cystoscopy and treatment	5.20	0.093	94	19	5	5	45	20
2011	<b>36246</b>	Ins cath abd/l-ext art 2nd	5.27	0.088	106	33	3	5	45	20
2001	<b>52402</b>	Cystourethro cut ejacul duct	5.27	0.085	95	30			50	15
2011	<b>36251</b>	Ins cath ren art 1st unilat	5.35	0.085	116	33	3	5	45	30
2008	<b>52341</b>	Cysto w/ureter stricture tx	5.35	0.079	135	45	10	15	45	20
	<b>43242</b>	EGD; US FNA, incl EUS	5.39	0.078	124	38	3	10	50	23
2012	<b>52235</b>	Cystoscopy and treatment	5.44	0.098	94	19	5	5	45	20
1994	<b>31267</b>	Endoscopy maxillary sinus	5.45	0.082	110	30			50	30
2005	<b>50382</b>	Change ureter stent percut	5.50	0.070	125	30	10	10	60	15
2012	<b>36222</b>	Place cath carotid/inom art	5.53	0.096	118	40	3	5	40	30
2010	<b>93455</b>	Coronary art/grft angio s&i	5.54	0.094	123	45	3	5	40	30
2012	<b>52351</b>	Cystouretero / pyeloscope	5.75	0.096	118	33	5	15	45	20
2010	<b>93458</b>	L hrt artery/ventricle angio	5.85	0.093	123	40	3	5	45	30

## SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43242

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 79500

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2011 ~ 26,500

Specialty Gastroenterology	Frequency 73935	Percentage 93.00 %
----------------------------	-----------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

26,500 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2011 ~ 26,500

Specialty Gastroenterology	Frequency 24645	Percentage 93.00 %
----------------------------	-----------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? No

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43242

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43243	Tracking Number 19	Original Specialty Recommended RVU: <b>4.37</b>
		Presented Recommended RVU: <b>4.37</b>
Global Period: 000		RUC Recommended RVU: <b>4.37</b>

CPT Descriptor: Esophagogastroduodenoscopy, flexible, transoral; with injection sclerosis of esophageal / gastric varices

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 53-year-old patient with a history of hepatitis C, and cirrhosis presents with hematemesis and hypotension. Therapeutic esophagogastroduodenoscopy with evaluation of the upper GI tract for the site(s) of bleeding is performed, followed by injection sclerosis of actively bleeding varices.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 82%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 73%

Description of Pre-Service Work: Review with the patient any symptoms including dysphagia and sleep apnea. The patient's history is reviewed to assess past problems with sedation and the need for pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays and other diagnostic tests are reviewed. The pre-service review is documented. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained. The physician verifies all endoscopic equipment is available and operational and appropriate computer entries are made. The patient is positioned on the examination table. The endoscopic and moderate sedation monitoring equipment is positioned to provide access for the procedure. A time out is performed. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide when indicated, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat. A bite block is placed in the mouth.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible upper endoscope is inserted through the mouth into the oropharynx and advanced through the esophagus into the proximal stomach. The stomach is insufflated with air after suctioning liquid contents and blood. Examination of the entire stomach in the forward and retroflexed positions is performed. The endoscope is advanced through the pylorus into the duodenal bulb. Circumferential inspection of the duodenum is performed after air insufflation. The endoscope is slowly withdrawn re-inspecting the stomach and duodenum. After suctioning air to deflate the stomach, the endoscope is withdrawn into the esophagus, allowing measurement of the squamocolumnar and gastro-esophageal junction from the incisors, assessment for presence of a hiatal hernia, and examination of the esophageal mucosa. When indicated, brushings or washings are

obtained of suspicious abnormalities. Actively bleeding 3-4+ esophageal varices are identified. The area is washed. After obtaining adequate visibility of the most likely bleeding site, a sclerotherapy needle is inserted into the bleeding varix. Injections of sclerosing agent are performed to the primary bleeding varix. The sclerotherapy needle is withdrawn, inserted at a second site in the varix, and injections of sclerosing agent are performed. Subsequent insertion of the sclerotherapy needle and injections of sclerosing agent are performed for all other prominent varices identified as active or potential bleeding sources. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. Supervision of the level of sedation and vital signs is performed during the procedure with additional measures taken to maintain an appropriate level of sedation, vital signs, airway and oxygenation as indicated. At the conclusion of the procedure, the endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. Post procedure orders are completed. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to referral source and other appropriate parties. Data is entered into procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others. Necessary prescriptions, follow-up tests and appointments are provided to the patient.



**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		01/2013				
<b>Presenter(s):</b>	Drs. Brill, Nickl, and Bentley					
<b>Specialty(s):</b>	AGA, ASGE					
<b>CPT Code:</b>	43243					
<b>Sample Size:</b>	1027	<b>Resp N:</b>	58	<b>Response:</b> 5.6 %		
<b>Description of Sample:</b>	The AGA and ASGE conducted a random sample of member gastroenterologists as approved by the Research Subcommittee. The sampling methodology was a random sample with the addition of survey volunteers who responded to educational articles and identified themselves as performers of therapeutic endoscopic services.					
		<b><u>Low</u></b>	<b><u>25<sup>th</sup> pctl</u></b>	<b><u>Median*</u></b>	<b><u>75<sup>th</sup> pctl</u></b>	<b><u>High</u></b>
<b>Service Performance Rate</b>		0.00	4.00	<b>10.00</b>	15.00	100.00
<b>Survey RVW:</b>		2.25	4.37	<b>4.89</b>	5.60	12.00
<b>Pre-Service Evaluation Time:</b>				<b>35.00</b>		
<b>Pre-Service Positioning Time:</b>				<b>5.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>5.00</b>		
<b>Intra-Service Time:</b>		15.00	25.00	<b>30.00</b>	40.00	60.00
<b>Immediate Post Service-Time:</b>	<b><u>20.00</u></b>					
<b><u>Post Operative Visits</u></b>	<b><u>Total Min**</u></b>	<b><u>CPT Code and Number of Visits</u></b>				
<b>Critical Care time/visit(s):</b>	<b><u>0.00</u></b>	99291x 0.00	99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b><u>0.00</u></b>	99231x 0.00	99232x 0.00	99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b><u>0.00</u></b>	99238x 0.00	99239x 0.00	99217x 0.00		
<b>Office time/visit(s):</b>	<b><u>0.00</u></b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00	15x 0.00
<b>Prolonged Services:</b>	<b><u>0.00</u></b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00	
<b>Sub Obs Care:</b>	<b><u>0.00</u></b>	99224x 0.00	99225x 0.00	99226x 0.00		

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	43243	Recommended Physician Work RVU: 4.37			
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:		33.00	33.00	0.00	
Pre-Service Positioning Time:		3.00	1.00	2.00	
Pre-Service Scrub, Dress, Wait Time:		5.00	5.00	0.00	
Intra-Service Time:		30.00			
Immediate Post Service-Time:	20.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	0.00	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00

<b>Sub Obs Care:</b>	<b><u>0.00</u></b>	99224x <b>0.00</b>	99225x <b>0.00</b>	99226x <b>0.00</b>
----------------------	--------------------	--------------------	--------------------	--------------------

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31631	000	4.36	RUC Time

CPT Descriptor BRONCHOSCOPY, RIGID OR FLEXIBLE, WITH OR WITHOUT FLUOROSCOPIC GUIDANCE; WITH PLACEMENT OF TRACHEAL STENT(S) (INCLUDES TRACHEAL/BRONCHIAL DILATION AS REQUIRED)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 14      % of respondents: 24.1 %

**TIME ESTIMATES (Median)**

	CPT Code: 43243	Key Reference CPT Code: 31631	Source of Time RUC Time
Median Pre-Service Time	41.00	45.00	
Median Intra-Service Time	30.00	45.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>91.00</b>	<b>120.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.19	3.81
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.48	3.95
--	------	------

Urgency of medical decision making	4.79	3.88
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.72	4.00
--------------------------	------	------

Physical effort required	4.31	3.72
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.88	3.98
---	------	------

Outcome depends on the skill and judgment of physician	4.78	4.07
--	------	------

Estimated risk of malpractice suit with poor outcome	4.36	3.79
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.41	3.76
----------------------------------	------	------

Intra-Service intensity/complexity	4.69	3.98
------------------------------------	------	------

Post-Service intensity/complexity	4.31	3.66
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUR analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**

Several EGD codes were identified through CMS and RUC screens as potentially misvalued, including: MPC list screen; high expenditures screen; and fastest growing screen. The specialties agreed to survey the entire family of codes (43235-43259). In review of this family of codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In October 2012, the CPT Editorial Panel approved revised guidelines along with revision, addition, and deletion of codes within the EGD codeset.

### Overview of EGD Family RVW Recommendations

The specialty consensus panel spent a significant amount of time reviewing the survey data for the current set of EGD codes, comparing the data and values with the esophagoscopy codes (43200-43228) that were approved by the RUC at the October 2012 RUC meeting. The compelling arguments from the esophagoscopy review are the same as for the EGD codes, with the additional fact that the times for codes built on increments from the base code (43235) would require adjustment.

After reviewing the survey data, the consensus panel determined that for the EGD codeset, the incremental value above the base code for EGD (43235) should be similar where possible to the analogous incremental value above the esophagoscopy base code (43200) previously approved. For the existing codes, the RVW recommendations are based on the lower of the current value or the EGD base+increment from the esophagoscopy pair (ie, valuing the increment). Where there was no exact match for existing codes, the RVW recommendation is the lower of the current RVW or the 25<sup>th</sup> percentile RVW. For all new codes that bundle multiple codes and/or deleted codes, the RVW recommendation is based on endoscopy multiple procedure payment policy or surgical multiple procedure payment policy, as applicable. For this last set of codes, all but two recommendations are less than the survey 25<sup>th</sup> percentile. For the two exceptions, the recommendation is between the 25<sup>th</sup> and median survey RVW.

### 43243 – Discussion and Recommendation

Code 43243 *Esophagogastroduodenoscopy, flexible, transoral; with injection sclerosis of esophageal / gastric varices* was identified as a family code through the MPC List screen. This service has never been reviewed by the RUC. The AGA and ASGE conducted a RUC survey and received 58 responses.

The expert panel determined that direct application of the esophagoscopy code pair (43200/43204) to EGD work was not appropriate for 43243 because the presence of pooled blood and clot in the stomach requires additional work to achieve adequate gastroduodenal visualization which is not a factor in examination confined to the esophagus alone. Based on our consensus panel determination to recommend the lower of the current value or 25<sup>th</sup> percentile for existing codes, **we recommend the 25<sup>th</sup> percentile RVW of 4.37.**

**Pre-time Package 2b** is appropriate for 43243, with an additional 2 minutes for positioning the patient, endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

### Comparison to Key Ref 31631

Key Reference code 31631 was surveyed and presented to the RUC in 2004. The RUC agreed with the specialty presentation that the work had not changed and maintained the RVW and accepted the survey times. Code 31631 does not include the additional work/intensity of physician administered moderate sedation.

### Comparison to Other RUC-Reviewed Codes with 30 Minutes Intra-Service Time

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2007	<b>20660</b>	Apply rem fixation device	4.00	0.093	90	20		10	<b>30</b>	30
2012	<b>52224</b>	Cystoscopy and treatment	4.05	0.101	79	19	5	5	<b>30</b>	20
2004	<b>32550</b>	Insert pleural cath	4.17	0.099	90	15	15	10	<b>30</b>	20
		<b>EGD inject for bleeding</b>	<b>4.37</b>	<b>0.103</b>	<b>91</b>	<b>33</b>	<b>3</b>	<b>5</b>	<b>30</b>	<b>20</b>
2012	<b>52234</b>	Cystoscopy and treatment	4.62	0.120	79	19	5	5	<b>30</b>	20
2011	<b>37191</b>	Ins endovas vena cava filtr	4.71	0.120	83	30	3	5	<b>30</b>	15
2010	<b>93452</b>	Left hrt cath w/ventrclgrphy	4.75	0.102	108	40	3	5	<b>30</b>	30
2010	<b>93454</b>	Coronary artery angio s&i	4.79	0.104	108	40	3	5	<b>30</b>	30

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43243

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology How often? Commonly

Specialty GI Surgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 6600

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare database for 2011 is approximately 2,200. 2,200 times 3 considering commercial patients is 6,600

Specialty Gastroenterology Frequency 5610 Percentage 85.00 %

Specialty GI Surgery Frequency 66 Percentage 1.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,263

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare database for 2011 is 2263.

Specialty Gastroenterology Frequency 1870 Percentage 85.00 %

Specialty GI Surgery Frequency 22 Percentage 1.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

**Professional Liability Insurance Information (PLI)**

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43243

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43244	Tracking Number I10	Original Specialty Recommended RVU: <b>4.50</b>
		Presented Recommended RVU: <b>4.50</b>
Global Period: 000		RUC Recommended RVU: <b>4.50</b>

CPT Descriptor: Esophagogastroduodenoscopy, flexible, transoral; with band ligation of esophageal / gastric varices

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 55-year-old patient with a history of alcoholism and cirrhosis presents with hematemesis. Esophagogastroduodenoscopy of the upper GI tract reveals varices with stigmata of recent hemorrhage; band ligation of the varices is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 79%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 69%

Description of Pre-Service Work: Review with the patient any symptoms including dysphagia and sleep apnea. The patient's history is reviewed to assess past problems with sedation and the need for pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays and other diagnostic tests are reviewed. The pre-service review is documented. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained. The physician verifies all endoscopic equipment is available and operational and appropriate computer entries are made. The patient is positioned on the examination table. The endoscopic and moderate sedation monitoring equipment is positioned to provide access for the procedure. A time out is performed. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide when indicated, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat. A bite block is placed in the mouth.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible upper endoscope is inserted through the mouth into the oropharynx and advanced through the esophagus into the proximal stomach. The stomach is insufflated with air after suctioning liquid contents. Examination of the entire stomach in the forward and retroflexed positions is performed. The endoscope is advanced through the pylorus into the duodenal bulb. Circumferential inspection of the duodenum is performed after air insufflation. The endoscope is slowly withdrawn re-inspecting the stomach and duodenum. After suctioning air to deflate the stomach, the endoscope is withdrawn into the esophagus, allowing measurement of the squamocolumnar and gastro-esophageal junction from the incisors, assessment

for presence of a hiatal hernia, and examination of the esophageal mucosa. When indicated, brushings or washings are obtained of suspicious abnormalities. The endoscope is withdrawn and the band ligator is attached to the end of the scope. The endoscope is reinserted, advanced into the stomach and then withdrawn to the largest varix just proximal to the gastroesophageal junction. The varix is banded and observed. The level of sedation of the patient is reassessed and additional medication is administered as needed. The endoscope is withdrawn to the next largest varix. The varix is banded and observed. All remaining varices in the distal esophagus are banded. Photodocumentation of the exam findings including measurements of the varices and labeling of the identified structures are obtained and sent to a hard copy device. After observation to confirm the absence of bleeding, the endoscope is then withdrawn. Supervision of the level of sedation and vital signs is performed during the procedure with additional measures taken to maintain an appropriate level of sedation, vital signs, airway and oxygenation as indicated.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. Post procedure orders are completed. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to referral source and other appropriate parties. Data is entered into procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others. Necessary prescriptions, follow-up tests and appointments are provided to the patient.



**SURVEY DATA**

RUC Meeting Date (mm/yyyy)		01/2013				
Presenter(s):	Drs. Brill, Nickl, and Bentley					
Specialty(s):	AGA, ASGE					
CPT Code:	43244					
Sample Size:	1028	Resp N:	69	Response: 6.7 %		
Description of Sample:	The AGA and ASGE conducted a random sample of member gastroenterologists as approved by the Research Subcommittee. The sampling methodology was a random sample with the addition of survey volunteers who responded to educational articles and identified themselves as performers of therapeutic endoscopic services.					
		Low	25 <sup>th</sup> pctl	Median*	75 <sup>th</sup> pctl	High
Service Performance Rate		1.00	10.00	20.00	25.00	500.00
Survey RVW:		2.25	4.50	4.90	5.60	9.50
Pre-Service Evaluation Time:				35.00		
Pre-Service Positioning Time:				5.00		
Pre-Service Scrub, Dress, Wait Time:				5.00		
Intra-Service Time:		15.00	25.00	30.00	40.00	60.00
Immediate Post Service-Time:	20.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00		
Discharge Day Mgmt:	0.00	99238x 0.00	99239x 0.00	99217x 0.00		
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00	15x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00	
Sub Obs Care:	0.00	99224x 0.00	99225x 0.00	99226x 0.00		

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	43244	Recommended Physician Work RVU: 4.50			
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:		33.00	33.00	0.00	
Pre-Service Positioning Time:		3.00	1.00	2.00	
Pre-Service Scrub, Dress, Wait Time:		5.00	5.00	0.00	
Intra-Service Time:		30.00			
Immediate Post Service-Time:	<u>20.00</u>				
<u>Post Operative Visits</u>	<u>Total Min**</u>	<u>CPT Code and Number of Visits</u>			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00

<b>Sub Obs Care:</b>	<b><u>0.00</u></b>	99224x <b>0.00</b>	99225x <b>0.00</b>	99226x <b>0.00</b>
----------------------	--------------------	--------------------	--------------------	--------------------

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31631	000	4.36	RUC Time

CPT Descriptor BRONCHOSCOPY, RIGID OR FLEXIBLE, WITH OR WITHOUT FLUOROSCOPIC GUIDANCE; WITH PLACEMENT OF TRACHEAL STENT(S) (INCLUDES TRACHEAL/BRONCHIAL DILATION AS REQUIRED)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 16      % of respondents: 23.1 %

**TIME ESTIMATES (Median)**

	CPT Code: 43244	Key Reference CPT Code: 31631	Source of Time RUC Time
Median Pre-Service Time	41.00	45.00	
Median Intra-Service Time	30.00	45.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>91.00</b>	<b>120.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.19	3.91
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.41	4.03
--	------	------

Urgency of medical decision making	4.80	3.87
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.75	4.20
--------------------------	------	------

Physical effort required	4.28	3.78
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.81	4.01
---	------	------

Outcome depends on the skill and judgment of physician	4.80	4.10
--	------	------

Estimated risk of malpractice suit with poor outcome	4.43	3.93
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.38	3.81
----------------------------------	------	------

Intra-Service intensity/complexity	4.64	4.09
------------------------------------	------	------

Post-Service intensity/complexity	4.13	3.75
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUR analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**

Several EGD codes were identified through CMS and RUC screens as potentially misvalued, including: MPC list screen; high expenditures screen; and fastest growing screen. The specialties agreed to survey the entire family of codes (43235-43259). In review of this family of codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In October 2012, the CPT Editorial Panel approved revised guidelines along with revision, addition, and deletion of codes within the EGD codeset.

### Compelling Evidence

For a detailed discussion of compelling evidence, please see the Attachment to the cover letter that was submitted with the SoRs for this family of EGD codes.

### Overview of EGD Family RVW Recommendations

The specialty consensus panel spent a significant amount of time reviewing the survey data for the current set of EGD codes, comparing the data and values with the esophagoscopy codes (43200-43228) that were approved by the RUC at the October 2012 RUC meeting. The compelling arguments from the esophagoscopy review are the same as for the EGD codes, with the additional fact that the times for codes built on increments from the base code (43235) would require adjustment.

After reviewing the survey data, the consensus panel determined that for the EGD codeset, the incremental value above the base code for EGD (43235) should be similar where possible to the analogous incremental value above the esophagoscopy base code (43200) previously approved. For the existing codes, the RVW recommendations are based on the lower of the current value or the EGD base+increment from the esophagoscopy pair (ie, valuing the increment). Where there was no exact match for existing codes, the RVW recommendation is the lower of the current RVW or the 25<sup>th</sup> percentile RVW. For all new codes that bundle multiple codes and/or deleted codes, the RVW recommendation is based on endoscopy multiple procedure payment policy or surgical multiple procedure payment policy, as applicable. For this last set of codes, all but two recommendations are less than the survey 25<sup>th</sup> percentile. For the two exceptions, the recommendation is between the 25<sup>th</sup> and median survey RVW.

### 43244 – Discussion and Recommendation

Code 43244 *Esophagogastroduodenoscopy, flexible, transoral; with band ligation of esophageal / gastric varices* was identified as a family code through the MPC List screen. This service was reviewed by the RUC twice. In 1993, the RUC reviewed 43244 as a new code for 1994. The RUC utilized CMS's methodology of valuing the increment to identify consistent physician work relationships. The RUC recommended an RVW of 4.68 and accepted pre/intra/post times of 20/30/20. The RUC again reviewed 43244 in 2000 as part of the second 5YR and determined that the work and time had increased based on compelling evidence and a new survey using a value the increment survey. The RUC recommended an increased RVW of 5.05. The AGA and ASGE conducted a RUC survey and received 69 responses. The current survey time is the same as the times surveyed in 1993.

The expert panel determined that direct application of the esophagoscopy code pair (43200/43205) to EGD work was not appropriate for 43244 because the presence of pooled blood and clot in the stomach requires additional work to achieve adequate gastroduodenal visualization which is not a factor in examination confined to the esophagus alone. Based on our consensus panel determination to recommend the lower of the current value or 25<sup>th</sup> percentile for existing codes, **we recommend the 25<sup>th</sup> percentile RVW of 4.50**. This value is below the RUC recommended value from 1993, even though the times are the same as they were in 1993.

**Pre-time Package 2b** is appropriate for 43244, with an additional 2 minutes for positioning the patient, endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

### Comparison to Key Ref 31631

Key Reference code 31631 was surveyed and presented to the RUC in 2004. The RUC agreed with the specialty presentation that the work had not changed and maintained the RVW and accepted the survey times. Code 31631 does not include the additional work/intensity of physician administered moderate sedation.

### Comparison to Other RUC-Reviewed Codes with 30 Minutes Intra-Service Time

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2007	<b>20660</b>	Apply rem fixation device	4.00	0.093	90	20		10	<b>30</b>	30
2012	<b>52224</b>	Cystoscopy and treatment	4.05	0.101	79	19	5	5	<b>30</b>	20
2004	<b>32550</b>	Insert pleural cath	4.17	0.099	90	15	15	10	<b>30</b>	20

		EGD band for bleeding	4.50	0.107	91	33	3	5	30	20
2012	52234	Cystoscopy and treatment	4.62	0.120	79	19	5	5	30	20
2011	37191	Ins endovas vena cava filtr	4.71	0.120	83	30	3	5	30	15
2010	93452	Left hrt cath w/ventrclgrphy	4.75	0.102	108	40	3	5	30	30
2010	93454	Coronary artery angio s&i	4.79	0.104	108	40	3	5	30	30

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43244

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology How often? Commonly

Specialty GI Surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 46800

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare database for 2011 is approximately 15,600. 15,600 times 3 considering commercial patients is 46,800

Specialty Gastroenterology Frequency 42120 Percentage 90.00 %

Specialty GI Surgery Frequency 468 Percentage 1.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?  
 15,600 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.  
 Please explain the rationale for this estimate. Medicare database for 2011 is approximately 15,600.

Specialty Gastroenterology	Frequency 14040	Percentage 90.00 %
----------------------------	-----------------	--------------------

Specialty GI Surgery	Frequency 156	Percentage 1.00 %
----------------------	---------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? No

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43244

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

## AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 43245	Tracking Number 111	Original Specialty Recommended RVU: <b>3.18</b>
		Presented Recommended RVU: <b>3.18</b>
Global Period: 000		RUC Recommended RVU: <b>3.18</b>

CPT Descriptor: Esophagogastroduodenoscopy, flexible, transoral; with dilation of gastric / duodenal stricture(s) (eg, balloon, bougie)

### CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year old patient with a previous history of gastric surgery and gastro-enteric anastomosis has developed progressive early satiety with nausea and recurrent vomiting. Imaging studies reveal an anastomotic stricture. The patient undergoes esophagogastroduodenoscopy with evaluation of the upper GI tract, and dilation of the stricture.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

### Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

### Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 70%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 63%

Description of Pre-Service Work: Review with the patient any symptoms including dysphagia and sleep apnea. The patient's history is reviewed to assess past problems with sedation and the need for pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays and other diagnostic tests are reviewed. The pre-service review is documented. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained. The physician verifies all endoscopic equipment is available and operational and appropriate computer entries are made. The patient is positioned on the examination table. The endoscopic and moderate sedation monitoring equipment is positioned to provide access for the procedure. A time out is performed. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide when indicated, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat. A bite block is placed in the mouth.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible upper endoscope is inserted through the mouth into the oropharynx and advanced through the esophagus into the proximal stomach. The stomach is insufflated with air after suctioning liquid contents. Examination of the entire stomach in the forward and retroflexed positions is performed. The endoscope cannot be advanced beyond pyloric channel because of stenosis. The lesion in need of dilation is identified and assessed. A balloon catheter is selected and inserted under direct vision. The balloon is inflated with saline adjusting position as needed. The balloon is deflated and the effect of dilation

viewed, repeating the inflation of balloon as indicated. The balloon is removed and blood is removed with suction, observing the dilation site while bleeding dissipates. The endoscope is slowly withdrawn re-inspecting the stomach and advanced into the duodenum with circumferential inspection performed after air insufflations. After suctioning air to deflate the stomach, the endoscope is withdrawn into the esophagus, allowing measurement of the squamocolumnar and gastro-esophageal junction from the incisors, assessment for presence of a hiatal hernia, and examination of the esophageal mucosa. When indicated, brushings or washings are obtained of suspicious abnormalities. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. Supervision of the level of sedation and vital signs is performed during the procedure with additional measures taken to maintain an appropriate level of sedation, vital signs, airway and oxygenation as indicated. At the conclusion of the procedure, the endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. Post procedure orders are completed. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to referral source and other appropriate parties. Data is entered into procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others. Necessary prescriptions, follow-up tests and appointments are provided to the patient.



**SURVEY DATA**

RUC Meeting Date (mm/yyyy)		01/2013				
Presenter(s):	Drs. Brill, Nickl, Bentley, and Selzer					
Specialty(s):	AGA, ASGE, SAGES					
CPT Code:	43245					
Sample Size:	1906	Resp N:	56	Response: 2.9 %		
Description of Sample:	The AGA and ASGE conducted a random sample of member gastroenterologists as approved by the Research Subcommittee. The sampling methodology was a random sample with the addition of survey volunteers who responded to educational articles and identified themselves as performers of therapeutic endoscopic services. SAGES conducted a random sample.					
		Low	25 <sup>th</sup> pctl	Median*	75 <sup>th</sup> pctl	High
Service Performance Rate		0.00	6.00	21.00	71.00	500.00
Survey RVW:		1.80	3.58	4.13	5.16	7.50
Pre-Service Evaluation Time:				25.00		
Pre-Service Positioning Time:				5.00		
Pre-Service Scrub, Dress, Wait Time:				5.00		
Intra-Service Time:		10.00	18.00	23.00	30.00	75.00
Immediate Post Service-Time:	15.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00		
Discharge Day Mgmt:	0.00	99238x 0.00	99239x 0.00	99217x 0.00		
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00	15x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00	
Sub Obs Care:	0.00	99224x 0.00	99225x 0.00	99226x 0.00		

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	43245	Recommended Physician Work RVU: 3.18				
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package		Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:		25.00	33.00		-8.00	
Pre-Service Positioning Time:		3.00	1.00		2.00	
Pre-Service Scrub, Dress, Wait Time:		5.00	5.00		0.00	
Intra-Service Time:		23.00				
Immediate Post Service-Time:	15.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00		
Discharge Day Mgmt:	0.00	99238x 0.0	99239x 0.0	99217x 0.00		
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00	

<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
52342	000	5.85	RUC Time

CPT Descriptor Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
51102	000	2.70	RUC Time	14,057

CPT Descriptor 1 Aspiration of bladder; with insertion of suprapubic catheter

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
15002	000	3.65	RUC Time	15,981

CPT Descriptor 2 Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 12      % of respondents: 54.5 %**

**TIME ESTIMATES (Median)**

	<b>CPT Code:</b> 43245	<b>Key Reference CPT Code:</b> 52342	<b>Source of Time</b> RUC Time
Median Pre-Service Time	33.00	60.00	
Median Intra-Service Time	23.00	60.00	
Median Immediate Post-service Time	15.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>71.00</b>	<b>140.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.07	3.82
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.05	3.82
--	------	------

Urgency of medical decision making	4.14	3.79
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.48	3.84
--------------------------	------	------

Physical effort required	4.02	3.52
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.50	3.75
---	------	------

Outcome depends on the skill and judgment of physician	4.38	3.91
--	------	------

Estimated risk of malpractice suit with poor outcome	4.30	3.70
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.77	3.45
----------------------------------	------	------

Intra-Service intensity/complexity	4.41	3.98
------------------------------------	------	------

Post-Service intensity/complexity	3.71	3.30
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

## Background

Several EGD codes were identified through CMS and RUC screens as potentially misvalued, including: MPC list screen; high expenditures screen; and fastest growing screen. The specialties agreed to survey the entire family of codes (43235-43259). In review of this family of codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In October 2012, the CPT Editorial Panel approved revised guidelines along with revision, addition, and deletion of codes within the EGD codeset.

## Overview of EGD Family RVW Recommendations

The specialty consensus panel spent a significant amount of time reviewing the survey data for the current set of EGD codes, comparing the data and values with the esophagoscopy codes (43200-43228) that were approved by the RUC at the October 2012 RUC meeting. The compelling arguments from the esophagoscopy review are the same as for the EGD codes, with the additional fact that the times for codes built on increments from the base code (43235) would require adjustment.

After reviewing the survey data, the consensus panel determined that for the EGD codeset, the incremental value above the base code for EGD (43235) should be similar where possible to the analogous incremental value above the esophagoscopy base code (43200) previously approved. For the existing codes, the RVW recommendations are based on the lower of the current value or the EGD base+increment from the esophagoscopy pair (ie, valuing the increment). Where there was no exact match for existing codes, the RVW recommendation is the lower of the current RVW or the 25<sup>th</sup> percentile RVW. For all new codes that bundle multiple codes and/or deleted codes, the RVW recommendation is based on endoscopy multiple procedure payment policy or surgical multiple procedure payment policy, as applicable. For this last set of codes, all but two recommendations are less than the survey 25<sup>th</sup> percentile. For the two exceptions, the recommendation is between the 25<sup>th</sup> and median survey RVW.

## 43245 – Discussion and Recommendation

Code 43245 *Esophagogastroduodenoscopy, flexible, transoral; with dilation of gastric / duodenal stricture(s) (eg, balloon, bougie)* was identified as a family code through the MPC List screen. The 1992 RVW for 43245 was 4.58. This service was reviewed by the RUC twice. In 1993, the RUC reviewed 43245 as part of an overall review of the EGD family in relation to new codes that were created for 1994. In 1993, the RUC recommended maintaining the RVW of 3.48 for 43245. The RUC again reviewed 43245 in 2002 as part of a revision to several EGD codes. The RUC did not accept the specialty recommendation for an increased RVW. Instead, the RUC recommended a reduced RVW to 3.18 (from 3.48) taking into consideration an assessment of incremental of work over the base code. Although the RUC reduced the RVW, it accepted the survey times. The survey in 2002 was conducted prior to the discussion of moderate sedation and pre-time packages. The AGA, ASGE, and SAGES conducted a RUC survey and received 56 responses.

There is no direct esophagoscopy code pair increment that would apply to 43245. Based on our consensus panel determination to recommend the lower of the current value or 25<sup>th</sup> percentile for existing codes, **we recommend the current RVW of 3.18**. This value is below the 1992 Harvard-based RVW of 3.58, even though the survey times are similar to Harvard data.

**Pre-time Package 2b** is appropriate for 43245, with an additional 2 minutes for positioning the patient, endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation. In addition, the recommended evaluation time matches the survey median which is lower than the package time.

## Comparison to Key Ref 52342

Key reference code was reviewed by the RUC in 2008 as a site of service anomaly. The RUC did not accept the specialty recommendation for an increased RVW to 8.64. Instead the RUC determined work had not changed and subtracted RVUs related to a deleted hospital visit (99231). Although the RUC did not accept the specialty survey-based RVW recommendation, the RUC did accept the new survey data. Therefore, there is a disconnect between the survey data and the RVW. Give the time and RVW difference, key reference code 52342 is not a good comparator to 43245, but was likely chosen by survey respondents because of the similarity in service description.

## Comparison to MPC and Other RUC-Reviewed Codes with ~20 Minutes Intra-Service Time

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
MPC 2008	<b>51102</b>	Drain bl w/cath insertion	2.70	0.094	60	19	1	5	<b>20</b>	15
2010	<b>52281</b>	Cystoscopy and treatment	2.75	0.112	46	10	1	5	<b>20</b>	10

CPT Code: 43245										
2008	<b>49452</b>	Replace g-j tube perc	2.86	0.102	60	20	5	5	<b>20</b>	10
	<b>43245</b>	EGD – dilate strictures	3.18	0.097	71	25	3	5	<b>23</b>	15
2012	<b>52287</b>	Cystoscopy chemodenerv	3.20	0.120	51	15			<b>21</b>	15
2012	<b>32551</b>	Insertion of chest tube	3.29	0.101	83	30	3	10	<b>20</b>	20
2011	<b>15273</b>	Skin sub grft t/arm/lg child	3.50	0.093	100	40	10	10	<b>20</b>	20
<b>MPC 2006</b>	<b>15002</b>	Wound prep trk/arm/leg	3.65	0.087	115	45	15	15	<b>20</b>	20

## SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43245

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology How often? Sometimes

Specialty GI Surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 37800

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare database for 2011 is approximately 12,600. 12,600 times 3 considering commercial patients is 37,800

Specialty Gastroenterology Frequency 25326 Percentage 67.00 %

Specialty GI Surgery Frequency 7560 Percentage 20.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?  
 12,605 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.  
 Please explain the rationale for this estimate. Medicare database for 2011 is 12605.

Specialty Gastroenterology	Frequency 8442	Percentage 67.00 %
----------------------------	----------------	--------------------

Specialty GI Surgery	Frequency 2520	Percentage 20.00 %
----------------------	----------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43245

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:43246	Tracking Number I12	Original Specialty Recommended RVU: <b>4.32</b>
		Presented Recommended RVU: <b>4.32</b>
Global Period: 000		RUC Recommended RVU: <b>4.32</b>

CPT Descriptor: Esophagogastroduodenoscopy, flexible, transoral; with directed placement of percutaneous gastrostomy tube

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 75 year old patient presents with a massive CVA and inability to take oral nutrition. The patient is malnourished and needs enteral nutritional support. A swallowing evaluation is performed confirming aspiration. The decision is made to proceed with esophagogastroduodenoscopy for evaluation of the upper GI tract, with placement of a percutaneous endoscopic gastrostomy tube for nutritional support.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 60%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 54%

Description of Pre-Service Work: Review with the patient any symptoms including dysphagia and sleep apnea. The patient's history is reviewed to assess past problems with sedation and the need for pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays and other diagnostic tests are reviewed. The pre-service review is documented. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained. The physician verifies all endoscopic equipment is available and operational and appropriate computer entries are made. The patient is positioned on the examination table. The endoscopic and moderate sedation monitoring equipment is positioned to provide access for the procedure. A time out is performed. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide when indicated, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat. A bite block is placed in the mouth.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible upper endoscope is inserted through the mouth into the oropharynx and advanced through the esophagus into the proximal stomach. The stomach is insufflated with air after suctioning liquid contents. Examination of the entire stomach in the forward and retroflexed positions is performed. The endoscope is advanced through the pylorus into the duodenal bulb. Circumferential inspection of the duodenum is performed after air insufflation. The endoscope is slowly withdrawn re-inspecting the stomach and duodenum. The stomach is insufflated with air until trans-illumination allows external

visualization on the upper abdominal wall of the endoscope light. The abdomen site is prepped with bactericidal solution. A finger is pressed on the abdominal wall site to endoscopically confirm apposition of the stomach against the abdominal wall. Local anesthetic is infiltrated into the subcutaneous and intramuscular portions of the abdomen site, and a scalpel is used to make an incision in the abdominal wall. A gastrostomy introducer catheter is introduced through the incision into the stomach. A snare is introduced through the endoscope and looped around the catheter. The catheter introducer needle is withdrawn and a guide wire is passed externally through the introducer into the stomach. The snare is tightened around the guide wire, and the endoscope, snare and guidewire are withdrawn through the mouth. The guide wire is removed from the endoscope. A percutaneous gastrostomy is secured to the guide wire through the mouth and pushed or pulled until it exits through the abdominal wall incision. The gastrostomy is gently pulled until resistance is felt. The endoscope is introduced through the mouth into the stomach to confirm positioning of the internal bolster of the gastrostomy against the stomach wall. An external bolster is slipped over the guidewire and introducer to position the gastrostomy in place. The tube is shortened to the appropriate length, an outer clamp is slid over the tube, and a connector with cap is inserted into the end of the tube. The abdominal site is cleaned, bandaged and dressed. After suctioning air to deflate the stomach, the endoscope is withdrawn into the esophagus, allowing measurement of the squamocolumnar and gastro-esophageal junction from the incisors, assessment for presence of a hiatal hernia, and examination of the esophageal mucosa. When indicated, brushings or washings are obtained of suspicious abnormalities. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. Supervision of the level of sedation and vital signs is performed during the procedure with additional measures taken to maintain an appropriate level of sedation, vital signs, airway and oxygenation as indicated. At the conclusion of the procedure, the endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. Post procedure orders are completed. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to referral source and other appropriate parties. Data is entered into procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others. Necessary prescriptions, follow-up tests and appointments are provided to the patient.



**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2013				
<b>Presenter(s):</b>	Bruce Cameron, MD (ACG), Joel Brill, MD (AGA), Nicholas Nickl, MD (ASGE), Edward Bentley (ASGE), Don Selzer, MD (SAGES)					
<b>Specialty(s):</b>	ACG, AGA, ASGE, SAGES					
<b>CPT Code:</b>	43246					
<b>Sample Size:</b>	2742	<b>Resp N:</b>	57	<b>Response:</b> 2.0 %		
<b>Description of Sample:</b>	The ACG, AGA, ASGE and SAGES conducted a random sample of member physicians.					
		<b><u>Low</u></b>	<b><u>25<sup>th</sup> pctl</u></b>	<b><u>Median*</u></b>	<b><u>75th pctl</u></b>	<b><u>High</u></b>
<b>Service Performance Rate</b>		0.00	11.00	<b>20.00</b>	50.00	100.00
<b>Survey RVW:</b>		1.00	4.30	<b>5.12</b>	6.75	14.34
<b>Pre-Service Evaluation Time:</b>				<b>40.00</b>		
<b>Pre-Service Positioning Time:</b>				<b>5.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>5.00</b>		
<b>Intra-Service Time:</b>		5.00	20.00	<b>30.00</b>	30.00	60.00
<b>Immediate Post Service-Time:</b>	<b><u>15.00</u></b>					
<b><u>Post Operative Visits</u></b>	<b><u>Total Min**</u></b>	<b><u>CPT Code and Number of Visits</u></b>				
<b>Critical Care time/visit(s):</b>	<b><u>0.00</u></b>	99291x 0.00	99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b><u>0.00</u></b>	99231x 0.00	99232x 0.00	99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b><u>0.00</u></b>	99238x 0.00	99239x 0.00	99217x 0.00		
<b>Office time/visit(s):</b>	<b><u>0.00</u></b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00	15x 0.00
<b>Prolonged Services:</b>	<b><u>0.00</u></b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00	
<b>Sub Obs Care:</b>	<b><u>0.00</u></b>	99224x 0.00	99225x 0.00	99226x 0.00		

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

**Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:**

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	43246	<b>Recommended Physician Work RVU: 4.32</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		33.00	33.00	0.00
<b>Pre-Service Positioning Time:</b>		3.00	1.00	2.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00
<b>Intra-Service Time:</b>		30.00		
<b>Immediate Post Service-Time:</b>	15.00			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	0.00	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	0.00	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	0.00	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	0.00	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	0.00	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	0.00	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31600	000	7.17	RUC Time

CPT Descriptor Tracheostomy, planned (separate procedure)**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 10      % of respondents: 17.5 %

**TIME ESTIMATES (Median)**

	<b>CPT Code:</b> 43246	<b>Key Reference CPT Code:</b> 31600	<b>Source of Time</b> RUC Time
Median Pre-Service Time	41.00	50.00	
Median Intra-Service Time	30.00	40.00	
Median Immediate Post-service Time	15.00	66.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
<b>Median Total Time</b>	<b>86.00</b>	<b>156.00</b>	
<b>Other time if appropriate</b>			

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered

3.25

3.27

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed

3.60

3.52

Urgency of medical decision making

3.04

3.11

**Technical Skill/Physical Effort (Mean)**

Technical skill required

3.79

3.73

Physical effort required

3.39

3.27

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality

4.05

3.73

Outcome depends on the skill and judgment of physician

3.93

3.84

Estimated risk of malpractice suit with poor outcome

3.84

3.71

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity

3.56

3.39

Intra-Service intensity/complexity

3.67

3.48

Post-Service intensity/complexity

3.39

3.11

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**

Several EGD codes were identified through CMS and RUC screens as potentially misvalued, including: MPC list screen; high expenditures screen; and fastest growing screen. The specialties agreed to survey the entire family of codes (43235-43259). In review of this family of codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current

practice. In October 2012, the CPT Editorial Panel approved revised guidelines along with revision, addition, and deletion of codes within the EGD codeset.

A survey was conducted and data presented to the RUC at the January 2013 meeting. The RUC reviewed the survey data for 43246 and agreed with the specialty societies that a median intra-service time of 23 minutes grossly underestimates the time it takes to perform this procedure. An eight minute time differential between the base code, 15 minutes, and this code, 23 minutes, does not accurately account for the additional work in placing the percutaneous gastrostomy tube. Therefore, the RUC recommends that CPT code 43246 be re-surveyed for presentation at the April 2013 RUC meeting.

#### 43246 – Discussion and Recommendation

Code 43246 *Esophagogastroduodenoscopy, flexible, transoral; with directed placement of percutaneous gastrostomy tube* was identified as a family code through the MPC List screen. The 1992 RVW for 43246 was 4.57. This service was reviewed by the RUC three times. In 1993, the RUC reviewed it as part of an overall review of the EGD family in relation to new codes that were created for 1994 and recommended maintaining the existing RVW. The RUC again reviewed 43246 in 1995 as part of the first 5YR and recommended maintaining the value. In 2005, the RUC reviewed 43246 again. The RUC agreed with the specialties that there had not been a change in work and recommended maintaining the RVW. It should be noted that the code has devalued for budget neutrality reasons resulting in the current value of 4.32. With respect to intraservice time, the RUC reviewed 43259 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum and/or jejunum as appropriate* and believed the typical intra-service time of 43246 is approximately 38 minutes instead of the median survey time of 30 minutes. The survey in 2005 was conducted prior to the discussion of moderate sedation and pre-time packages. A new RUC survey was conducted by the ACG, AGA, ASGE, and SAGES and 57 responses were received.

There is no direct esophagoscopy code pair increment that would apply to 43246. The panel noted that the current survey IS time of 30 minutes is the same as the survey time in 2005. The panel also noted that the 25<sup>th</sup> percentile survey RVW (4.30) is approximately the same as the current value. **We recommend maintaining the current value of 4.32.**

**Pre-time Package 2b** is appropriate for 43246 with an additional 2 minutes for positioning the patient, endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

#### Comparison to Key Ref 31600

Key Reference code 31600 clinically is similar to 43246. Both procedures are an elective insertion of a tube in a critically ill patient.

#### Comparison To Other RUC-Reviewed Codes with similar IWPUT

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2007	<b>93053</b>	Insert/place heart catheter	2.91	0.166	37	5	2	5	<b>15</b>	10
2000	<b>16035</b>	Incision of burn scab initi	3.74	0.131	70	30			<b>20</b>	20
2007	<b>20660</b>	Apply rem fixation device	4.00	0.093	90	20		10	<b>30</b>	30
2012	<b>52224</b>	Cystoscopy and treatment	4.05	0.101	79	19	5	5	<b>30</b>	20
2004	<b>32550</b>	Insert pleural cath	4.17	0.099	90	15	15	10	<b>30</b>	20
	<b>43246</b>	<b>EGD – PEG</b>	<b>4.32</b>	<b>0.105</b>	<b>86</b>	<b>33</b>	<b>3</b>	<b>5</b>	<b>30</b>	<b>15</b>
2012	<b>52234</b>	Cystoscopy and treatment	4.62	0.120	79	19	5	5	<b>30</b>	20
2011	<b>37191</b>	Ins endovas vena cava filtr	4.71	0.120	83	30	3	5	<b>30</b>	15
2010	<b>93452</b>	Left hrt cath w/ventriclgrphy	4.75	0.102	108	40	3	5	<b>30</b>	30
2010	<b>93454</b>	Coronary artery angio s&i	4.79	0.104	108	40	3	5	<b>30</b>	30
2000	<b>31600</b>	Trach planned	7.17	0.114	156	50			<b>40</b>	66
2011	<b>37193</b>	Rmove IVC filter	7.35	0.137	101	33	3	5	<b>45</b>	15

---

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.
- 

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43246

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology                      How often? Commonly

Specialty General Surgery                      How often? Sometimes

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 366000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2011 ~ 122,000. (122,000 \* 3 = 366,000)

Specialty Gastroenterology	Frequency 241560	Percentage 66.00 %
----------------------------	------------------	--------------------

Specialty General Surgery	Frequency 84180	Percentage 23.00 %
---------------------------	-----------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 122,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2011 ~ 122,000

Specialty Gastroenterology	Frequency 80520	Percentage 66.00 %
----------------------------	-----------------	--------------------

Specialty General Surgery	Frequency 28060	Percentage 23.00 %
---------------------------	-----------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? Yes

---

### **Professional Liability Insurance Information (PLI)**

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43246

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43247      Tracking Number I13      Original Specialty Recommended RVU: **3.38**  
 Presented Recommended RVU: **3.38**  
 Global Period: 000      RUC Recommended RVU: **3.27**

CPT Descriptor: Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 69 year old patient with schizophrenia presents with abdominal discomfort. Imaging study reveals a foreign body in the stomach. Therapeutic esophagogastroduodenoscopy with examination of the upper GI tract and removal of the foreign body is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 78%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 77%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 79%

Description of Pre-Service Work: Review with the patient any symptoms including dysphagia and sleep apnea. The patient's history is reviewed to assess past problems with sedation and the need for pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays and other diagnostic tests are reviewed. The pre-service review is documented. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained. The physician verifies all endoscopic equipment is available and operational and appropriate computer entries are made. The patient is positioned on the examination table. The endoscopic and moderate sedation monitoring equipment is positioned to provide access for the procedure. A time out is performed. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide when indicated, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat. A bite block is placed in the mouth.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible upper endoscope is inserted through the mouth into the oropharynx and advanced through the esophagus into the proximal stomach. The stomach is insufflated with air after suctioning liquid contents. Examination of the entire stomach in the forward and retroflexed positions is performed. The endoscope is advanced through the pylorus into the duodenal bulb. Circumferential inspection of the duodenum is performed after air insufflation. The endoscope is slowly withdrawn re-inspecting the stomach and duodenum. The foreign body is identified in the stomach and assessed for endoscopic removal. The endoscope is withdrawn through the mouth, and a retrieval hood or overtube is affixed to the tip of the endoscope. The endoscope is then inserted through the mouth into the oropharynx and advanced through the esophagus to the area of the

foreign body. Using a retrieval device advanced through the biopsy channel of the endoscope, the foreign body is grasped, and pulled to the tip of the endoscope. The endoscope and foreign body are withdrawn through the mouth. The foreign body is removed and the endoscope is reinserted through the mouth into the oropharynx and advanced through the esophagus into the stomach. The procedure is repeated until the foreign body is completely removed. After suctioning air to deflate the stomach, the endoscope is withdrawn into the esophagus, allowing measurement of the squamocolumnar and gastro-esophageal junction from the incisors, assessment for presence of a hiatal hernia, and examination of the esophageal mucosa. When indicated, brushings or washings are obtained of suspicious abnormalities. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. Supervision of the level of sedation and vital signs is performed during the procedure with additional measures taken to maintain an appropriate level of sedation, vital signs, airway and oxygenation as indicated. At the conclusion of the procedure, the endoscope with any affixed device(s) is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. Post procedure orders are completed. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to referral source and other appropriate parties. Data is entered into procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others. Necessary prescriptions, follow-up tests and appointments are provided to the patient.



**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	01/2013				
<b>Presenter(s):</b>	Drs. Brill, Nickl, Bentley, and Selzer				
<b>Specialty(s):</b>	AGA, ASGE, SAGES				
<b>CPT Code:</b>	43247				
<b>Sample Size:</b>	1890	<b>Resp N:</b>	68	<b>Response:</b> 3.5 %	
<b>Description of Sample:</b>	The AGA and ASGE conducted a random sample of member gastroenterologists as approved by the Research Subcommittee. The sampling methodology was a random sample with the addition of survey volunteers who responded to educational articles and identified themselves as performers of therapeutic endoscopic services. SAGES conducted a random sample of their members.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	10.00	<b>15.00</b>	25.00	70.00
<b>Survey RVW:</b>	2.00	3.98	<b>4.50</b>	5.20	10.60
<b>Pre-Service Evaluation Time:</b>			<b>15.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>5.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>5.00</b>		
<b>Intra-Service Time:</b>	6.00	20.00	<b>30.00</b>	45.00	75.00
<b>Immediate Post Service-Time:</b>	<b>15.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	43247	<b>Recommended Physician Work RVU: 3.27</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>15.00</b>	<b>33.00</b>	<b>-18.00</b>
<b>Pre-Service Positioning Time:</b>		<b>3.00</b>	<b>1.00</b>	<b>2.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>5.00</b>	<b>5.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>30.00</b>		
<b>Immediate Post Service-Time:</b>	<b>15.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00

<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31638	000	4.88	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code:** 14      **% of respondents:** 20.5 %

**TIME ESTIMATES (Median)**

	<u>CPT Code:</u> 43247	<u>Key Reference CPT Code:</u> 31638	<u>Source of Time</u> RUC Time
Median Pre-Service Time	23.00	50.00	
Median Intra-Service Time	30.00	60.00	
Median Immediate Post-service Time	15.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>68.00</b>	<b>140.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.66	3.59
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.54	3.54
--	------	------

Urgency of medical decision making	4.38	3.59
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.65	3.90
--------------------------	------	------

Physical effort required	4.19	3.38
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.50	3.65
---	------	------

Outcome depends on the skill and judgment of physician	4.54	4.00
--	------	------

Estimated risk of malpractice suit with poor outcome	4.16	3.50
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.99	3.56
----------------------------------	------	------

Intra-Service intensity/complexity	4.38	3.87
------------------------------------	------	------

Post-Service intensity/complexity	3.75	3.41
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**

Several EGD codes were identified through CMS and RUC screens as potentially misvalued, including: MPC list screen; high expenditures screen; and fastest growing screen. The specialties agreed to survey the entire family of codes (43235-43259). In review of this family of codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In October 2012, the CPT Editorial Panel approved revised guidelines along with revision, addition, and deletion of codes within the EGD codeset.

## Overview of EGD Family RVW Recommendations

The specialty consensus panel spent a significant amount of time reviewing the survey data for the current set of EGD codes, comparing the data and values with the esophagoscopy codes (43200-43228) that were approved by the RUC at the October 2012 RUC meeting. The compelling arguments from the esophagoscopy review are the same as for the EGD codes, with the additional fact that the times for codes built on increments from the base code (43235) would require adjustment.

After reviewing the survey data, the consensus panel determined that for the EGD codeset, the incremental value above the base code for EGD (43235) should be similar where possible to the analogous incremental value above the esophagoscopy base code (43200) previously approved. For the existing codes, the RVW recommendations are based on the lower of the current value or the EGD base+increment from the esophagoscopy pair (ie, valuing the increment). Where there was no exact match for existing codes, the RVW recommendation is the lower of the current RVW or the 25<sup>th</sup> percentile RVW. For all new codes that bundle multiple codes and/or deleted codes, the RVW recommendation is based on endoscopy multiple procedure payment policy or surgical multiple procedure payment policy, as applicable. For this last set of codes, all but two recommendations are less than the survey 25<sup>th</sup> percentile. For the two exceptions, the recommendation is between the 25<sup>th</sup> and median survey RVW.

## 43247 – Discussion and Recommendation

Code 43247 *Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body* was identified as a family code through the MPC List screen. This service was reviewed by the RUC twice. In 1993, the RUC reviewed 43247 as part of an overall review of the EGD family in relation to new codes that were created for 1994. The RUC again reviewed 43246 in 2000 as part of the second 5YR. The RUC agreed that there had been an increase in both time and intensity based on a survey of valuing the increment, however the RUC did not agree with the specialty survey-based incremental RVW. Instead, the RUC chose to use the increment between the esophagoscopy base and esophagoscopy FBR code pair (43200 / 43215) added to the base EGD code. This resulted in a recommendation significantly below the survey. CMS did not accept the RUC recommendation and instead maintained the current RVW for 43247. Therefore, the current RVW is not related to either the survey data or the RUC recommendation and has caused a discordant work intensity calculation. The AGA, ASGE, and SAGES conducted a RUC survey and received 68 responses. The current survey time is similar to the Harvard time – which the current RVW is based on.

Based on our consensus panel determination to recommend the lower of the current value or 25<sup>th</sup> percentile for existing codes, **we recommend the current RVW of 3.38**. This value is only slightly different than valuing the increment [43235 + (43215-43200)] or [2.35 + (2.60-1.59)] = 3.36.

**Pre-time Package 2b** is appropriate for 43247, with an additional 2 minutes for positioning the patient, endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation. In addition, the recommended evaluation time matches the survey median which is lower than the package time.

### Comparison to Key Ref 31638

Key Reference code 31638 requires lower intensity fluoroscopic guidance which increases the intra-service time. The difference in RVW compared with 43247 accounts for longer total time, but at lower intensity.

### Comparison to Other RUC-Reviewed Codes with 30 Minutes Intra-time

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2012	<b>32557</b>	Insert cath pleura w/ image	<b>3.12</b>	0.079	67	13	3	6	<b>30</b>	15
2010	<b>31296</b>	Sinus endo w/balloon dil	<b>3.29</b>	0.071	88	30	3	10	<b>30</b>	15
2007	<b>50386</b>	Remove stent via transureth	<b>3.30</b>	0.070	90	25	10	10	<b>30</b>	15
2003	<b>31625</b>	Bronchoscopy w/biopsy(s)	<b>3.36</b>	0.087	70	10	5	10	<b>30</b>	15
	<b>43247</b>	<b>EGD w-FBR</b>	<b>3.27</b>	<b>0.087</b>	<b>68</b>	<b>15</b>	<b>3</b>	<b>5</b>	<b>30</b>	<b>15</b>

2012	<b>52214</b>	Cystoscopy and treatment	<b>3.50</b>	0.082	79	19	5	5	<b>30</b>	20
2007	<b>20660</b>	Apply rem fixation device	<b>4.00</b>	0.093	90	20		10	<b>30</b>	30
2003	<b>31629</b>	Bronchoscopy/needle bx	<b>4.09</b>	0.104	80	10	10	10	<b>30</b>	20
2012	<b>36221</b>	Place cath thoracic aorta	<b>4.17</b>	0.083	108	40	3	5	<b>30</b>	30
2004	<b>32550</b>	Insert pleural cath	<b>4.17</b>	0.099	90	15	15	10	<b>30</b>	20
1995	<b>52275</b>	Cystoscopy & revise urethra	<b>4.69</b>	0.112	90	30			<b>30</b>	30
2011	<b>37191</b>	Ins endovas vena cava filter	<b>4.71</b>	0.120	83	30	3	5	<b>30</b>	15

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43247

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology How often? Sometimes

Specialty GI Surgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 82800

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare database for 2011 is approximately 27,600. 27,600 times 3 considering commercial patients is 82800

Specialty Gastroenterology Frequency 66240 Percentage 80.00 %

Specialty GI Surgery Frequency 9108 Percentage 11.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?  
 28,306 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.  
 Please explain the rationale for this estimate. Medicare database for 2011 is 28306.

Specialty Gastroenterology	Frequency 22080	Percentage 80.00 %
----------------------------	-----------------	--------------------

Specialty GI Surgery	Frequency 3036	Percentage 11.00 %
----------------------	----------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43247

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:43248	Tracking Number I14	Original Specialty Recommended RVU: <b>3.15</b>
		Presented Recommended RVU: <b>3.15</b>
Global Period: 000		RUC Recommended RVU: <b>3.01</b>

CPT Descriptor: Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by dilation of passage of dilator(s) through esophagus over guide wire

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 73-year-old patient with dysphagia and weight loss undergoes imaging studies revealing the presence of a stricture lesion in the distal esophagus. The patient is referred for therapeutic esophagogastroduodenoscopy for evaluation of the upper GI tract, and dilation of the stricture.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 75%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 79%

Description of Pre-Service Work: Review with the patient any symptoms including dysphagia and sleep apnea. The patient's history is reviewed to assess past problems with sedation and the need for pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays and other diagnostic tests are reviewed. The pre-service review is documented. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained. The physician verifies all endoscopic equipment is available and operational and appropriate computer entries are made. The patient is positioned on the examination table. The endoscopic and moderate sedation monitoring equipment is positioned to provide access for the procedure. A time out is performed. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide when indicated, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat. A bite block is placed in the mouth.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible upper endoscope is inserted through the mouth into the oropharynx and advanced through the esophagus into the proximal stomach. The stomach is insufflated with air after suctioning liquid contents. Examination of the entire stomach in the forward and retroflexed positions is performed. The endoscope is advanced through the pylorus into the duodenal bulb. Circumferential inspection of the duodenum is performed after air insufflation. The endoscope is slowly withdrawn re-inspecting the stomach and duodenum. After suctioning air to deflate the stomach, the endoscope is withdrawn into the esophagus, allowing measurement of the squamocolumnar and gastro-esophageal junction from the incisors, assessment

for presence of a hiatal hernia, and examination of the esophageal mucosa. When indicated, brushings or washings are obtained of suspicious abnormalities. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. The lesion to be dilated is identified and assessed. A guidewire is placed through the endoscope into the esophagus and advanced into the stomach, beyond the area to be dilated. The endoscope is withdrawn through the mouth while visually confirming proper positioning of the guidewire. A dilator is advanced over the guidewire through the mouth into the esophagus past the area to be dilated, while the endoscopist monitors the patient for signs of pain or discomfort. The level of sedation of the patient is reassessed and additional medication is administered as needed. The initial dilator is withdrawn, and dilators of increasing diameter are passed sequentially over the guide wire through the mouth into the esophagus and passed distally to an appropriate extent in a similar manner. At the conclusion of the sequential dilations, the guidewire is withdrawn and the endoscope is inserted through the mouth into the esophagus and sufficiently distal to assess the site of dilation for bleeding, trauma and/or injury. Supervision of the level of sedation and vital signs is performed during the procedure with additional measures taken to maintain an appropriate level of sedation, vital signs, airway and oxygenation as indicated. At the conclusion of the procedure, the endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. Post procedure orders are completed. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to referral source and other appropriate parties. Data is entered into procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others. Necessary prescriptions, follow-up tests and appointments are provided to the patient.



**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	01/2013				
<b>Presenter(s):</b>	Drs. Brill, Nickl, Bentley, and Selzer				
<b>Specialty(s):</b>	AGA, ASGE, SAGES				
<b>CPT Code:</b>	43248				
<b>Sample Size:</b>	1906	<b>Resp N:</b>	50	<b>Response:</b> 2.6 %	
<b>Description of Sample:</b>	The AGA and ASGE conducted a random sample of member gastroenterologists as approved by the Research Subcommittee. The sampling methodology was a random sample with the addition of survey volunteers who responded to educational articles and identified themselves as performers of therapeutic endoscopic services. SAGES conducted a random sample of their members.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	31.00	<b>50.00</b>	100.00	500.00
<b>Survey RVW:</b>	1.60	3.94	<b>4.10</b>	4.88	8.00
<b>Pre-Service Evaluation Time:</b>			<b>20.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>5.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>5.00</b>		
<b>Intra-Service Time:</b>	10.00	15.00	<b>20.00</b>	30.00	60.00
<b>Immediate Post Service-Time:</b>	<b>15.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1b-FAC Straightforw Pat Procedure(w sedate/anes)

<b>CPT Code:</b>	43248	<b>Recommended Physician Work RVU: 3.01</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>19.00</b>	<b>19.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>3.00</b>	<b>1.00</b>	<b>2.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>5.00</b>	<b>5.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>20.00</b>		
<b>Immediate Post Service-Time:</b>	<b>15.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00

<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31631	000	4.36	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of tracheal stent(s) (includes tracheal/bronchial dilation as required)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
51102	000	2.70	RUC Time	14,057

CPT Descriptor 1 Aspiration of bladder; with insertion of suprapubic catheter

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
15002	000	3.65	RUC Time	15,981

CPT Descriptor 2 Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 11      % of respondents: 22.0 %**

**TIME ESTIMATES (Median)**

	<b>CPT Code: 43248</b>	<b>Key Reference CPT Code: 31631</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	27.00	45.00	
Median Intra-Service Time	20.00	45.00	
Median Immediate Post-service Time	15.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>62.00</b>	<b>120.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.96	3.76
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.86	3.72
--	------	------

Urgency of medical decision making	3.94	3.60
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.32	3.90
--------------------------	------	------

Physical effort required	4.02	3.56
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.30	3.72
---	------	------

Outcome depends on the skill and judgment of physician	4.32	4.00
--	------	------

Estimated risk of malpractice suit with poor outcome	4.28	3.66
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.70	3.44
----------------------------------	------	------

Intra-Service intensity/complexity	4.28	4.00
------------------------------------	------	------

Post-Service intensity/complexity	3.70	3.34
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

## Background

Several EGD codes were identified through CMS and RUC screens as potentially misvalued, including: MPC list screen; high expenditures screen; and fastest growing screen. The specialties agreed to survey the entire family of codes (43235-43259). In review of this family of codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In October 2012, the CPT Editorial Panel approved revised guidelines along with revision, addition, and deletion of codes within the EGD codeset.

## Overview of EGD Family RVW Recommendations

The specialty consensus panel spent a significant amount of time reviewing the survey data for the current set of EGD codes, comparing the data and values with the esophagoscopy codes (43200-43228) that were approved by the RUC at the October 2012 RUC meeting. The compelling arguments from the esophagoscopy review are the same as for the EGD codes, with the additional fact that the times for codes built on increments from the base code (43235) would require adjustment.

After reviewing the survey data, the consensus panel determined that for the EGD codeset, the incremental value above the base code for EGD (43235) should be similar where possible to the analogous incremental value above the esophagoscopy base code (43200) previously approved. For the existing codes, the RVW recommendations are based on the lower of the current value or the EGD base+increment from the esophagoscopy pair (ie, valuing the increment). Where there was no exact match for existing codes, the RVW recommendation is the lower of the current RVW or the 25<sup>th</sup> percentile RVW. For all new codes that bundle multiple codes and/or deleted codes, the RVW recommendation is based on endoscopy multiple procedure payment policy or surgical multiple procedure payment policy, as applicable. For this last set of codes, all but two recommendations are less than the survey 25<sup>th</sup> percentile. For the two exceptions, the recommendation is between the 25<sup>th</sup> and median survey RVW.

## 43248 – Discussion and Recommendation

Code 43248 *Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by dilation of passage of dilator(s) through esophagus over guide wire* was identified as a family code through the MPC List screen. In 1993, the RUC reviewed 43244 as a new code for 1994. The RUC RVW recommendation was based on the method of valuing the increment. The RUC database includes physician time that indicates "do not use to value physician work."

The AGA, ASGE, and SAGES conducted a RUC survey and received 50 responses. The consensus panel agrees that physician work for this service has not changed, however, the panel believes the increment of 0.75 established by the RUC in October 2012 for the esophagoscopy code pair 43200/43226 should apply to the EGD code pair 43235/43248.

Based on our consensus panel determination to recommend the lower of the current value or 25<sup>th</sup> percentile for existing codes, **we recommend the current RVW of 3.15**. This value is only slightly different than valuing the increment  $[43235 + (43226-43200)]$  or  $[2.39 + (2.34-1.59)] = 3.14$ .

**Pre-time Package 2b** is appropriate for 43248, with an additional 2 minutes for positioning the patient, endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

### Comparison to Key Ref 31631

Key Reference code 31631 was surveyed and presented to the RUC in 2004. The RUC agreed with the specialty presentation that the work had not changed and maintained the RVW and accepted the survey times. Code 31631 does not include the additional work/intensity of physician administered moderate sedation. The difference in RVW compared with 43248 accounts for longer total time, but at lower intensity.

### Comparison to MPC and Other RUC-Reviewed Codes with ~20 Minutes Intra-Service Time

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
MPC 2008	<b>51102</b>	Drain bl w/cath insertion	2.70	0.094	60	19	1	5	<b>20</b>	15
2010	<b>52281</b>	Cystoscopy and treatment	2.75	0.112	46	10	1	5	<b>20</b>	10
2008	<b>49452</b>	Replace g-j tube perc	2.86	0.102	60	20	5	5	<b>20</b>	10
	<b>43248</b>	EGD w-guide wire & dilator	<b>3.15</b>	<b>0.114</b>	<b>62</b>	<b>19</b>	<b>3</b>	<b>5</b>	<b>20</b>	<b>15</b>

2012	<b>52287</b>	Cystoscopy chemodenerv	3.20	0.120	51	15			<b>21</b>	15
2012	<b>32551</b>	Insertion of chest tube	3.29	0.101	83	30	3	10	<b>20</b>	20
2011	<b>15273</b>	Skin sub grft t/arm/lg child	3.50	0.093	100	40	10	10	<b>20</b>	20
<b>MPC 2006</b>	<b>15002</b>	Wound prep trk/arm/leg	3.65	0.087	115	45	15	15	<b>20</b>	20

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43248

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology How often? Commonly

Specialty GI Surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 312000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare database for 2011 is approximately 104,000. 104,000 times 3 considering commercial patients is 312,000

Specialty Gastroenterology Frequency 280800 Percentage 90.00 %

Specialty GI Surgery Frequency 6240 Percentage 2.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 102,871 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare database for 2011 is 102871.

Specialty Gastroenterology Frequency 93600 Percentage 90.00 %

Specialty GI Surgery	Frequency 2080	Percentage 2.00 %
----------------------	----------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? Yes

---

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43248

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43249      Tracking Number I15      Original Specialty Recommended RVU: **2.90**  
 Presented Recommended RVU: **2.90**  
 Global Period: 000      RUC Recommended RVU: **2.77**

CPT Descriptor: Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 67-year-old patient with dysphagia, weight loss and abdominal pain unresponsive to pharmacological therapy undergoes imaging studies revealing a stricture in the distal esophagus. The patient is referred for esophagogastroduodenoscopy with evaluation of the upper GI tract, and dilation of the stricture.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 71%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 56%

Description of Pre-Service Work: Review with the patient any symptoms including dysphagia and sleep apnea. The patient's history is reviewed to assess past problems with sedation and the need for pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays and other diagnostic tests are reviewed. The pre-service review is documented. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained. The physician verifies all endoscopic equipment is available and operational and appropriate computer entries are made. The patient is positioned on the examination table. The endoscopic and moderate sedation monitoring equipment is positioned to provide access for the procedure. A time out is performed. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide when indicated, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat. A bite block is placed in the mouth.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible upper endoscope is inserted through the mouth into the oropharynx and advanced through the esophagus into the proximal stomach. The stomach is insufflated with air after suctioning liquid contents. Examination of the entire stomach in the forward and retroflexed positions is performed. The endoscope is advanced through the pylorus into the duodenal bulb. Circumferential inspection of the duodenum is performed after air insufflation. The endoscope is slowly withdrawn re-inspecting the stomach and duodenum. After suctioning air to deflate the stomach, the endoscope is withdrawn into the esophagus, allowing measurement of the squamocolumnar and gastro-esophageal junction from the incisors, assessment

for presence of a hiatal hernia, and examination of the esophageal mucosa. When indicated, brushings or washings are obtained of suspicious abnormalities. The stricture to be dilated is identified and assessed. The endoscope is positioned. A through-the-scope fixed wire balloon catheter is advanced through the endoscope, positioned across the stricture, and inflated to a diameter of approximately 15 mm. The balloon catheter is deflated and the stricture is observed. The level of sedation of the patient is reassessed and additional medication is administered as needed. If necessary, the balloon dilator is removed and subsequent balloon catheters of larger diameter are inserted through the endoscope, positioned across the stricture, and inflated. The balloon catheter is then deflated, and the stricture is observed to confirm adequate dilation of the stricture. When dilation is adequate, the balloon catheter is removed. Following dilation, the area is observed for bleeding. If inspection of stomach and duodenum described above were not feasible prior to dilation, this inspection is completed after dilation. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. Supervision of the level of sedation and vital signs is performed during the procedure with additional measures taken to maintain an appropriate level of sedation, vital signs, airway and oxygenation as indicated. At the conclusion of the procedure, the endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. Post procedure orders are completed. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to referral source and other appropriate parties. Data is entered into procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others. Necessary prescriptions, follow-up tests and appointments are provided to the patient.



**SURVEY DATA**

RUC Meeting Date (mm/yyyy)		01/2013				
Presenter(s):	Drs. Brill, Nickl, Bentley, and Selzer					
Specialty(s):	AGA, ASGE, SAGES					
CPT Code:	43249					
Sample Size:	1907	Resp N:	56	Response: 2.9 %		
Description of Sample:	The AGA and ASGE conducted a random sample of member gastroenterologists as approved by the Research Subcommittee. The sampling methodology was a random sample with the addition of survey volunteers who responded to educational articles and identified themselves as performers of therapeutic endoscopic services. SAGES conducted a random sample of their members.					
		Low	25 <sup>th</sup> pctl	Median*	75 <sup>th</sup> pctl	High
Service Performance Rate		0.00	15.00	30.00	79.00	500.00
Survey RVW:		1.60	3.36	4.07	4.82	6.55
Pre-Service Evaluation Time:				20.00		
Pre-Service Positioning Time:				5.00		
Pre-Service Scrub, Dress, Wait Time:				5.00		
Intra-Service Time:		10.00	15.00	20.00	30.00	60.00
Immediate Post Service-Time:	15.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00		
Discharge Day Mgmt:	0.00	99238x 0.00	99239x 0.00	99217x 0.00		
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00	15x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00	
Sub Obs Care:	0.00	99224x 0.00	99225x 0.00	99226x 0.00		

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1b-FAC Straightforw Pat Procedure(w sedate/anes)

CPT Code:	43249	Recommended Physician Work RVU: 2.77				
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time		
Pre-Service Evaluation Time:		19.00	19.00	0.00		
Pre-Service Positioning Time:		3.00	1.00	2.00		
Pre-Service Scrub, Dress, Wait Time:		5.00	5.00	0.00		
Intra-Service Time:		20.00				
Immediate Post Service-Time:	15.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00		
Discharge Day Mgmt:	0.00	99238x 0.0	99239x 0.0	99217x 0.00		
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00	15x 0.00

<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31631	000	4.36	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of tracheal stent(s) (includes tracheal/bronchial dilation as required)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
51102	000	2.70	RUC Time	14,057

CPT Descriptor 1 Aspiration of bladder; with insertion of suprapubic catheter

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
15002	000	3.65	RUC Time	15,981

CPT Descriptor 2 Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 9      % of respondents: 16.0 %**

**TIME ESTIMATES (Median)**

	<b>CPT Code: 43249</b>	<b>Key Reference CPT Code: 31631</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	27.00	45.00	
Median Intra-Service Time	20.00	45.00	
Median Immediate Post-service Time	15.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>62.00</b>	<b>120.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.80	3.79
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.84	3.73
--	------	------

Urgency of medical decision making	3.80	3.55
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.30	3.70
--------------------------	------	------

Physical effort required	3.84	3.32
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.25	3.68
---	------	------

Outcome depends on the skill and judgment of physician	4.20	3.86
--	------	------

Estimated risk of malpractice suit with poor outcome	4.23	3.68
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.57	3.38
----------------------------------	------	------

Intra-Service intensity/complexity	4.21	3.86
------------------------------------	------	------

Post-Service intensity/complexity	3.55	3.32
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

## Background

Several EGD codes were identified through CMS and RUC screens as potentially misvalued, including: MPC list screen; high expenditures screen; and fastest growing screen. The specialties agreed to survey the entire family of codes (43235-43259). In review of this family of codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In October 2012, the CPT Editorial Panel approved revised guidelines along with revision, addition, and deletion of codes within the EGD code set.

## Overview of EGD Family RVW Recommendations

The specialty consensus panel spent a significant amount of time reviewing the survey data for the current set of EGD codes, comparing the data and values with the esophagoscopy codes (43200-43228) that were approved by the RUC at the October 2012 RUC meeting. The compelling arguments from the esophagoscopy review are the same as for the EGD codes, with the additional fact that the times for codes built on increments from the base code (43235) would require adjustment.

After reviewing the survey data, the consensus panel determined that for the EGD codeset, the incremental value above the base code for EGD (43235) should be similar where possible to the analogous incremental value above the esophagoscopy base code (43200) previously approved. For the existing codes, the RVW recommendations are based on the lower of the current value or the EGD base+increment from the esophagoscopy pair (ie, valuing the increment). Where there was no exact match for existing codes, the RVW recommendation is the lower of the current RVW or the 25<sup>th</sup> percentile RVW. For all new codes that bundle multiple codes and/or deleted codes, the RVW recommendation is based on endoscopy multiple procedure payment policy or surgical multiple procedure payment policy, as applicable. For this last set of codes, all but two recommendations are less than the survey 25<sup>th</sup> percentile. For the two exceptions, the recommendation is between the 25<sup>th</sup> and median survey RVW.

## 43249 – Discussion and Recommendation

Code 43249 *Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)* was identified as a family code through the MPC List screen. This service was reviewed by the RUC twice. In 1993, the RUC reviewed 43249 as part of an overall review of the EGD family in relation to new codes that were created for 1994. The RUC again reviewed 43249 in 2000 as part of the second 5YR. The RUC agreed that there had been an increase in both time and intensity based on a survey of valuing the increment, however the RUC did not agree with the specialty recommended RVW increase based on time. Instead, the RUC chose to recommend the increment survey median RVW of 3.35. CMS did not accept the RUC recommendation and instead maintained the current RVW for 43249. Therefore, the current RVW is not related to either the survey data or the RUC recommendation and has caused a discordant work intensity calculation. The AGA, ASGE, and SAGES conducted a RUC survey and received 56 responses.

**We recommend the current RVW of 2.90.** This value is equal to valuing the increment  $[(43235 + (43220-43200)) \text{ or } (2.39 + 0.51)]$ .

**Pre-time Package 1b** is appropriate for 43249, with an additional 2 minutes for positioning the patient, endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

### Comparison to Key Ref 31625

Key Reference code 31625 was surveyed and presented to the RUC in 2003 prior to the discussion of pre-time packages and moderate sedation work. The RUC agreed that the CPT change was editorial and that work had not changed. The RVW was maintained and the survey data was accepted. The recommended RVW of 2.90 for 43249 compares favorably with the RVW for 31625.

### Comparison to EGD Base Code 43235

*Estimating time in 5 minute increments.* As discussed in the compelling evidence, respondents for the EGD surveys reported intra-time in increments of 5 minutes. The median of 15 minutes for 43235 and 20 minutes for 43249 mask slight differences of +/- a few minutes that would be shown using time and motion studies.

*Establishment of increments.* Harvard conducted an extensive review of the endoscopy families prior to the publication of the first PFS. The increments established between and within families were key to maintaining relativity. The consensus panel reviewing this family of codes believes the increment of 0.51 established for the esophagoscopy pair 43200/43220 by the RUC in October 2012 is correct for the similar EGD pair 43235/43249.

#### Comparison To MPC And Other RUC-Reviewed Codes with 20 Minutes Intra-Service Time

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2012	<b>32556</b>	Insert cath pleura w/o image	2.50	0.084	60	13	3	6	<b>20</b>	18
2003	<b>36555</b>	Insert non-tunnel cv cath	2.68	0.093	60	20	5	5	<b>20</b>	10
<b>MPC 2008</b>	<b>51102</b>	Drain bl w/cath insertion	2.70	0.094	60	19	1	5	<b>20</b>	15
2010	<b>52281</b>	Cystoscopy and treatment	2.75	0.112	46	10	1	5	<b>20</b>	10
2008	<b>49452</b>	Replace g-j tube perc	2.86	0.102	60	20	5	5	<b>20</b>	10
	<b>43249</b>	EGD with balloon <30mm	2.77	0.102	62	19	3	5	<b>20</b>	15
2012	<b>32551</b>	Insertion of chest tube	3.29	0.101	83	30	3	10	<b>20</b>	20
2011	<b>15273</b>	Skin sub grft t/arm/lg child	3.50	0.093	100	40	10	10	<b>20</b>	20
<b>MPC 2006</b>	<b>15002</b>	Wound prep trk/arm/leg	3.65	0.087	115	45	15	15	<b>20</b>	20

#### SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.  
☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.  
☐ Multiple codes allow flexibility to describe exactly what components the procedure included.  
☐ Multiple codes are used to maintain consistency with similar codes.  
☐ Historical precedents.  
☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

#### FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43249

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
 If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology How often? Commonly

Specialty GI Surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 276000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare database for 2011 is approximately 92,000. 92,000 times 3 considering commercial patients is 276,000

Specialty Gastroenterology	Frequency 234600	Percentage 85.00 %
----------------------------	------------------	--------------------

Specialty GI Surgery	Frequency 19320	Percentage 7.00 %
----------------------	-----------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 91,802 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare database for 2011 is 91802.

Specialty Gastroenterology	Frequency 78200	Percentage 85.00 %
----------------------------	-----------------	--------------------

Specialty GI Surgery	Frequency 6440	Percentage 7.00 %
----------------------	----------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43249

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43233      Tracking Number I16      Original Specialty Recommended RVU: **4.26**  
 Presented Recommended RVU: **4.26**  
 Global Period: 000      RUC Recommended RVU: **4.45**

CPT Descriptor: Esophagogastroduodenoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 69-year-old patient with malnutrition, abdominal discomfort and increasing inability to swallow liquids undergoes imaging studies revealing a tapered, "bird's beak" appearance of the distal esophagus. Esophageal motility studies confirm findings consistent with achalasia. The patient is referred for esophagogastroduodenoscopy with evaluation of the upper GI tract, and large diameter balloon dilation of the lower esophageal sphincter.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 63%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 60%

Description of Pre-Service Work: Review with the patient any symptoms including dysphagia and sleep apnea. The patient's history is reviewed to assess past problems with sedation and the need for pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays and other diagnostic tests are reviewed. The pre-service review is documented. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained. The physician verifies all endoscopic equipment is available and operational and appropriate computer entries are made. The patient is positioned on the examination table. The endoscopic and moderate sedation monitoring equipment is positioned to provide access for the procedure. A time out is performed. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide when indicated, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat. A bite block is placed in the mouth.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible upper endoscope is inserted through the mouth into the oropharynx and advanced through the esophagus into the proximal stomach. The stomach is insufflated with air after suctioning liquid contents. Examination of the entire stomach in the forward and retroflexed positions is performed. The endoscope is advanced through the pylorus into the duodenal bulb. Circumferential inspection of the duodenum is performed after air insufflation. The endoscope is slowly withdrawn re-

inspecting the stomach and duodenum. After suctioning air to deflate the stomach, the endoscope is withdrawn into the esophagus, allowing measurement of the squamocolumnar and gastro-esophageal junction from the incisors, assessment for presence of a hiatal hernia, and examination of the esophageal mucosa. When indicated, brushings or washings are obtained of suspicious abnormalities. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. The gastroesophageal junction is identified and assessed. A guidewire is inserted through the biopsy channel of the endoscope into the stomach and the endoscope is withdrawn maintaining the position of the guidewire. A greater than 30 cm balloon catheter is advanced over the guidewire and positioned across the lower esophageal sphincter using fluoroscopy and/or a reinserted endoscope to confirm the position. The balloon is inflated to a diameter of greater than 30 mm. The balloon catheter is deflated and the stricture is observed. Supervision of the level of sedation and vital signs is performed during the procedure with additional measures taken to maintain an appropriate level of sedation, vital signs, airway and oxygenation as indicated. At the conclusion of the procedure, the endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. Post procedure orders are completed. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Post procedure radiologic tests are ordered and reviewed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to referral source and other appropriate parties. Data is entered into procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others. Necessary prescriptions, follow-up tests and appointments are provided to the patient.



**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		01/2013				
<b>Presenter(s):</b>	Joel V. Brill, MD (AGA), Nicholas Nickl, MD (ASGE), Edward S. Bentley, MD (ASGE)					
<b>Specialty(s):</b>	AGA, ASGE					
<b>CPT Code:</b>	43233					
<b>Sample Size:</b>	1007	<b>Resp N:</b>	35	<b>Response:</b> 3.4 %		
<b>Description of Sample:</b>	The AGA and ASGE conducted a random sample of member gastroenterologists as approved by the Research Subcommittee. The sampling methodology was a random sample with the addition of survey volunteers who responded to educational articles and identified themselves as performers of therapeutic endoscopic services.					
		<b><u>Low</u></b>	<b><u>25<sup>th</sup> pctl</u></b>	<b><u>Median*</u></b>	<b><u>75<sup>th</sup> pctl</u></b>	<b><u>High</u></b>
<b>Service Performance Rate</b>		0.00	1.00	<b>5.00</b>	11.00	250.00
<b>Survey RVW:</b>		3.50	4.45	<b>4.98</b>	5.73	8.00
<b>Pre-Service Evaluation Time:</b>				<b>30.00</b>		
<b>Pre-Service Positioning Time:</b>				<b>10.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>10.00</b>		
<b>Intra-Service Time:</b>		10.00	23.00	<b>30.00</b>	43.00	90.00
<b>Immediate Post Service-Time:</b>	<b><u>20.00</u></b>					
<b><u>Post Operative Visits</u></b>	<b><u>Total Min**</u></b>	<b><u>CPT Code and Number of Visits</u></b>				
<b>Critical Care time/visit(s):</b>	<b><u>0.00</u></b>	99291x 0.00	99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b><u>0.00</u></b>	99231x 0.00	99232x 0.00	99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b><u>0.00</u></b>	99238x 0.00	99239x 0.00	99217x 0.00		
<b>Office time/visit(s):</b>	<b><u>0.00</u></b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00	15x 0.00
<b>Prolonged Services:</b>	<b><u>0.00</u></b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00	
<b>Sub Obs Care:</b>	<b><u>0.00</u></b>	99224x 0.00	99225x 0.00	99226x 0.00		

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	43233	Recommended Physician Work RVU: 4.45			
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:		30.00	33.00	-3.00	
Pre-Service Positioning Time:		3.00	1.00	2.00	
Pre-Service Scrub, Dress, Wait Time:		5.00	5.00	0.00	
Intra-Service Time:		30.00			
Immediate Post Service-Time:	20.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	0.00	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00

Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00
---------------	-------------	-------------	-------------	-------------

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31638	000	4.88	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
---------------------------------	---------------	-----------------	--------------------

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 8      % of respondents: 22.8 %

**TIME ESTIMATES (Median)**

	<u>CPT Code:</u> 43233	<u>Key Reference CPT Code:</u> 31638	<u>Source of Time</u> RUC Time
Median Pre-Service Time	38.00	20.00	
Median Intra-Service Time	30.00	15.00	
Median Immediate Post-service Time	20.00	15.00	
Median Critical Care Time	0.0	60.00	
Median Other Hospital Visit Time	0.0	30.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

<b>Median Total Time</b>	<b>88.00</b>	<b>140.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.88	3.88
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.88	3.75
--	------	------

Urgency of medical decision making	3.88	3.75
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.63	4.38
--------------------------	------	------

Physical effort required	4.50	3.75
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.50	4.00
---	------	------

Outcome depends on the skill and judgment of physician	4.88	4.25
--	------	------

Estimated risk of malpractice suit with poor outcome	4.38	4.13
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.63	3.50
----------------------------------	------	------

Intra-Service intensity/complexity	4.63	4.13
------------------------------------	------	------

Post-Service intensity/complexity	3.88	3.50
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**

Several EGD codes were identified through CMS and RUC screens as potentially misvalued, including: MPC list screen; high expenditures screen; and fastest growing screen. The specialties agreed to survey the entire family of codes (43235-

43259). In review of this family of codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In October 2012, the CPT Editorial Panel approved revised guidelines along with revision, addition, and deletion of codes within the EGD code set.

### Overview of EGD Family RVW Recommendations

The specialty consensus panel spent a significant amount of time reviewing the survey data for the current set of EGD codes, comparing the data and values with the esophagoscopy codes (43200-43228) that were approved by the RUC at the October 2012 RUC meeting. The compelling arguments from the esophagoscopy review are the same as for the EGD codes, with the additional fact that the times for codes built on increments from the base code (43235) would require adjustment.

After reviewing the survey data, the consensus panel determined that for the EGD codeset, the incremental value above the base code for EGD (43235) should be similar where possible to the analogous incremental value above the esophagoscopy base code (43200) previously approved. For the existing codes, the RVW recommendations are based on the lower of the current value or the EGD base+increment from the esophagoscopy pair (ie, valuing the increment). Where there was no exact match for existing codes, the RVW recommendation is the lower of the current RVW or the 25<sup>th</sup> percentile RVW. For all new codes that bundle multiple codes and/or deleted codes, the RVW recommendation is based on endoscopy multiple procedure payment policy or surgical multiple procedure payment policy, as applicable. For this last set of codes, all but two recommendations are less than the survey 25<sup>th</sup> percentile. For the two exceptions, the recommendation is between the 25<sup>th</sup> and median survey RVW.

Code 43233 *Esophagogastroduodenoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)* is a new code for 2014. The AGA and ASGE conducted a RUC survey and received 35 responses.

**We recommend an RVW of 4.26.** This value is less than the 25<sup>th</sup> percentile and is based on: 1) the sum of to-be-deleted code 43458 plus 0.5 x the base EGD (43235); and 2) multiple procedure payment policy.

Code 43458 *Dilation of esophagus with balloon (30 mm diameter or larger) for achalasia* has a 000-global period and does not include endoscopy work. The new code will bundle 43458 with 43235 (EGD base) which also has a 000-global period. Payment for this bundled work would be based on the multiple procedure payment rule (100%x43458 plus 50%x43235) or  $3.06 + 0.5 \times 2.39 = 4.26$ .

**Pre-time Package 2b** is appropriate for 43233, with an additional 2 minutes for positioning the patient, endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation. In addition, the recommended evaluation time matches the survey median which is lower than the package time.

### Comparison to Key Ref 31638

Key Reference code 31638 requires lower intensity fluoroscopic guidance which increases the intra-service time. The difference in RVW compared with 43233 accounts for longer total time, but at lower intensity.

### Comparison To Other RUC-Reviewed Codes with 30 Minutes Intra-Service Time

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2007	<b>20660</b>	Apply rem fixation device	4.00	0.093	90	20		10	<b>30</b>	30
2012	<b>52224</b>	Cystoscopy and treatment	4.05	0.101	79	19	5	5	<b>30</b>	20
2004	<b>32550</b>	Insert pleural cath	4.17	0.099	90	15	15	10	<b>30</b>	20
	<b>43233</b>	EGD, balloon >30mm	<b>4.45</b>	<b>0.101</b>	<b>88</b>	<b>30</b>	<b>3</b>	<b>5</b>	<b>30</b>	<b>20</b>
2012	<b>52234</b>	Cystoscopy and treatment	4.62	0.120	79	19	5	5	<b>30</b>	20
2011	<b>37191</b>	Ins endovas vena cava filtr	4.71	0.120	83	30	3	5	<b>30</b>	15
2010	<b>93452</b>	Left hrt cath w/ventrclgrphy	4.75	0.102	108	40	3	5	<b>30</b>	30
2010	<b>93454</b>	Coronary artery angio s&i	4.79	0.104	108	40	3	5	<b>30</b>	30

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43458 + 74360

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 3600

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2011 data for 43458 (Dilation of esophagus with balloon (30 mm diameter or larger) for achalasia) is approximately 1,600. Approximately 80% of the volume for 43458 will be reported with 43233 (~1,200) multiplied by 3 = ~4,000.

Specialty Gastroenterology Frequency 2200 Percentage 61.11 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 781

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2011 data for 43458 (Dilation of esophagus with balloon (30 mm diameter or larger) for achalasia) is 1,561. Approximately 50% of the volume for 43458 will be reported with 43233 = 781.

Specialty Gastroenterology Frequency 730 Percentage 60.83 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

**Professional Liability Insurance Information (PLI)**

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 43271

## AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 43250	Tracking Number I17	Original Specialty Recommended RVU: <b>3.20</b>
		Presented Recommended RVU: <b>3.20</b>
Global Period: 000		RUC Recommended RVU: <b>3.07</b>

CPT Descriptor: Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery

### CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66-year-old patient with persistent dyspepsia unresponsive to pharmacological therapy is referred for endoscopic examination. Esophagogastroduodenoscopy of the upper GI tract reveals a polypoid lesion in the gastric fundus; a hot biopsy forceps is used to remove the lesion.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

### Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

### Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 73%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 88%

Description of Pre-Service Work: Review with the patient any symptoms including dysphagia and sleep apnea. The patient's history is reviewed to assess past problems with sedation and the need for pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays and other diagnostic tests are reviewed. The pre-service review is documented. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained. The physician verifies all endoscopic equipment is available and operational and appropriate computer entries are made. The patient is positioned on the examination table. The endoscopic and moderate sedation monitoring equipment is positioned to provide access for the procedure. A time out is performed. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide when indicated, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat. A bite block is placed in the mouth.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible upper endoscope is inserted through the mouth into the oropharynx and advanced through the esophagus into the proximal stomach. The stomach is insufflated with air after suctioning liquid contents. Examination of the entire stomach in the forward and retroflexed positions is performed. The endoscope is advanced through the pylorus into the duodenal bulb. Circumferential inspection of the duodenum is performed after air insufflation. The endoscope is slowly withdrawn re-inspecting the stomach and duodenum. The lesion to be removed is identified and assessed. The identified lesion is removed with hot biopsy forceps until there is no residual. The area is assessed for bleeding. After suctioning air to deflate

the stomach, the endoscope is withdrawn into the esophagus, allowing measurement of the squamocolumnar and gastro-esophageal junction from the incisors, assessment for presence of a hiatal hernia, and examination of the esophageal mucosa. When indicated, brushings or washings are obtained of suspicious abnormalities. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. Supervision of the level of sedation and vital signs is performed during the procedure with additional measures taken to maintain an appropriate level of sedation, vital signs, airway and oxygenation as indicated. At the conclusion of the procedure, the endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. Post procedure orders are completed. Cytology and pathology forms are completed; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to referral source and other appropriate parties. Data is entered into procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others. Necessary prescriptions, follow-up tests and appointments are provided to the patient.



**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		01/2013				
<b>Presenter(s):</b>	Drs. Brill, Nickl, Bentley, and Selzer					
<b>Specialty(s):</b>	AGA, ASGE, SAGES					
<b>CPT Code:</b>	43250					
<b>Sample Size:</b>	1890	<b>Resp N:</b>	59	<b>Response:</b> 3.1 %		
<b>Description of Sample:</b>	The AGA and ASGE conducted a random sample of member gastroenterologists as approved by the Research Subcommittee. The sampling methodology was a random sample with the addition of survey volunteers who responded to educational articles and identified themselves as performers of therapeutic endoscopic services. SAGES conducted a random sample of their members.					
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Service Performance Rate</b>		0.00	5.00	<b>10.00</b>	50.00	500.00
<b>Survey RVW:</b>		1.25	3.25	<b>3.50</b>	4.43	9.99
<b>Pre-Service Evaluation Time:</b>				<b>16.00</b>		
<b>Pre-Service Positioning Time:</b>				<b>5.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>5.00</b>		
<b>Intra-Service Time:</b>		6.00	15.00	<b>20.00</b>	25.00	50.00
<b>Immediate Post Service-Time:</b>		<b>14.00</b>				
<b>Post Operative Visits</b>		<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>		<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>		<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>		<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>		<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>		<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>		<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1b-FAC Straightforw Pat Procedure(w sedate/anes)

CPT Code:	43250	Recommended Physician Work RVU: 3.07				
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time		
Pre-Service Evaluation Time:		16.00	19.00	-3.00		
Pre-Service Positioning Time:		3.00	1.00	2.00		
Pre-Service Scrub, Dress, Wait Time:		5.00	5.00	0.00		
Intra-Service Time:		20.00				
Immediate Post Service-Time:	14.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00		
Discharge Day Mgmt:	0.00	99238x 0.0	99239x 0.0	99217x 0.00		
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00	15x 0.00

<b>Prolonged Services:</b>	<u><b>0.00</b></u>	99354x <b>0.00</b>	55x <b>0.00</b>	56x <b>0.00</b>	57x <b>0.00</b>
<b>Sub Obs Care:</b>	<u><b>0.00</b></u>	99224x <b>0.00</b>	99225x <b>0.00</b>	99226x <b>0.00</b>	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31635	000	3.67	Harvard Time

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of foreign body**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
51102	000	2.70	RUC Time	14,057

CPT Descriptor 1 Aspiration of bladder; with insertion of suprapubic catheter

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
15002	000	3.65	RUC Time	15,981

CPT Descriptor 2 Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 23      % of respondents: 38.9 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 43250</b>	<b>Key Reference CPT Code: 31635</b>	<b>Source of Time Harvard Time</b>
Median Pre-Service Time	24.00	43.00	
Median Intra-Service Time	20.00	39.00	
Median Immediate Post-service Time	14.00	19.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>58.00</b>	<b>101.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.68	3.53
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.46	3.39
--	------	------

Urgency of medical decision making	3.56	3.20
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.98	3.56
--------------------------	------	------

Physical effort required	3.44	3.17
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.78	3.42
---	------	------

Outcome depends on the skill and judgment of physician	3.86	3.64
--	------	------

Estimated risk of malpractice suit with poor outcome	3.71	3.39
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.32	3.15
----------------------------------	------	------

Intra-Service intensity/complexity	3.75	3.64
------------------------------------	------	------

Post-Service intensity/complexity	3.27	3.10
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

## Background

Several EGD codes were identified through CMS and RUC screens as potentially misvalued, including: MPC list screen; high expenditures screen; and fastest growing screen. The specialties agreed to survey the entire family of codes (43235-43259). In review of this family of codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In October 2012, the CPT Editorial Panel approved revised guidelines along with revision, addition, and deletion of codes within the EGD codeset.

## Overview of EGD Family RVW Recommendations

The specialty consensus panel spent a significant amount of time reviewing the survey data for the current set of EGD codes, comparing the data and values with the esophagoscopy codes (43200-43228) that were approved by the RUC at the October 2012 RUC meeting. The compelling arguments from the esophagoscopy review are the same as for the EGD codes, with the additional fact that the times for codes built on increments from the base code (43235) would require adjustment.

After reviewing the survey data, the consensus panel determined that for the EGD codeset, the incremental value above the base code for EGD (43235) should be similar where possible to the analogous incremental value above the esophagoscopy base code (43200) previously approved. For the existing codes, the RVW recommendations are based on the lower of the current value or the EGD base+increment from the esophagoscopy pair (ie, valuing the increment). Where there was no exact match for existing codes, the RVW recommendation is the lower of the current RVW or the 25<sup>th</sup> percentile RVW. For all new codes that bundle multiple codes and/or deleted codes, the RVW recommendation is based on endoscopy multiple procedure payment policy or surgical multiple procedure payment policy, as applicable. For this last set of codes, all but two recommendations are less than the survey 25<sup>th</sup> percentile. For the two exceptions, the recommendation is between the 25<sup>th</sup> and median survey RVW.

## 43250 – Discussion and Recommendation

Code 43250 *Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery* was identified as a family code through the MPC List screen. In 1993, the RUC reviewed 43250 as a new code for 1994. The RUC RVW recommendation was based on the method of valuing the increment. In addition, the RUC took into consideration the weighted average of the different specialties reviewing the new code. The AGA, ASGE, and SAGES conducted a RUC survey and received 59 responses.

The consensus panel agrees that physician work for this service has not changed. **We recommend the current RVW of 3.20.** This recommended RVW is the same as the value of the base code plus the increment of 0.75 established by the RUC in October 2012 for the comparable esophagoscopy code pair 43200/43216 and is below the survey 25th percentile RVW.

**Pre-time Package 1b** is appropriate for 43250, with an additional 2 minutes for positioning the patient, endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation. In addition, the recommended evaluation time matches the survey median which is lower than the package time.

### Comparison to Key Ref 31625

Key Reference code 31625 was surveyed and presented to the RUC in 2003 prior to the discussion of pre-time packages and moderate sedation work. The RUC agreed that the CPT change was editorial and that work had not changed. The RVW was maintained and the survey data was accepted. The recommended RVW of 3.20 for 43250 compares favorably with the RVW for 31625.

### Comparison to EGD Base Code 43235

*Estimating time in 5 minute increments.* As discussed in the compelling evidence, respondents for the EGD surveys reported intra-time in increments of 5 minutes. The median of 15 minutes for 43235 and 20 minutes for 43250 mask slight differences of +/- a few minutes that would be shown using time and motion studies.

*Establishment of increments.* Harvard conducted an extensive review of the endoscopy families prior to the publication of the first PFS. The increments established between and within families were key to maintaining relativity. The

consensus panel reviewing this family of codes believes the increment of 0.75 established for the esophagoscopy pair 43200/43216 by the RUC in October 2012 is correct for the similar EGD pair 43235/43250.

#### Comparison To MPC And Other RUC-Reviewed Codes with 20 Minutes Intra-Service Time

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
MPC 2008	51102	Drain bl w/cath insertion	2.70	0.094	60	19	1	5	20	15
2010	52281	Cystoscopy and treatment	2.75	0.112	46	10	1	5	20	10
2008	49452	Replace g-j tube perc	2.86	0.102	60	20	5	5	20	10
	43250	EGD; hot biopsy	3.07	0.121	58	16	3	5	20	14
2012	32551	Insertion of chest tube	3.29	0.101	83	30	3	10	20	20
2011	15273	Skin sub grft t/arm/lg child	3.50	0.093	100	40	10	10	20	20
MPC 2006	15002	Wound prep trk/arm/leg	3.65	0.087	115	45	15	15	20	20

#### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

#### FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43250

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology

How often? Sometimes

Specialty GI Surgery

How often? Sometimes

Specialty

How often?

Estimate the number of times this service might be provided nationally in a one-year period? 19500

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare database for 2011 is approximately 6,500. 6,500 times 3 considering commercial patients is 19,500

Specialty Gastroenterology

Frequency 12090

Percentage 62.00 %

Specialty GI Surgery	Frequency 5265	Percentage 27.00 %
----------------------	----------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 6,514  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare database for 2011 is 6514.

Specialty Gastroenterology	Frequency 4030	Percentage 62.00 %
----------------------------	----------------	--------------------

Specialty GI Surgery	Frequency 1755	Percentage 27.00 %
----------------------	----------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? No

---

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43250

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43251      Tracking Number I18      Original Specialty Recommended RVU: **3.57**  
 Presented Recommended RVU: **3.57**  
 Global Period: 000      RUC Recommended RVU: **3.57**

CPT Descriptor: Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 69-year-old patient with chronic dyspepsia unresponsive to pharmacological therapy is referred for endoscopic examination. Esophagogastroduodenoscopy of the upper GI tract reveals a sessile polypoid lesion in the stomach; snare removal of the lesion is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 76%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 59%

Description of Pre-Service Work: Review with the patient any symptoms including dysphagia and sleep apnea. The patient's history is reviewed to assess past problems with sedation and the need for pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays and other diagnostic tests are reviewed. The pre-service review is documented. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained. The physician verifies all endoscopic equipment is available and operational and appropriate computer entries are made. The patient is positioned on the examination table. The endoscopic and moderate sedation monitoring equipment is positioned to provide access for the procedure. A time out is performed. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide when indicated, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat. A bite block is placed in the mouth.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible upper endoscope is inserted through the mouth into the oropharynx and advanced through the esophagus into the proximal stomach. The stomach is insufflated with air after suctioning liquid contents. Examination of the entire stomach in the forward and retroflexed positions is performed. The endoscope is advanced through the pylorus into the duodenal bulb. Circumferential inspection of the duodenum is performed after air insufflation. The endoscope is slowly withdrawn re-inspecting the stomach and duodenum. A polypoid lesion is identified and assessed. A snare is passed through the endoscope and looped around the lesion. As the snare is tightened, electrocautery is applied in a controlled manner and the

identified lesion is removed. The snare is withdrawn, and a retrieval device is inserted through the endoscope to capture the polyp. The retrieval device and polyp are withdrawn to the tip of the endoscope. The endoscope with the device and polyp are withdrawn through the mouth. The lesion is placed in a biopsy container. The endoscope is reinserted through the mouth to the area of the lesion. The base of the lesion is examined; if there is residual tissue the snare technique is repeated until there is no residual. The area is observed for bleeding. After suctioning air to deflate the stomach, the endoscope is withdrawn into the esophagus, allowing measurement of the squamocolumnar and gastro-esophageal junction from the incisors, assessment for presence of a hiatal hernia, and examination of the esophageal mucosa. When indicated, brushings or washings are obtained of suspicious abnormalities. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. Supervision of the level of sedation and vital signs is performed during the procedure with additional measures taken to maintain an appropriate level of sedation, vital signs, airway and oxygenation as indicated. At the conclusion of the procedure, the endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. Post procedure orders are completed. Cytology and pathology forms are completed; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to referral source and other appropriate parties. Data is entered into procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others. Necessary prescriptions, follow-up tests and appointments are provided to the patient.



**SURVEY DATA**

RUC Meeting Date (mm/yyyy)		04/2013				
Presenter(s):	Bruce Cameron, MD (ACG), Joel Brill, MD (AGA), Nicholas Nickl, MD (ASGE), Edward Bentley, MD (ASGE)					
Specialty(s):	ACG, AGA, ASGE					
CPT Code:	43251					
Sample Size:	742	Resp N:	39	Response: 5.2 %		
Description of Sample:	The ACG, AGA and ASGE conducted a random sample of member gastroenterologists.					
		Low	25 <sup>th</sup> pctl	Median*	75 <sup>th</sup> pctl	High
Service Performance Rate		0.00	10.00	25.00	63.00	800.00
Survey RVW:		1.00	3.36	3.80	4.68	10.08
Pre-Service Evaluation Time:				25.00		
Pre-Service Positioning Time:				5.00		
Pre-Service Scrub, Dress, Wait Time:				5.00		
Intra-Service Time:		9.00	15.00	20.00	28.00	35.00
Immediate Post Service-Time:	10.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00				
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00				
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00				
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00				
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00				
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00				

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	43251	Recommended Physician Work RVU: 3.57			
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:		25.00	33.00	-8.00	
Pre-Service Positioning Time:		3.00	1.00	2.00	
Pre-Service Scrub, Dress, Wait Time:		5.00	5.00	0.00	
Intra-Service Time:		20.00			
Immediate Post Service-Time:	10.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	0.00	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	0.00	99224x 0.00	99225x 0.00	99226x 0.00	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31625	000	3.36	RUC Time

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

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 10      % of respondents: 25.6 %

**TIME ESTIMATES (Median)**

	CPT Code: 43251	Key Reference CPT Code: 31625	Source of Time RUC Time
Median Pre-Service Time	33.00	25.00	
Median Intra-Service Time	20.00	30.00	
Median Immediate Post-service Time	10.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
<b>Median Total Time</b>	<b>63.00</b>	<b>70.00</b>	

Other time if appropriate		
---------------------------	--	--

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.40	3.60
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.10	3.30
--	------	------

Urgency of medical decision making	3.10	3.20
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.70	3.70
--------------------------	------	------

Physical effort required	3.30	3.40
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.60	3.50
---	------	------

Outcome depends on the skill and judgment of physician	3.80	3.80
--	------	------

Estimated risk of malpractice suit with poor outcome	3.60	3.60
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.00	3.00
----------------------------------	------	------

Intra-Service intensity/complexity	3.40	3.50
------------------------------------	------	------

Post-Service intensity/complexity	3.10	3.10
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**

Several EGD codes were identified through CMS and RUC screens as potentially misvalued, including: MPC list screen; high expenditures screen; and fastest growing screen. The specialties agreed to survey the entire family of codes (43235-43259). In review of this family of codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current

practice. In October 2012, the CPT Editorial Panel approved revised guidelines along with revision, addition, and deletion of codes within the EGD codeset.

A survey was conducted and data presented to the RUC at the January 2013 meeting. The RUC reviewed the survey data for 43251 and agreed with the specialty societies that a median intra-service time of 20 minutes grossly underestimates the time it takes to perform this procedure. A five minute time differential between the base code, 15 minutes, and this code, 20 minutes, does not accurately account for the additional work in removing a lesion by snare technique. Additionally, the esophagoscopy equivalent codes had a time differential of 15 minutes. Therefore, the RUC recommends that CPT code 43251 be re-surveyed for presentation at the April 2013 RUC meeting.

### 43251 – Discussion and Recommendation

Code 43251 *Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique* was identified as a family code through the MPC List screen. In 1993, the RUC reviewed 43251 as a new code for 1994. The RUC RVW recommendation was based on the method of valuing the increment. In addition, the RUC took into consideration the weighted average of the different specialties reviewing the new code. A new RUC survey was conducted by the ACG, AGA and ASGE and 39 responses were received.

The panel noted that the survey time is again 20 minutes. The panel continues to believe that this time is anomalous compared to the base code time of 15 minutes. The analogous code for esophageal snare polypectomy is 43217; the incremental intraservice time above the base code 43200, both surveyed in 2012; was 15 minutes. The panel felt that snare polypectomy in the stomach or duodenum is not less complex or time consuming than in the esophagus. The panel recommends intraservice time of 20 minutes but cautions that this time and the resulting IWPUT should not be used for comparison purposes.

The consensus panel agrees that physician work for this service compared to the based code has not changed. **We recommend an RVW of 3.57.** This recommended RVW is less than the current value and equal to the base code 43235 (2.26 RVW approved at January 2013 meeting) plus the increment of 1.31 established by the RUC in October 2012 for the comparable esophagoscopy code pair 43200/43217. This value maintains relativity within the code family and is between the 25<sup>th</sup> and median survey values.

**Pre-time Package 2b** is appropriate for 43251, with an additional 2 minutes for positioning the patient, endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation. In addition, the recommended evaluation time matches the survey median which is lower than the package time.

#### Comparison to Key Ref 31625

Key Reference code 31625 was surveyed and presented to the RUC in 2003 prior to the discussion of pre-time packages and moderate sedation work. The RUC agreed that the CPT change was editorial and that work had not changed. The RVW was maintained and the survey data was accepted.

#### Comparison to EGD Base Code 43235

*Establishment of increments.* Harvard conducted an extensive review of the endoscopy families prior to the publication of the first PFS. The increments established between and within families were key to maintaining relativity. The consensus panel reviewing this family of codes believes the increment of 1.31 established for the esophagoscopy pair 43200/43217 by the RUC in October 2012 is correct for the similar EGD pair 43235/43251.

#### Comparison To Other RUC-Reviewed Codes with similar IWPUT and time

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2007	<b>93053</b>	Insert/place heart catheter	2.91	0.166	37	5	2	5	<b>15</b>	10
2012	<b>32551</b>	Insertion of chest tube	3.29	0.101	83	30	3	10	<b>20</b>	20

CPT Code: 43251										
2011	<b>15273</b>	Skin sub grft t/arm/lg child	3.50	0.093	100	40	10	10	<b>20</b>	20
	<b>43251</b>	EGD – snare lesion removal	3.57	0.134	63	25	3	5	<b>20</b>	10
2000	<b>16035</b>	Incision of burn scab initi	3.74	0.131	70	30			<b>20</b>	20
2007	<b>20660</b>	Apply rem fixation device	4.00	0.093	90	20		10	<b>30</b>	30
2012	<b>52224</b>	Cystoscopy and treatment	4.05	0.101	79	19	5	5	<b>30</b>	20
2012	<b>52234</b>	Cystoscopy and treatment	4.62	0.120	79	19	5	5	<b>30</b>	20
2011	<b>37191</b>	Ins endovas vena cava filtr	4.71	0.120	83	30	3	5	<b>30</b>	15

## SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43251

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 81000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2011 ~ 27,000 (27,000 \* 3 = 81,000)

Specialty Gastroenterology Frequency 68040 Percentage 84.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?  
 27,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.  
 Please explain the rationale for this estimate. Medicare 2011 ~ 27,000

Specialty Gastroenterology	Frequency 22680	Percentage 84.00 %
----------------------------	-----------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43251

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43252      Tracking Number I19      Original Specialty Recommended RVU: **3.19**  
 Presented Recommended RVU: **3.19**  
 Global Period: 000      RUC Recommended RVU: **3.06**

CPT Descriptor: Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 66-year-old patient with weight loss, dyspepsia and chronic reflux symptoms unresponsive to pharmacological therapy is referred for evaluation. On diagnostic esophagogastroduodenoscopy, the patient is found to have an area of Barrett's esophagus with mucosal irregularity in the distal esophagus. Optical endomicroscopy with cellular level examination of abnormal mucosa is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 77%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 71%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 50%

Description of Pre-Service Work: Review with the patient any symptoms including dysphagia and sleep apnea. The patient's history is reviewed to assess past problems with sedation and the need for pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays and other diagnostic tests are reviewed. The pre-service review is documented. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained. The physician verifies all endoscopic equipment is available and operational and appropriate computer entries are made. The patient is positioned on the examination table. The endoscopic and moderate sedation monitoring equipment is positioned to provide access for the procedure. A time out is performed. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide when indicated, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat. A bite block is placed in the mouth.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible upper endoscope is inserted through the mouth into the oropharynx and advanced through the esophagus into the proximal stomach. The stomach is insufflated with air after suctioning liquid contents. Examination of the entire stomach in the forward and retroflexed positions is performed. The endoscope is advanced through the pylorus into the duodenal bulb. Circumferential inspection of the duodenum is performed after air insufflation. The endoscope is slowly withdrawn re-inspecting the stomach and duodenum. After suctioning air to deflate the stomach, the endoscope is withdrawn into the esophagus, allowing measurement of the squamocolumnar and gastro-esophageal junction from the incisors, assessment

for presence of a hiatal hernia, and examination of the esophageal mucosa. When indicated, brushings or washings are obtained of suspicious abnormalities. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. Abnormal tissue in the distal esophagus suspicious for Barrett's esophagus is identified. An optical endomicroscopy probe is passed through the endoscope to examine the abnormal tissue. Real-time images are reviewed by the endoscopist, identifying areas that are suspicious for pre-malignant and/or malignant tissue, facilitating performance of biopsy (separate procedure). Supervision of the level of sedation and vital signs is performed during the procedure with additional measures taken to maintain an appropriate level of sedation, vital signs, airway and oxygenation as indicated. At the conclusion of the procedure, the endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. Post procedure orders are completed. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to referral source and other appropriate parties. Data is entered into procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others. Necessary prescriptions, follow-up tests and appointments are provided to the patient.



**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	01/2013				
<b>Presenter(s):</b>	Joel V. Brill, MD (AGA), Nicholas Nickl, MD (ASGE), Edward S. Bentley, MD (ASGE)				
<b>Specialty(s):</b>	AGA, ASGE				
<b>CPT Code:</b>	43252				
<b>Sample Size:</b>	96	<b>Resp N:</b>	26	<b>Response:</b> 27.0 %	
<b>Description of Sample:</b>	The AGA and ASGE received permission from the Research Subcommittee to administer surveys for the more specialized and less frequently performed EGD and esophagoscopy procedures, including 43252 (Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy) to an expert panel only. The expert panel included gastroenterologists recommended from Industry who perform optical endomicroscopy.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	2.00	10.50	<b>27.50</b>	43.00	300.00
<b>Survey RVW:</b>	1.50	3.66	<b>4.00</b>	4.65	10.00
<b>Pre-Service Evaluation Time:</b>			<b>30.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>10.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>8.00</b>		
<b>Intra-Service Time:</b>	15.00	20.00	<b>30.00</b>	43.00	60.00
<b>Immediate Post Service-Time:</b>	<b>20.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

**Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:** 1b-FAC Straightforw Pat Procedure(w sedate/anes)

<b>CPT Code:</b>	43252	<b>Recommended Physician Work RVU: 3.06</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>19.00</b>	<b>19.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>3.00</b>	<b>1.00</b>	<b>2.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>5.00</b>	<b>5.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>30.00</b>		
<b>Immediate Post Service-Time:</b>	<b>20.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		

<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? Yes

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
91110	XXX	3.64	RUC Time

CPT Descriptor Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
31622	000	2.78	RUC Time	83,622

CPT Descriptor 1 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
---------------------------------	---------------	-----------------	--------------------

CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 12      % of respondents: 46.1 %**

**TIME ESTIMATES (Median)**

	<b>CPT Code: 43252</b>	<b>Key Reference CPT Code: 91110</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	27.00	5.00	
Median Intra-Service Time	30.00	80.00	
Median Immediate Post-service Time	20.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>77.00</b>	<b>100.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.08	3.50
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.33	3.58
--	------	------

Urgency of medical decision making	4.17	3.25
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.22	3.33
--------------------------	------	------

Physical effort required	3.58	2.83
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.33	2.50
---	------	------

Outcome depends on the skill and judgment of physician	4.67	3.42
--	------	------

Estimated risk of malpractice suit with poor outcome	4.00	3.17
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.08	2.67
----------------------------------	------	------

Intra-Service intensity/complexity	4.25	3.42
------------------------------------	------	------

Post-Service intensity/complexity	3.75	2.83
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**

Several EGD codes were identified through CMS and RUC screens as potentially misvalued, including: MPC list screen; high expenditures screen; and fastest growing screen. The specialties agreed to survey the entire family of codes (43235-43259). In review of this family of codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In October 2012, the CPT Editorial Panel approved revised guidelines along with revision, addition, and deletion of codes within the EGD codeset.

### Overview of EGD Family RVW Recommendations

The specialty consensus panel spent a significant amount of time reviewing the survey data for the current set of EGD codes, comparing the data and values with the esophagoscopy codes (43200-43228) that were approved by the RUC at the October 2012 RUC meeting. The compelling arguments from the esophagoscopy review are the same as for the EGD codes, with the additional fact that the times for codes built on increments from the base code (43235) would require adjustment.

After reviewing the survey data, the consensus panel determined that for the EGD codeset, the incremental value above the base code for EGD (43235) should be similar where possible to the analogous incremental value above the esophagoscopy base code (43200) previously approved. For the existing codes, the RVW recommendations are based on the lower of the current value or the EGD base+increment from the esophagoscopy pair (ie, valuing the increment). Where there was no exact match for existing codes, the RVW recommendation is the lower of the current RVW or the 25<sup>th</sup> percentile RVW. For all new codes that bundle multiple codes and/or deleted codes, the RVW recommendation is based on endoscopy multiple procedure payment policy or surgical multiple procedure payment policy, as applicable. For this last set of codes, all but two recommendations are less than the survey 25<sup>th</sup> percentile. For the two exceptions, the recommendation is between the 25<sup>th</sup> and median survey RVW.

Code 43252 *Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy* is a new code for 2013. The AGA and ASGE conducted a RUC survey and received 26 responses; all from physicians with experience and no financial conflict.

**We recommend an RVW of 3.19.** This value is less than the survey 25<sup>th</sup> percentile and equal to the base EGD code (43235) plus the RVW increment (0.80) approved by the RUC in October 2012 for the comparable esophagoscopy code pair (43206/43200).

**Pre-time Package 1b** is appropriate for 43252, with an additional 2 minutes for positioning the patient, endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

### Comparison to Key Ref 91110

Key Reference code 91110 was surveyed and presented to the RUC in 2003 as a new code for 2004. Code 91110 requires more time than 43252 for lower intensity review of reports. This service is non-invasive and does not include moderate sedation.

### Comparison to EGD Base Code 43235

*Establishment of increments.* Harvard conducted an extensive review of the endoscopy families prior to the publication of the first PFS. The increments established between and within families were key to maintaining relativity. The consensus panel reviewing this family of codes believes the increment of 0.80 established for the esophagoscopy pair 43200/43206 by the RUC in October 2012 is correct for the similar EGD pair 43235/43252.

### Comparison To MPC and Other RUC-Reviewed Codes with 30 Minutes Intra-service Time

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2010	<b>12016</b>	Rpr fe/e/en/l/m 12.6-20.0 cm	2.68	0.077	47	8	2	1	<b>30</b>	6
MPC 2005	<b>31622</b>	Dx bronchoscope/wash	2.78	0.069	65	10	5	5	<b>30</b>	15
2011	<b>36200</b>	Place catheter in aorta	3.02	0.058	91	33	3	5	<b>30</b>	20
2012	<b>32557</b>	Insert cath pleura w/ image	3.12	0.079	67	13	3	6	<b>30</b>	15
	<b>43252</b>	<b>EGD, optical microscopy</b>	<b>3.06</b>	<b>0.074</b>	<b>77</b>	<b>19</b>	<b>3</b>	<b>5</b>	<b>30</b>	<b>20</b>
2010	<b>31296</b>	Sinus endo w/balloon dil	3.29	0.071	88	30	3	10	<b>30</b>	15
2007	<b>50386</b>	Remove stent via transureth	3.30	0.070	90	25	10	10	<b>30</b>	15
2012	<b>52214</b>	Cystoscopy and treatment	3.50	0.082	79	19	5	5	<b>30</b>	20
2012	<b>52224</b>	Cystoscopy and treatment	4.05	0.101	79	19	5	5	<b>30</b>	20

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43200 + 43499 unlisted procedure, esophagus

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology                      How often? Commonly

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 5200

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. 4,500 cases per year for the first year with an 8% year increase each year for the next 2 years.

Specialty Gastroenterology                      Frequency 5000                      Percentage 96.15 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 700

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 700 cases per year for the first year with an 8%/year increase each year for the next 2 years.

Specialty Gastroenterolog                      Frequency 680                      Percentage 97.14 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? No

---

### **Professional Liability Insurance Information (PLI)**

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43200

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43253	Tracking Number I20	Original Specialty Recommended RVU: <b>5.41</b>
		Presented Recommended RVU: <b>5.39</b>
Global Period: 000		RUC Recommended RVU: <b>5.39</b>

CPT Descriptor: Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance(s) (eg, anesthetic, neurolytic agent) or fiducial marker(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 68-year-old patient with chronic pancreatitis, weight loss, and recurrent abdominal pain requiring chronic pharmacologic pain management is referred for esophagogastroduodenoscopy with evaluation of the upper GI tract, endoscopic ultrasound evaluation, and injection of neurolytic agent into the celiac plexus under ultrasound guidance.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 63%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 29%

Description of Pre-Service Work: Review with the patient any symptoms including dysphagia and sleep apnea. The patient's history is reviewed to assess past problems with sedation and the need for and timing of pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's imaging studies and other diagnostic tests are reviewed. The pre-service review is documented. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained. The physician verifies all endoscopic and echoendoscopy imaging and image capture equipment is available, operational and appropriate imaging settings and computer entries are made, with special attention to the transducer balloon sheath. The pharmaceuticals / fiducial markers to be injected / inserted are reviewed. A time out is performed. The patient is positioned on the procedure table. The endoscopic, imaging and moderate sedation monitoring equipment is positioned to provide access for the procedure. Appropriate protective attire is applied and verification that all others in the suite are properly protected including the patient. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide when indicated, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat. A bite block is placed in the mouth.

**Description of Intra-Service Work:** The level of sedation is assessed prior to inserting the endoscope. A standard upper endoscope is inserted into the mouth and the oropharynx and advanced through the esophagus into the stomach. Residual fluid is removed from the stomach. The endoscope is advanced through the pylorus into the duodenal bulb, and then around the bulb apex to the second portion of the duodenum. Examination is conducted of the duodenum, the entire stomach including the gastric cardia in a retroflexed scope position, and the entire esophagus, noting the abnormal area(s) to be evaluated by echoendoscopy and location as well as any other abnormalities present. The standard upper endoscope is withdrawn; the linear-view echoendoscope is inserted into the mouth and the oropharynx and advanced through the esophagus into the stomach and to the duodenum or jejunum. Echoendoscopic evaluation is conducted of all abnormalities identified, correlating the endoscopic and ultrasonographic images. The locations of the findings are noted, as is the relationship of abnormalities to adjoining normal and abnormal structures including the GI tract wall as well as vascular and other structures of the mediastinum or abdomen / retroperitoneum. Multiple transducer frequencies are utilized as needed to fully visualize the area of interest. Doppler imaging of appropriate areas is completed when indicated including identification of vascular structures in the anticipated track of the biopsy needle. A determination of risk and benefit to the planned injection is performed. The needle aspiration (FNA) device is prepared by loading the pharmaceuticals or fiducial. The FNA needle is inserted into the endoscope. Under continuous endoscopic and ultrasound guidance the FNA needle tip is advanced intramurally or transmurally into the correct location, taking care to avoid vascular structures and using Doppler imaging as needed to identify such structures. The FNA needle is inserted into the area and the pharmaceutical or fiducial is injected / inserted, taking care during the injection / insertion to maintain correct needle position. The FNA needle is withdrawn, an additional pharmaceutical or fiducial is loaded, and the injection / insertion is repeated as appropriate. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. Supervision of the level of sedation and vital signs is performed during the procedure with additional measures taken to maintain an appropriate level of sedation, vital signs, airway and oxygenation as indicated. At the conclusion of the procedure, the endoscope is withdrawn.

**Description of Post-Service Work:** The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. The patient is assessed for physical signs and symptoms suggestive of complications, including abdominal pain, nausea/vomiting, respiratory distress, and bleeding. A focused abdominal exam is conducted to evaluate for evidence of pseudocyst leakage or bleeding, and for effective cyst decompression. Post procedure orders are completed and discussed with staff. Photographs are reviewed and labeled. Radiographic images are reviewed with the technologist for entry into the image storing system. Cytology and/or pathology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. A procedure report is generated and forwarded to the referral source and other appropriate parties. Data is entered into the procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others including a discussion regarding potential procedure complications and follow-up plans or further treatments, specifically including stent removal plans. Restrictions, prescriptions, follow-up tests, instructions and appointments are provided to the patient and pertinent others.



**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Bruce Cameron, MD (ACG), Joel Brill, MD (AGA), Shivan Mehta, MD (AGA), Nicholas Nickl, MD (ASGE)				
<b>Specialty(s):</b>	ACG, AGA, ASGE				
<b>CPT Code:</b>	43253				
<b>Sample Size:</b>	985	<b>Resp N:</b>	34	<b>Response:</b> 3.4 %	
<b>Description of Sample:</b>	The ACG, AGA and ASGE conducted an enhanced random sample as approved by the Research Subcommittee. The sampling methodology was a random sample of member gastroenterologists with the addition of ASGE Special Interest Group physicians identified as performers of EUS procedures and survey volunteers who responded to educational articles and identified themselves as EUS performers.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	2.00	8.00	15.00	60.00
<b>Survey RVW:</b>	2.50	4.44	5.77	7.38	12.50
<b>Pre-Service Evaluation Time:</b>			40.00		
<b>Pre-Service Positioning Time:</b>			10.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10.00		
<b>Intra-Service Time:</b>	15.00	30.00	40.00	60.00	135.00
<b>Immediate Post Service-Time:</b>	<b>23.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	43253	<b>Recommended Physician Work RVU: 5.39</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		33.00	33.00	0.00
<b>Pre-Service Positioning Time:</b>		3.00	1.00	2.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00
<b>Intra-Service Time:</b>		40.00		
<b>Immediate Post Service-Time:</b>	<b>23.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		

<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? Yes

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31631	000	4.36	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of tracheal stent(s) (includes tracheal/bronchial dilation as required)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 9      % of respondents: 26.4 %**

**TIME ESTIMATES (Median)**

	<u>CPT Code:</u> 43253	<u>Key Reference CPT Code:</u> 31631	<u>Source of Time</u> RUC Time
Median Pre-Service Time	41.00	45.00	
Median Intra-Service Time	40.00	45.00	
Median Immediate Post-service Time	23.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>104.00</b>	<b>120.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.67	3.78
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.78	3.89
Urgency of medical decision making	3.56	3.67

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.22	3.89
Physical effort required	3.67	3.67
<b><u>Psychological Stress (Mean)</u></b>		
The risk of significant complications, morbidity and/or mortality	4.22	3.89
Outcome depends on the skill and judgment of physician	4.33	4.33
Estimated risk of malpractice suit with poor outcome	3.78	3.78

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.11	3.78
Intra-Service intensity/complexity	3.56	3.89
Post-Service intensity/complexity	4.00	3.33

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**43253 – Discussion and Recommendation**

Code 43253 *Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance(s) (eg, anesthetic, neurolytic agent) or fiducial marker(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)* is a new code for 2013. A survey was conducted and 34 responses were received, with almost all respondents familiar with the procedure.

The expert panel noted that the work of 43253 is similar to but slightly greater than existing 43242 in that endoscopic ultrasound guidance is used to position a needle in a desired extraluminal location, but that 43253 includes injection or insertion of a substance or device while 43242 includes aspiration of a biopsy specimen. The panel felt that the work of these two codes should be comparable, but notes that the 25th percentile and median survey RVWs were, respectively, 4.44 and 5.77 while 43242 has a recommended value of 5.39. Noting that the FNA biopsy increments for code pairs 43231/43232, 43247/43238, and 43259/43242 are, respectively, 0.65, 0.67, and 0.65 the panel recommends adding the increment of 0.67 to the value of 43259 (4.74) to yield 5.41 RVU. The panel notes that the slightly higher increment of 0.67 is justified by the slightly higher intensity of injection/insertion compared to aspiration. **We recommend 5.39 RVU.**

#### Comparison to Key Ref 31631

Key Reference code 31631 was surveyed and presented to the RUC in 2004. The RUC agreed with the specialty presentation that the work had not changed and maintained the RVW and accepted the survey times. Code 31631 does not include the additional work/intensity of physician administered moderate sedation which has been included in the pre-service work at a low intensity for code 43253. The additional work of injecting a neurolytic agent into the celiac plexus results in increased intensity and complexity for 43253 compared with 31631.

#### 43253 Comparison To Other RUC-Reviewed Codes with 40-50 Minutes Intra-Service Time

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2011	<b>52315</b>	Cystoscopy and treatment	5.20	0.093	94	19	5	5	45	20
2011	<b>36246</b>	Ins cath abd/l-ext art 2nd	5.27	0.088	106	33	3	5	45	20
2001	<b>52402</b>	Cystourethro cut ejacul duct	5.27	0.085	95	30			50	15
2011	<b>36251</b>	Ins cath ren art 1st unilat	5.35	0.085	116	33	3	5	45	30
2008	<b>52341</b>	Cysto w/ureter stricture tx	5.35	0.079	135	45	10	15	45	20
	<b>43253</b>	EGD; fiducial marker inj w/ EUS	5.39	0.099	104	35	3	10	40	23
2012	<b>52235</b>	Cystoscopy and treatment	5.44	0.098	94	19	5	5	45	20
1994	<b>31267</b>	Endoscopy maxillary sinus	5.45	0.082	110	30			50	30
2012	<b>36222</b>	Place cath carotid/inom art	5.53	0.096	118	40	3	5	40	30
2010	<b>93455</b>	Coronary art/grft angio s&i	5.54	0.094	123	45	3	5	40	30
2012	<b>52351</b>	Cystouretero / pyeloscope	5.75	0.096	118	33	5	15	45	20
2010	<b>93458</b>	L hrt artery/ventricle angio	5.85	0.093	123	40	3	5	45	30

#### SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.

☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43242, 43259, 64680, 43499, 44799

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology                      How often? Rarely

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 4200

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. 64530 (celiac plexus block) Medicare 2011 data ~ 2,000 claims, of which 70% are for pancreatic / abdominal symptoms / pain. The expert panel estimates that 70% of 64530 will be replaced by 43253 ~ 1,400. Commercial: 1,400\*3 = 4,200

Specialty Gastroenterology                      Frequency 3900                      Percentage 92.85 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 349  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 43259 Medicare 2011 data ~ 34,919 claims, of which 1% will be reported by this new bundled code.

Specialty Gastroenterology                      Frequency 320                      Percentage 91.69 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? No

## Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 43242



**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43254      Tracking Number I21

Original Specialty Recommended RVU: **5.42**

Global Period: 000

Presented Recommended RVU: **5.42**RUC Recommended RVU: **5.25**

CPT Descriptor: Esophagogastroduodenoscopy, flexible, transoral; with endoscopic mucosal resection

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 65-year-old patient with abdominal discomfort unresponsive to pharmacological therapy is referred for evaluation. On esophagogastroduodenoscopy, evaluation of the upper GI tract reveals a sessile neoplastic appearing mass lesion in the body of the stomach. Endoscopic mucosal resection of the lesion is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 58%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 38%

Description of Pre-Service Work: Review with the patient any symptoms including dysphagia and sleep apnea. The patient's history is reviewed to assess past problems with sedation and the need for pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays and other diagnostic tests are reviewed. The pre-service review is documented. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained. The physician verifies all endoscopic equipment is available and operational and appropriate computer entries are made. The patient is positioned on the examination table. The endoscopic and moderate sedation monitoring equipment is positioned to provide access for the procedure. A time out is performed. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide when indicated, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat. A bite block is placed in the mouth.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible upper endoscope is inserted through the mouth into the oropharynx and advanced through the esophagus into the proximal stomach. The stomach is insufflated with air after suctioning liquid contents. Examination of the entire stomach in the forward and retroflexed positions is performed. The endoscope is advanced through the pylorus into the duodenal bulb. Circumferential inspection of the duodenum is performed after air insufflation. The endoscope is slowly withdrawn re-inspecting the stomach and duodenum. After suctioning air to deflate the stomach, the endoscope is withdrawn into the esophagus, allowing measurement of the squamocolumnar and gastro-esophageal junction from the incisors, assessment for presence of a hiatal hernia, and examination of the esophageal mucosa. The lesion to be resected is identified and

assessed. The endoscope may be withdrawn and a cap placed on the endoscope tip for cap assisted resection or a band ligation device is fitted on the endoscope tip. Cautery marks are then applied to the borders of the lesion. Submucosal injection assisted EMR of saline with epinephrine and dilute methylene blue is performed circumferentially at the base of the lesion. The lesion is resected with appropriate cutting devices inserted through the biopsy channel. If a cap assisted EMR technique is used, the lesion is suctioned into the cap and then resected using a cutting device inserted through the biopsy channel. If band ligation EMR technique is used, the target is suctioned into the cap and a band is deployed to capture the lesion. The lesion is then resected with appropriate cutting devices inserted through the biopsy channel. Hemostasis is accomplished with electrocautery, clips, or other devices as appropriate. Mucosal defects are closed with endoscopically placed clips. The lesion is retrieved with a retrieval device and placed in a specimen container. The endoscope is reinserted to the point of mucosal resection and the area is observed for bleeding and assessed for perforation. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. Supervision of the level of sedation and vital signs is performed during the procedure with additional measures taken to maintain an appropriate level of sedation, vital signs, airway and oxygenation as indicated. At the conclusion of the procedure, the endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. Post procedure orders are completed. Pathology forms are completed; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. Post procedure radiographic studies are ordered and reviewed. A procedure report is generated and forwarded to referral source and other appropriate parties. Data is entered into procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others. Necessary prescriptions, follow-up tests and appointments are provided to the patient.



**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	01/2013				
<b>Presenter(s):</b>	Joel V. Brill, MD (AGA), Nicholas Nickl, MD (ASGE), Edward S. Bentley, MD (ASGE)				
<b>Specialty(s):</b>	AGA, ASGE				
<b>CPT Code:</b>	43254				
<b>Sample Size:</b>	1455	<b>Resp N:</b>	43	<b>Response:</b> 2.9 %	
<b>Description of Sample:</b>	The AGA and ASGE received permission from the Research Subcommittee to administer surveys for the specialized and less frequently performed EGD and esophagoscopy procedures, including 4325X4 to an expert panel. The expert panel included physicians recommended from Industry and members of ASGE Special Interest Groups (SIG) who perform specific procedures (e.g. stent placement, ablation, etc.).				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	5.00	<b>10.00</b>	25.00	250.00
<b>Survey RVW:</b>	3.20	5.25	<b>6.90</b>	8.40	15.85
<b>Pre-Service Evaluation Time:</b>			<b>30.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>10.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>10.00</b>		
<b>Intra-Service Time:</b>	20.00	35.00	<b>45.00</b>	60.00	90.00
<b>Immediate Post Service-Time:</b>	<b>20.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	43254	<b>Recommended Physician Work RVU: 5.25</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>30.00</b>	<b>33.00</b>	<b>-3.00</b>
<b>Pre-Service Positioning Time:</b>		<b>3.00</b>	<b>1.00</b>	<b>2.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>5.00</b>	<b>5.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>45.00</b>		
<b>Immediate Post Service-Time:</b>	<b>20.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00

<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? Yes

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
58561	000	9.99	RUC Time

CPT Descriptor Hysteroscopy, surgical; with removal of leiomyomata**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31267	000	5.45	RUC Time

CPT Descriptor Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.****Number of respondents who choose Key Reference Code: 9      % of respondents: 20.9 %****TIME ESTIMATES (Median)**

	<b>CPT Code:</b> <b>43254</b>	<b>Key Reference CPT Code:</b> <b>58561</b>	<b>Source of Time</b> <b>RUC Time</b>
Median Pre-Service Time	38.00	45.00	
Median Intra-Service Time	45.00	75.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>103.00</b>	<b>150.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.56	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.44	4.00
Urgency of medical decision making	4.00	3.67

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.78	4.00
Physical effort required	4.56	4.11
<b><u>Psychological Stress (Mean)</u></b>		
The risk of significant complications, morbidity and/or mortality	4.78	4.11
Outcome depends on the skill and judgment of physician	4.56	4.11
Estimated risk of malpractice suit with poor outcome	4.44	4.11

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.33	4.22
Intra-Service intensity/complexity	4.78	4.44
Post-Service intensity/complexity	4.33	4.00

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**

Several EGD codes were identified through CMS and RUC screens as potentially misvalued, including: MPC list screen; high expenditures screen; and fastest growing screen. The specialties agreed to survey the entire family of codes (43235-43259). In review of this family of codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In October 2012, the CPT Editorial Panel approved revised guidelines along with revision, addition, and deletion of codes within the EGD codeset.

### Overview of EGD Family RVW Recommendations

The specialty consensus panel spent a significant amount of time reviewing the survey data for the current set of EGD codes, comparing the data and values with the esophagoscopy codes (43200-43228) that were approved by the RUC at the October 2012 RUC meeting. The compelling arguments from the esophagoscopy review are the same as for the EGD codes, with the additional fact that the times for codes built on increments from the base code (43235) would require adjustment.

After reviewing the survey data, the consensus panel determined that for the EGD codeset, the incremental value above the base code for EGD (43235) should be similar where possible to the analogous incremental value above the esophagoscopy base code (43200) previously approved. For the existing codes, the RVW recommendations are based on the lower of the current value or the EGD base+increment from the esophagoscopy pair (ie, valuing the increment). Where there was no exact match for existing codes, the RVW recommendation is the lower of the current RVW or the 25<sup>th</sup> percentile RVW. For all new codes that bundle multiple codes and/or deleted codes, the RVW recommendation is based on endoscopy multiple procedure payment policy or surgical multiple procedure payment policy, as applicable. For this last set of codes, all but two recommendations are less than the survey 25<sup>th</sup> percentile. For the two exceptions, the recommendation is between the 25<sup>th</sup> and median survey RVW.

Code 43254 Esophagogastroduodenoscopy, flexible, transoral; with endoscopic mucosal resection is a new code for 2014. The AGA and ASGE conducted a RUC survey and received 43 responses.

**We recommend an RVW of 5.41.** This value is between the survey 25<sup>th</sup> percentile and median and is based: 1) on payment policy for multiple endoscopy work; and 2) increments approved by the RUC for esophagoscopy codes at the October 2012 meeting.

Code 43254 includes the work of snaring, banding, and injection. This incremental work would be added to the base EGD code 43235. To develop the incremental work, we used the RVW increment approved for the esophagoscopy code pairs (total RVW increment = 3.02) plus the RVW for 43235 (2.39). This equals 5.41.

		Rec RVW	Base 43200	RVW increment
43217	Snare	2.90	1.59	1.31
43205	Band	3.00	1.59	1.41
43201	Inject	1.89	1.59	0.30
				<b>3.02</b>

**Pre-time Package 2b** is appropriate for 43254, with an additional 2 minutes for positioning the patient, endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation. In addition, the recommended evaluation time matches the survey median which is lower than the package time.

### Comparison to Key Ref 58561

Many different codes were chosen by survey respondents for this new service. Code 58561 was chosen most often. This code was surveyed and presented to the RUC in 1997. The RUC agreed with the specialty median RVW. Because of the significant difference in time and RVW, this is not a good comparator code.

### Comparison To Other RUC-Reviewed Codes with 45 Minutes Intra-Service Time

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2010	<b>12018</b>	Rpr f/e/n/l/m >30.0 cm	3.61	0.071	64	8	2	1	<b>45</b>	8
2009	<b>31626</b>	Bronchoscopy w/markers	4.16	0.074	85	19	1	5	<b>45</b>	15
2011	<b>52315</b>	Cystoscopy and treatment	5.20	0.093	94	19	5	5	<b>45</b>	20
	<b>43254</b>	<b>EGD, EMR</b>	<b>5.41</b>	<b>0.093</b>	<b>103</b>	<b>30</b>	<b>3</b>	<b>5</b>	<b>45</b>	<b>20</b>
2011	<b>36246</b>	Ins cath abd/l-ext art 2nd	5.27	0.088	106	33	3	5	<b>45</b>	20

2008	<b>52341</b>	Cysto w/ureter stricture tx	5.35	0.079	135	45	10	15	<b>45</b>	20
2011	<b>36251</b>	Ins cath ren art 1st unilat	5.35	0.085	116	33	3	5	<b>45</b>	30

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43251, 43236, 43244, and/or 43999

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 21000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Approximately 25% of 43251 (Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique) will be billed using 43254. Code 43251 Medicare 2011 volume is ~ 27,000. 25% of 27,000 is approximately 7,000 multiplied by 3 = ~21,000.

Specialty Gastroenterology Frequency 21000 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 443

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Approximately 1.5% of the services previously reported with base code 43251.

Specialty Gastroenterology Frequency 443 Percentage 100.00 %

Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %

Do many physicians perform this service across the United States? No

---

**Professional Liability Insurance Information (PLI)**

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 43251

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43255      Tracking Number I22      Original Specialty Recommended RVU: **4.20**  
 Presented Recommended RVU: **4.20**  
 Global Period: 000      RUC Recommended RVU: **4.20**

CPT Descriptor: Esophagogastroduodenoscopy, flexible, transoral; with control of bleeding, any method

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 67-year-old patient taking over-the-counter pharmacological therapy for arthritic symptoms presents with melena and hematemesis. Esophagogastroduodenoscopy of the upper GI tract is performed, revealing an ulcer in the duodenal bulb with an adherent clot and bleeding from the ulcer base. Control of bleeding is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 82%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 80%

Description of Pre-Service Work: Review with the patient any symptoms including dysphagia and sleep apnea. The patient's history is reviewed to assess past problems with sedation and the need for pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays and other diagnostic tests are reviewed. The pre-service review is documented. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained. The physician verifies all endoscopic equipment is available and operational and appropriate computer entries are made. The patient is positioned on the examination table. The endoscopic and moderate sedation monitoring equipment is positioned to provide access for the procedure. A time out is performed. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide when indicated, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat. A bite block is placed in the mouth.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible upper endoscope is inserted through the mouth into the oropharynx and advanced through the esophagus into the proximal stomach. The stomach is insufflated with air after suctioning liquid contents and blood. Examination of the entire stomach in the forward and retroflexed positions is performed. The endoscope is advanced through the pylorus into the duodenal bulb. Circumferential inspection of the duodenum is performed after air insufflation. The endoscope is slowly withdrawn re-inspecting the stomach and duodenum. The bleeding lesion is identified and assessed. A bipolar cautery probe is inserted through the endoscope and positioned on the bleeding lesion; therapy is applied to control the bleeding. When indicated, epinephrine is injected submucosally and/or endoclips are placed. Once the bleeding is controlled, the area is assessed and

observed for further bleeding. After suctioning air to deflate the stomach, the endoscope is withdrawn into the esophagus, allowing measurement of the squamocolumnar and gastro-esophageal junction from the incisors, assessment for presence of a hiatal hernia, and examination of the esophageal mucosa. When indicated, brushings or washings are obtained of suspicious abnormalities. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. Supervision of the level of sedation and vital signs is performed during the procedure with additional measures taken to maintain an appropriate level of sedation, vital signs, airway and oxygenation as indicated. At the conclusion of the procedure, the endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. Post procedure orders are completed. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to referral source and other appropriate parties. Data is entered into procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others. Necessary prescriptions, follow-up tests and appointments are provided to the patient.



**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	01/2013				
<b>Presenter(s):</b>	Joel V. Brill, MD (AGA), Nicholas Nickl, MD (ASGE), Edward S. Bentley, MD (ASGE), Don J. Selzer, MD (SAGES)				
<b>Specialty(s):</b>	AGA, ASGE, SAGES				
<b>CPT Code:</b>	43255				
<b>Sample Size:</b>	2928	<b>Resp N:</b>	82	<b>Response:</b> 2.8 %	
<b>Description of Sample:</b>	The AGA and ASGE conducted a random sample of member gastroenterologists as approved by the Research Subcommittee. The sampling methodology was a random sample with the addition of survey volunteers who responded to educational articles and identified themselves as performers of therapeutic endoscopic services. SAGES conducted a random sample of their members.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	15.00	<b>25.00</b>	50.00	125.00
<b>Survey RVW:</b>	2.25	4.20	<b>4.93</b>	5.82	15.00
<b>Pre-Service Evaluation Time:</b>			<b>33.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>5.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>9.00</b>		
<b>Intra-Service Time:</b>	15.00	25.00	<b>30.00</b>	40.00	70.00
<b>Immediate Post Service-Time:</b>	<b>20.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	43255	<b>Recommended Physician Work RVU: 4.20</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>33.00</b>	<b>33.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>3.00</b>	<b>1.00</b>	<b>2.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>5.00</b>	<b>5.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>30.00</b>		
<b>Immediate Post Service-Time:</b>	<b>20.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		

<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31638	000	4.88	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31631	000	4.36	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of tracheal stent(s) (includes tracheal/bronchial dilation as required)

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 15      % of respondents: 18.2 %**

**TIME ESTIMATES (Median)**

	<b>CPT Code: 43255</b>	<b>Key Reference CPT Code: 31638</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	41.00	50.00	
Median Intra-Service Time	30.00	60.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>91.00</b>	<b>140.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.24	3.77
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.13	3.82
--	------	------

Urgency of medical decision making	4.70	3.84
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.72	3.99
--------------------------	------	------

Physical effort required	4.27	3.70
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.59	3.94
---	------	------

Outcome depends on the skill and judgment of physician	4.61	4.01
--	------	------

Estimated risk of malpractice suit with poor outcome	4.32	3.77
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.24	3.74
----------------------------------	------	------

Intra-Service intensity/complexity	4.49	3.98
------------------------------------	------	------

Post-Service intensity/complexity	4.10	3.66
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**

Several EGD codes were identified through CMS and RUC screens as potentially misvalued, including: MPC list screen; high expenditures screen; and fastest growing screen. The specialties agreed to survey the entire family of codes (43235-43259). In review of this family of codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In October 2012, the CPT Editorial Panel approved revised guidelines along with revision, addition, and deletion of codes within the EGD codeset.

### Overview of EGD Family RVW Recommendations

The specialty consensus panel spent a significant amount of time reviewing the survey data for the current set of EGD codes, comparing the data and values with the esophagoscopy codes (43200-43228) that were approved by the RUC at the October 2012 RUC meeting. The compelling arguments from the esophagoscopy review are the same as for the EGD codes, with the additional fact that the times for codes built on increments from the base code (43235) would require adjustment.

After reviewing the survey data, the consensus panel determined that for the EGD codeset, the incremental value above the base code for EGD (43235) should be similar where possible to the analogous incremental value above the esophagoscopy base code (43200) previously approved. For the existing codes, the RVW recommendations are based on the lower of the current value or the EGD base+increment from the esophagoscopy pair (ie, valuing the increment). Where there was no exact match for existing codes, the RVW recommendation is the lower of the current RVW or the 25<sup>th</sup> percentile RVW. For all new codes that bundle multiple codes and/or deleted codes, the RVW recommendation is based on endoscopy multiple procedure payment policy or surgical multiple procedure payment policy, as applicable. For this last set of codes, all but two recommendations are less than the survey 25<sup>th</sup> percentile. For the two exceptions, the recommendation is between the 25<sup>th</sup> and median survey RVW.

Code 43255 *Esophagogastroduodenoscopy, flexible, transoral; with control of bleeding, any method* was identified as a family code through the MPC List screen. The 1992 RVW for 43255 was 4.64. This service was reviewed by the RUC twice. In 1993, the RUC reviewed 43255 as part of an overall review of the EGD family in relation to new codes that were created for 1994. In 1993, the RUC recommended maintaining the RVW for 43255. The RUC again reviewed 43255 in 2000 as part of the second 5YR and determined that complexity had increased because of technology and a new survey using a value the increment. The RUC recommended an increased RVW of 4.82. The AGA, ASGE, and SAGES conducted a RUC survey and received 82 responses.

The expert panel determined that direct application of the esophagoscopy code pair (43200/43227) to EGD work was not appropriate for 43255 because the presence of pooled blood and clot in the stomach requires additional work to achieve adequate gastroduodenal visualization which is not a factor in examination confined to the esophagus alone. We do not believe the work has changed, however, based on our consensus panel determination to recommend the lower of the current value or 25<sup>th</sup> percentile for existing codes, **we recommend the 25<sup>th</sup> percentile RVW of 4.20**. This value is below current RVW.

**Pre-time Package 2b** is appropriate for 43255 with an additional 2 minutes for positioning the patient, endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

### Comparison to Key Ref 31638

Key Reference code 31638 requires lower intensity fluoroscopic guidance which increases the intra-service time. The difference in RVW compared with 43255 accounts for longer total time, but at lower intensity.

### Comparison To Other RUC-Reviewed Codes with 30 Minutes Intra-Service Time

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2007	<b>20660</b>	Apply rem fixation device	4.00	0.093	90	20		10	<b>30</b>	30
2012	<b>52224</b>	Cystoscopy and treatment	4.05	0.101	79	19	5	5	<b>30</b>	20
2004	<b>32550</b>	Insert pleural cath	4.17	0.099	90	15	15	10	<b>30</b>	20
	<b>43255</b>	<b>EGD for bleeding control</b>	<b>4.20</b>	<b>0.097</b>	<b>91</b>	<b>33</b>	<b>3</b>	<b>5</b>	<b>30</b>	<b>20</b>
2012	<b>52234</b>	Cystoscopy and treatment	4.62	0.120	79	19	5	5	<b>30</b>	20
2011	<b>37191</b>	Ins endovas vena cava filtr	4.71	0.120	83	30	3	5	<b>30</b>	15
2010	<b>93452</b>	Left hrt cath w/ventriclgrphy	4.75	0.102	108	40	3	5	<b>30</b>	30
2010	<b>93454</b>	Coronary artery angio s&i	4.79	0.104	108	40	3	5	<b>30</b>	30

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43255

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology How often? Commonly

Specialty General Surgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 157500

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare data 2011 = 52500.  $(52500 \times 3) = \sim 157,500$

Specialty Gastroenterology Frequency 141750 Percentage 90.00 %

Specialty General Surgery Frequency 3150 Percentage 2.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

54,055 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare data 2011 = 54055

Specialty Gastroenterology Frequency 47250 Percentage 90.00 %

Specialty General Surgery Frequency 1050 Percentage 2.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

### **Professional Liability Insurance Information (PLI)**

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43255

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43266      Tracking Number I23

Original Specialty Recommended RVU: **4.34**Presented Recommended RVU: **4.34**

Global Period: 000

RUC Recommended RVU: **4.40**

CPT Descriptor: Esophagogastroduodenoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 70-year-old patient with progressive dysphagia and weight loss is found to have an obstructing, concentric mass lesion in the mid-esophagus that is not amenable to surgical resection. The patient is referred for esophagogastroduodenoscopy for evaluation of the upper GI tract, and placement of an esophageal stent.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 61%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 38%

Description of Pre-Service Work: Review with the patient any symptoms including dysphagia and sleep apnea. The patient's history is reviewed to assess past problems with sedation and the need for pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays and other diagnostic tests are reviewed. The pre-service review is documented. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained. The physician verifies all endoscopic equipment is available and operational and appropriate computer entries are made. The patient is positioned on the examination table. The endoscopic and moderate sedation monitoring equipment is positioned to provide access for the procedure. A time out is performed. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide when indicated, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat. A bite block is placed in the mouth.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible upper endoscope is inserted through the mouth into the oropharynx and advanced through the esophagus into the proximal stomach. The stomach is insufflated with air after suctioning liquid contents. Examination of the entire stomach in the forward and retroflexed positions is performed. The endoscope is advanced to an obstructing, concentric tumor which prohibits passage of the standard endoscope. The endoscope is withdrawn and a thin caliber flexible endoscope is inserted through the mouth into the esophagus. The endoscope is passed to the tumor. When necessary, a balloon dilating catheter is positioned through the tumor using endoscopic and fluoroscopic guidance and inflated to allow passage of the endoscope.

through the tumor, confirming its extent. The endoscope is withdrawn, allowing measurement of the tumor and marking the distal and proximal margins for stent placement. The endoscope is reinserted to 2 cm past the distal end of the tumor and a guidewire is inserted through the endoscope. Using fluoroscopic and endoscopic guidance, the expandable wire stent is advanced over the guidewire and positioned across the tumor. If necessary, contrast is inserted under fluoroscopic guidance to confirm positioning of the stent. Fluoroscopic imaging is obtained and spot digital images are taken. The stent is slowly deployed across the tumor under fluoroscopic guidance, with repositioning if necessary. Once the stent is placed, the guidewire and introducing device are withdrawn through the mouth and the thin caliber endoscope is reinserted through the mouth to confirm proper positioning of the stent. The thin caliber endoscope is withdrawn through the mouth and the standard caliber endoscope is reinserted through the mouth into the esophagus, confirming that the endoscope can be passed through the stented area without difficulty. Contrast is injected through the endoscope to assess placement and patency. As needed, deployment of balloon dilating catheter is utilized to expand the stent to sufficient lumen size. The area is observed to confirm absence of active bleeding. After suctioning air to deflate the stomach, the endoscope is withdrawn into the esophagus, allowing measurement of the squamocolumnar and gastro-esophageal junction from the incisors, assessment for presence of a hiatal hernia, and examination of the esophageal mucosa. When indicated, brushings or washings are obtained of suspicious abnormalities. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. Supervision of the level of sedation and vital signs is performed during the procedure with additional measures taken to maintain an appropriate level of sedation, vital signs, airway and oxygenation as indicated. At the conclusion of the procedure, the endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. Post procedure orders are completed. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to referral source and other appropriate parties. Data is entered into procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others. Necessary prescriptions, follow-up tests and appointments are provided to the patient.



**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	01/2013				
<b>Presenter(s):</b>	Joel V. Brill, MD (AGA), Nicholas Nickl, MD (ASGE), Edward S. Bentley, MD (ASGE)				
<b>Specialty(s):</b>	AGA, ASGE				
<b>CPT Code:</b>	43266				
<b>Sample Size:</b>	1455	<b>Resp N:</b>	51	<b>Response:</b> 3.5 %	
<b>Description of Sample:</b>	The AGA and ASGE received permission from the Research Subcommittee to administer surveys for the specialized and less frequently performed EGD and esophagoscopy procedures, including 4326X8 to an expert panel. The expert panel included physicians recommended from Industry and members of ASGE Special Interest Groups (SIG) who perform specific procedures (e.g. stent placement, ablation, etc.).				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	4.00	6.00	14.00	75.00
<b>Survey RVW:</b>	2.60	4.40	5.20	6.25	11.20
<b>Pre-Service Evaluation Time:</b>			35.00		
<b>Pre-Service Positioning Time:</b>			10.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10.00		
<b>Intra-Service Time:</b>	20.00	30.00	40.00	45.00	75.00
<b>Immediate Post Service-Time:</b>	<u>20.00</u>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	43266	<b>Recommended Physician Work RVU: 4.40</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		33.00	33.00	0.00
<b>Pre-Service Positioning Time:</b>		3.00	1.00	2.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00
<b>Intra-Service Time:</b>		40.00		
<b>Immediate Post Service-Time:</b>	<u>20.00</u>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		

<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31631	000	4.36	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of tracheal stent(s) (includes tracheal/bronchial dilation as required)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
31628	000	3.80	RUC Time	39,047

CPT Descriptor 1 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31638	000	4.88	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required)

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code:** 24      **% of respondents:** 47.0 %

**TIME ESTIMATES (Median)**

	<b>CPT Code:</b> 43266	<b>Key Reference CPT Code:</b> 31631	<b>Source of Time</b> RUC Time
Median Pre-Service Time	41.00	45.00	
Median Intra-Service Time	40.00	45.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>101.00</b>	<b>120.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.04	4.00
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.08	3.96
--	------	------

Urgency of medical decision making	4.04	3.92
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.63	4.25
--------------------------	------	------

Physical effort required	4.04	3.88
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.42	4.25
---	------	------

Outcome depends on the skill and judgment of physician	4.58	4.29
--	------	------

Estimated risk of malpractice suit with poor outcome	4.00	3.92
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.88	3.75
----------------------------------	------	------

Intra-Service intensity/complexity	4.38	4.21
------------------------------------	------	------

Post-Service intensity/complexity	4.83	3.71
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

## Background

Several EGD codes were identified through CMS and RUC screens as potentially misvalued, including: MPC list screen; high expenditures screen; and fastest growing screen. The specialties agreed to survey the entire family of codes (43235-43259). In review of this family of codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In October 2012, the CPT Editorial Panel approved revised guidelines along with revision, addition, and deletion of codes within the EGD codeset.

## Overview of EGD Family RVW Recommendations

The specialty consensus panel spent a significant amount of time reviewing the survey data for the current set of EGD codes, comparing the data and values with the esophagoscopy codes (43200-43228) that were approved by the RUC at the October 2012 RUC meeting. The compelling arguments from the esophagoscopy review are the same as for the EGD codes, with the additional fact that the times for codes built on increments from the base code (43235) would require adjustment.

After reviewing the survey data, the consensus panel determined that for the EGD codeset, the incremental value above the base code for EGD (43235) should be similar where possible to the analogous incremental value above the esophagoscopy base code (43200) previously approved. For the existing codes, the RVW recommendations are based on the lower of the current value or the EGD base+increment from the esophagoscopy pair (ie, valuing the increment). Where there was no exact match for existing codes, the RVW recommendation is the lower of the current RVW or the 25<sup>th</sup> percentile RVW. For all new codes that bundle multiple codes and/or deleted codes, the RVW recommendation is based on endoscopy multiple procedure payment policy or surgical multiple procedure payment policy, as applicable. For this last set of codes, all but two recommendations are less than the survey 25<sup>th</sup> percentile. For the two exceptions, the recommendation is between the 25<sup>th</sup> and median survey RVW.

Code 43266 *Esophagogastroduodenoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)* is a new/revised code for 2014 that adds "post-dilation and passage of guidewire" to the CPT descriptor of to-be-deleted code 43256 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic stent placement (includes predilation)*. The AGA and ASGE conducted a RUC survey and received 51 responses.

**We recommend an RVW of 4.34.** This is less than the 25<sup>th</sup> percentile and is the current RVW for to-be-deleted code 43256. This recommendation is conservative in that it does not include the additional work related to post-dilation and passage of guidewire.

**Pre-time Package 2b** is appropriate for 43266, with an additional 2 minutes for positioning the patient, endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

## Comparison to Key Ref 31631

Key Reference code 31631 was surveyed and presented to the RUC in 2004. The RUC agreed with the specialty presentation that the work had not changed and maintained the RVW and accepted the survey times. Code 31631 does not include the additional work/intensity of physician administered moderate sedation. Code 31631, which is also an endoscopic stent placement code compares well with the recommendation for 43266.

## Comparison To MPC Other RUC-Reviewed Codes with ~40 Minutes Intra-Service Time

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
MPC 2003	<b>31628</b>	Bronchoscopy/lung bx each	3.80	0.071	90	10	10	10	<b>40</b>	20
2009	<b>49411</b>	Ins mark abd/pel for rt perq	3.82	0.072	85	19	1	5	<b>40</b>	20
	<b>43266</b>	<b>EGD, stent w-p/p dilation</b>	<b>4.40</b>	<b>0.076</b>	<b>101</b>	<b>33</b>	<b>3</b>	<b>5</b>	<b>40</b>	<b>20</b>
1995	<b>93505</b>	Biopsy of heart lining	4.37	0.084	100	27		15	<b>38</b>	20
1997	<b>58558</b>	Hysteroscopy biopsy	4.74	0.091	90	30			<b>40</b>	20
2012	<b>36222</b>	Place cath carotid/inom art	5.53	0.096	118	40	3	5	<b>40</b>	30
2010	<b>93455</b>	Coronary art/grft angio s&i	5.54	0.094	123	45	3	5	<b>40</b>	30

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43256

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 12000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2011 volume for 43256 (Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic stent placement (includes predilation)) multiplied by 3 ( $4,000 \times 3$ ) = ~12,000, which will be deleted from CPT and replaced by 43266

Specialty Gastroenterology Frequency 9500 Percentage 79.16 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3,958

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2011 volume for 43256 = 3958

Specialty Gastroenterology Frequency 3200 Percentage 80.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

---

**Professional Liability Insurance Information (PLI)**

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 43256

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43257      Tracking Number    I24

Original Specialty Recommended RVU: **4.25**Presented Recommended RVU: **4.25**

Global Period: 000

RUC Recommended RVU: **4.25**

CPT Descriptor: Esophagogastroduodenoscopy, flexible, transoral; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 66-year-old patient has over 6 months of dyspepsia, heartburn and regurgitation symptoms occurring three times or more per week that has not responded to lifestyle management strategies and intensive daily pharmacologic therapy. Diagnostic workup includes esophageal motility and pH studies. The patient is referred for esophagogastroduodenoscopy with evaluation of the upper GI tract, followed by delivery of thermal energy to the lower esophageal sphincter for management of the patient's reflux symptoms.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 61%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 50%

Description of Pre-Service Work: Review with the patient any symptoms including dysphagia and sleep apnea. The patient's history is reviewed to assess past problems with sedation and the need for pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays and other diagnostic tests are reviewed. The pre-service review is documented. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained. The physician verifies all endoscopic equipment is available and operational and appropriate computer entries are made. The patient is positioned on the examination table. The endoscopic and moderate sedation monitoring equipment is positioned to provide access for the procedure. A time out is performed. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide when indicated, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat. A bite block is placed in the mouth.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible upper endoscope is inserted through the mouth into the oropharynx and advanced through the esophagus into the proximal stomach. The stomach is insufflated with air after suctioning liquid contents. Examination of the entire stomach in the forward and retroflexed positions is performed. The endoscope is advanced through the pylorus into the duodenal bulb. Circumferential inspection of the duodenum is performed after air insufflation. The endoscope is slowly withdrawn re-

inspecting the stomach and duodenum. The upper endoscope is then positioned in the gastric antrum, and a guide-wire is passed through the endoscope into the duodenum or gastric antrum. The endoscope is withdrawn while noting the distance from the incisors to the gastroesophageal junction. The thermal catheter is passed over the guide-wire and positioned 1 cm proximal to the squamocolumnar junction. The thermal catheter balloon is inflated to 2.5 psi, needle electrodes (4) deployed, and RF energy delivery commenced. This treatment is repeated after rotating the catheter 45 degrees and then again by advancing it 5 mm (4 treatments thus far). The catheter is then advanced into the stomach. An endoscope is re-introduced per-oral and passed alongside the catheter to confirm accurate positioning of the first 2 rings. The endoscope is then withdrawn. Third and fourth rings, comprised of eight lesions per ring, are then placed in 5 mm increments distal to the second ring, adjusting the measurements according to the endoscopic findings. The catheter is then advanced into the stomach, fully inflated to 25 cc of air, and withdrawn into the gastric cardia. Three such deployments and lesion sets are created, totaling 12 lesions in the distal cardia. This is repeated with a balloon inflated to 22cc, creating 12 lesions in the proximal cardia. A third EGD is performed to confirm lesion placement. The catheter is then withdrawn. After suctioning air to deflate the stomach, the endoscope is withdrawn into the esophagus, allowing measurement of the squamocolumnar and gastro-esophageal junction from the incisors, assessment for presence of a hiatal hernia, and examination of the esophageal mucosa. When indicated, brushings or washings are obtained of suspicious abnormalities. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. Supervision of the level of sedation and vital signs is performed during the procedure with additional measures taken to maintain an appropriate level of sedation, vital signs, airway and oxygenation as indicated. At the conclusion of the procedure, the endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. Post procedure orders are completed. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to referral source and other appropriate parties. Data is entered into procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others. Necessary prescriptions, follow-up tests and appointments are provided to the patient.



**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	01/2013				
<b>Presenter(s):</b>	Joel V. Brill, MD (AGA), Nicholas Nickl, MD (ASGE), Edward S. Bentley, MD (ASGE)				
<b>Specialty(s):</b>	AGA, ASGE				
<b>CPT Code:</b>	43257				
<b>Sample Size:</b>	1720	<b>Resp N:</b>	25	<b>Response:</b> 1.4 %	
<b>Description of Sample:</b>	The AGA and ASGE received permission from the Research Subcommittee to administer surveys for the specialized and less frequently performed EGD and esophagoscopy procedures, including 4320X5 to an expert panel. The expert panel included physicians recommended from Industry and members of ASGE Special Interest Groups (SIG) who perform specific procedures (e.g. stent placement, ablation, etc.).				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	0.00	<b>0.00</b>	2.00	300.00
<b>Survey RVW:</b>	2.65	4.25	<b>5.10</b>	6.54	8.50
<b>Pre-Service Evaluation Time:</b>			<b>45.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>10.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>10.00</b>		
<b>Intra-Service Time:</b>	25.00	35.00	<b>45.00</b>	45.00	75.00
<b>Immediate Post Service-Time:</b>	<b>15.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	43257	<b>Recommended Physician Work RVU: 4.25</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>33.00</b>	<b>33.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>3.00</b>	<b>1.00</b>	<b>2.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>5.00</b>	<b>5.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>45.00</b>		
<b>Immediate Post Service-Time:</b>	<b>15.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00

<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31631	000	4.36	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of tracheal stent(s) (includes tracheal/bronchial dilation as required)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
11044	000	4.10	RUC Time	53,852
<u>CPT Descriptor 1</u> Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
15004	000	4.58	RUC Time	19,876

CPT Descriptor 2 Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
52342	000	5.85	RUC Time

CPT Descriptor Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 7      % of respondents: 28.0 %**

**TIME ESTIMATES (Median)**

	<u>CPT Code:</u> 43257	<u>Key Reference CPT Code:</u> 31631	<u>Source of Time</u> RUC Time
Median Pre-Service Time	41.00	45.00	
Median Intra-Service Time	45.00	45.00	
Median Immediate Post-service Time	15.00	30.00	
Median Critical Care Time	0.0	0.00	

Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>101.00</b>	<b>120.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.86	3.86
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.86	3.71
Urgency of medical decision making	3.00	4.00

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.00	4.14
Physical effort required	3.57	3.71

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.14	4.14
Outcome depends on the skill and judgment of physician	3.71	4.29
Estimated risk of malpractice suit with poor outcome	4.00	3.86

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.86	3.86
Intra-Service intensity/complexity	4.29	4.14
Post-Service intensity/complexity	3.43	3.43

---

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

### Background

Several EGD codes were identified through CMS and RUC screens as potentially misvalued, including: MPC list screen; high expenditures screen; and fastest growing screen. The specialties agreed to survey the entire family of codes (43235-43259). In review of this family of codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In October 2012, the CPT Editorial Panel approved revised guidelines along with revision, addition, and deletion of codes within the EGD codeset.

### Overview of EGD Family RVW Recommendations

The specialty consensus panel spent a significant amount of time reviewing the survey data for the current set of EGD codes, comparing the data and values with the esophagoscopy codes (43200-43228) that were approved by the RUC at the October 2012 RUC meeting. The compelling arguments from the esophagoscopy review are the same as for the EGD codes, with the additional fact that the times for codes built on increments from the base code (43235) would require adjustment.

After reviewing the survey data, the consensus panel determined that for the EGD codeset, the incremental value above the base code for EGD (43235) should be similar where possible to the analogous incremental value above the esophagoscopy base code (43200) previously approved. For the existing codes, the RVW recommendations are based on the lower of the current value or the EGD base+increment from the esophagoscopy pair (ie, valuing the increment). Where there was no exact match for existing codes, the RVW recommendation is the lower of the current RVW or the 25<sup>th</sup> percentile RVW. For all new codes that bundle multiple codes and/or deleted codes, the RVW recommendation is based on endoscopy multiple procedure payment policy or surgical multiple procedure payment policy, as applicable. For this last set of codes, all but two recommendations are less than the survey 25<sup>th</sup> percentile. For the two exceptions, the recommendation is between the 25<sup>th</sup> and median survey RVW.

Code 43257 *Esophagogastroduodenoscopy, flexible, transoral; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease* was identified as a family code through the MPC List screen. This code was surveyed in 2003 as a new CPT code for 2005. The RUC compared this new code to 43262 (ERCP) and recommended the survey 25<sup>th</sup> percentile. The AGA and ASGE conducted a RUC survey and received 25 responses. This is a very low volume code.

There is no direct esophagoscopy code pair increment that would apply to 43257. We do not believe the work has changed for this service, however, based on our consensus panel determination to recommend the lower of the current value or 25<sup>th</sup> percentile for existing codes, **we recommend the 25<sup>th</sup> percentile RVW of 4.25.**

**Pre-time Package 2b** is appropriate for 43257, with an additional 2 minutes for positioning the patient, endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

### Comparison to Key Ref 31631

Key Reference code 31631 was surveyed and presented to the RUC in 2004. The RUC agreed with the specialty presentation that the work had not changed and maintained the RVW and accepted the survey times. Code 31631 does not include the additional work/intensity of physician administered moderate sedation.

### Comparison To MPC and Other RUC-Reviewed Codes with 45 Minutes Intra-Service Time

	CPT	DESC	RVW	IWP/UT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
MPC 2010	<b>11044</b>	Deb bone 20 sq cm/<	4.10	0.061	116	33	3	15	<b>45</b>	20
2009	<b>31626</b>	Bronchoscopy w/markers	4.16	0.074	85	19	1	5	<b>45</b>	15
2012	<b>31648</b>	Bronchial valve addl insert	4.20	0.068	100	19	1	5	<b>45</b>	30
	<b>43257</b>	EGD, thermal energy for GERD	<b>4.25</b>	<b>0.068</b>	<b>101</b>	<b>33</b>	<b>3</b>	<b>5</b>	<b>45</b>	<b>15</b>

MPC 2006	<b>15004</b>	Wound prep f/n/hf/g	4.58	0.054	150	45	15	15	<b>45</b>	30
2011	<b>36246</b>	Ins cath abd/l-ext art 2nd	5.27	0.088	106	33	3	5	<b>45</b>	20
2008	<b>52341</b>	Cysto w/ureter stricture tx	5.35	0.079	135	45	10	15	<b>45</b>	20

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43257

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 255

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare data 2011 = 85.  $(85 \times 3) = \sim 225$

Specialty Gastroenterology Frequency 171 Percentage 67.05 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 89 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare data 2011 = 89

Specialty Gastroenterology Frequency 57 Percentage 67.05 %

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? No

---

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43257

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

## AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 43270	Tracking Number I25	Original Specialty Recommended RVU: <b>5.05</b>
		Presented Recommended RVU: <b>5.05</b>
Global Period: 000		RUC Recommended RVU: <b>4.39</b>

CPT Descriptor: Esophagogastroduodenoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)

### CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 74-year-old patient with reflux symptoms and dyspepsia unresponsive to pharmacological therapy is found to have Barrett's esophagus with dysplasia. The patient undergoes esophagogastroduodenoscopy for evaluation of the upper GI tract, and thermal ablation of the dysplastic tissue.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

### Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

### Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 62%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 33%

Description of Pre-Service Work: Review with the patient any symptoms including dysphagia and sleep apnea. The patient's history is reviewed to assess past problems with sedation and the need for pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays and other diagnostic tests are reviewed. The pre-service review is documented. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained. The physician verifies all endoscopic equipment is available and operational and appropriate computer entries are made. The patient is positioned on the examination table. The endoscopic and moderate sedation monitoring equipment is positioned to provide access for the procedure. A time out is performed. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide when indicated, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat. A bite block is placed in the mouth.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible upper endoscope is inserted through the mouth into the oropharynx and advanced through the esophagus into the proximal stomach. The stomach is insufflated with air after suctioning liquid contents. Examination of the entire stomach in the forward and retroflexed positions is performed. The endoscope is advanced through the pylorus into the duodenal bulb. Circumferential inspection of the duodenum is performed after air insufflation. The endoscope is slowly withdrawn re-inspecting the stomach and duodenum. After suctioning air to deflate the stomach, the endoscope is withdrawn into the esophagus, allowing measurement of the squamocolumnar and gastro-esophageal junction from the incisors, assessment

for presence of a hiatal hernia, and examination of the esophageal mucosa. When indicated, brushings or washings are obtained of suspicious abnormalities. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. Abnormal tissue in the esophagus is identified, which has previously been confirmed as consistent with Barrett's esophagus, high grade dysplasia. Under endoscopic visualization, a guidewire is passed through the endoscope beyond the gastroesophageal junction, and the endoscope is withdrawn. The endoscope is reinserted through the mouth into the distal esophagus, and a sizing balloon catheter is placed through the endoscope into the esophagus to straddle the region of abnormality to be ablated. The sizing balloon is inflated to ascertain the luminal diameter to be treated. The sizing balloon is removed and an ablation catheter of appropriate caliber is passed over the guidewire into the esophagus. The level of sedation of the patient is reassessed and additional medication is administered as needed. The endoscope is withdrawn into the mid-esophagus and radiofrequency ablation of the lesion proceeds under direct visualization. The catheter is deflated and the endoscope is advanced to inspect the esophageal mucosa for extent of coagulation effect. The ablation process is repeated. If inadequately treated regions remain, the endoscope is removed. A cap device with spot ablation capability is fitted on the tip of the endoscope. The endoscope is passed through the mouth into the esophagus to the level of lesion to be treated, and further ablation applied under direct visualization. At the conclusion of the ablation procedure, the area is observed for bleeding. Supervision of the level of sedation and vital signs is performed during the procedure with additional measures taken to maintain an appropriate level of sedation, vital signs, airway and oxygenation as indicated. At the conclusion of the procedure, the endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. Post procedure orders are completed. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to referral source and other appropriate parties. Data is entered into procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others. Necessary prescriptions, follow-up tests and appointments are provided to the patient.



**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		01/2013			
<b>Presenter(s):</b>	Joel V. Brill, MD (AGA), Nicholas Nickl, MD (ASGE), Edward S. Bentley, MD (ASGE)				
<b>Specialty(s):</b>	AGA, ASGE				
<b>CPT Code:</b>	43270				
<b>Sample Size:</b>	1721	<b>Resp N:</b>	49	<b>Response:</b> 2.8 %	
<b>Description of Sample:</b>	The AGA and ASGE received permission from the Research Subcommittee to administer surveys for the specialized and less frequently performed EGD and esophagoscopy procedures, including 4326X9 to an expert panel. The expert panel included physicians recommended from Industry and members of ASGE Special Interest Groups (SIG) who perform specific procedures (e.g. stent placement, ablation, etc.).				
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>
<b>Service Performance Rate</b>		0.00	5.00	10.00	25.00
<b>Survey RVW:</b>		3.10	4.39	5.75	6.49
<b>Pre-Service Evaluation Time:</b>				35.00	
<b>Pre-Service Positioning Time:</b>				10.00	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				10.00	
<b>Intra-Service Time:</b>		20.00	40.00	45.00	50.00
<b>Immediate Post Service-Time:</b>	<b>15.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	43270	Recommended Physician Work RVU: 4.39				
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time		
Pre-Service Evaluation Time:		33.00	33.00	0.00		
Pre-Service Positioning Time:		3.00	1.00	2.00		
Pre-Service Scrub, Dress, Wait Time:		5.00	5.00	0.00		
Intra-Service Time:		45.00				
Immediate Post Service-Time:	15.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00		
Discharge Day Mgmt:	0.00	99238x 0.0	99239x 0.0	99217x 0.00		
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00	15x 0.00

<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
52342	000	5.85	RUC Time

CPT Descriptor Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31631	000	4.36	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of tracheal stent(s) (includes tracheal/bronchial dilation as required)

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code:** 16      **% of respondents:** 32.6 %

**TIME ESTIMATES (Median)**

	<b>CPT Code:</b> 43270	<b>Key Reference CPT Code:</b> 52342	<b>Source of Time</b> RUC Time
Median Pre-Service Time	41.00	60.00	
Median Intra-Service Time	45.00	60.00	
Median Immediate Post-service Time	15.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>101.00</b>	<b>140.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.19	4.13
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.25	4.06
--	------	------

Urgency of medical decision making	3.81	3.88
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.44	4.31
--------------------------	------	------

Physical effort required	4.06	3.94
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.31	4.19
---	------	------

Outcome depends on the skill and judgment of physician	4.56	4.25
--	------	------

Estimated risk of malpractice suit with poor outcome	4.19	3.94
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.19	3.88
----------------------------------	------	------

Intra-Service intensity/complexity	4.44	4.13
------------------------------------	------	------

Post-Service intensity/complexity	4.06	3.88
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**

Several EGD codes were identified through CMS and RUC screens as potentially misvalued, including: MPC list screen; high expenditures screen; and fastest growing screen. The specialties agreed to survey the entire family of codes (43235-43259). In review of this family of codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In October 2012, the CPT Editorial Panel approved revised guidelines along with revision, addition, and deletion of codes within the EGD code set.

### Overview of EGD Family RVW Recommendations

The specialty consensus panel spent a significant amount of time reviewing the survey data for the current set of EGD codes, comparing the data and values with the esophagoscopy codes (43200-43228) that were approved by the RUC at the October 2012 RUC meeting. The compelling arguments from the esophagoscopy review are the same as for the EGD codes, with the additional fact that the times for codes built on increments from the base code (43235) would require adjustment.

After reviewing the survey data, the consensus panel determined that for the EGD codeset, the incremental value above the base code for EGD (43235) should be similar where possible to the analogous incremental value above the esophagoscopy base code (43200) previously approved. For the existing codes, the RVW recommendations are based on the lower of the current value or the EGD base+increment from the esophagoscopy pair (ie, valuing the increment). Where there was no exact match for existing codes, the RVW recommendation is the lower of the current RVW or the 25<sup>th</sup> percentile RVW. For all new codes that bundle multiple codes and/or deleted codes, the RVW recommendation is based on endoscopy multiple procedure payment policy or surgical multiple procedure payment policy, as applicable. For this last set of codes, all but two recommendations are less than the survey 25<sup>th</sup> percentile. For the two exceptions, the recommendation is between the 25<sup>th</sup> and median survey RVW.

Code 43270 *Esophagogastroduodenoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)* is a new/revised code for 2014 that adds dilation and passage of guidewire to the work of to-be-deleted code 43258 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique*. The AGA and ASGE conducted a RUC survey and received 49 responses.

**We recommend an RVW of 5.05.** This value is between the survey 25<sup>th</sup> percentile and median and is based: 1) on payment policy for multiple endoscopy work; and 2) increments approved by the RUC for esophagoscopy codes at the October 2012 meeting.

Code 43270 includes the work of balloon dilation and ablation. To develop the incremental work, we used the RVW increment approved for the esophagoscopy code pair 43200/43220 (0.51) plus the RVW for 43258 (4.54). This equals 5.05. The RVW of 5.05 ranks 43270 correctly with other EGD services.

**Pre-time Package 2b** is appropriate for 43270, with an additional 2 minutes for positioning the patient, endoscopy equipment/monitor, and anesthesia lines/equipment prior to induction of moderate sedation.

### Comparison to Key Ref 52342

Many different codes were chosen by survey respondents for this new service. Code 52342 was chosen most often. This code was surveyed and presented to the RUC in 2010. Because of the difference in time and RVW, this is not a good comparator code.

### Comparison To Other RUC-Reviewed Codes with 45 Minutes Intra-Service Time

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2010	<b>12018</b>	Rpr f/e/n/l/m >30.0 cm	3.61	0.071	64	8	2	1	<b>45</b>	8
2009	<b>31626</b>	Bronchoscopy w/markers	4.16	0.074	85	19	1	5	<b>45</b>	15
	<b>43270</b>	EGD; ablation lesion w-pre/post dilation	<b>4.39</b>	<b>0.086</b>	<b>101</b>	<b>33</b>	<b>3</b>	<b>5</b>	<b>45</b>	<b>15</b>
2011	<b>52315</b>	Cystoscopy and treatment	5.20	0.093	94	19	5	5	<b>45</b>	20
2011	<b>36246</b>	Ins cath abd/l-ext art 2nd	5.27	0.088	106	33	3	5	<b>45</b>	20
2011	<b>36251</b>	Ins cath ren art 1st unilat	5.35	0.085	116	33	3	5	<b>45</b>	30

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43258

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology                      How often? Sometimes

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 51000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2011 volume for 43258 (Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique) multiplied by 3 (17,000\*3) = ~51,000, which will be deleted from CPT and replaced by 43270

Specialty Gastroenterology                      Frequency 46000                      Percentage 90.19 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 16,695 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2011 volume for 43258 = 16695

Specialty Gastroenterology                      Frequency 15500                      Percentage 91.17 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? No

---

### **Professional Liability Insurance Information (PLI)**

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 43258

## AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 43259	Tracking Number I27	Original Specialty Recommended RVU: <b>4.74</b>
		Presented Recommended RVU: <b>4.74</b>
Global Period: 000		RUC Recommended RVU: <b>4.74</b>

CPT Descriptor: Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)

### CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 71-year-old patient with abdominal and back discomfort and weight loss develops painless jaundice. Imaging studies reveal dilation of the pancreatic and bile ducts; a discrete mass lesion is not identified. The patient is referred for esophagogastroduodenoscopy with evaluation of the upper GI tract, with endoscopic ultrasound to identify if a mass lesion is present and, if so, to then stage the tumor and determine operability.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

#### Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

#### Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 68%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 56%

Description of Pre-Service Work: Review with the patient any symptoms including dysphagia and sleep apnea. The patient's history is reviewed to assess past problems with sedation and the need for and timing of pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's imaging studies and other diagnostic tests are reviewed. The pre-service review is documented. The risks and benefits of the procedure and moderate sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained. The physician verifies all endoscopic and echoendoscopy imaging and image capture equipment is available, operational and appropriate imaging settings and computer entries are made, with special attention to the transducer balloon sheath. A time out is performed. The patient is positioned on the procedure table. The endoscopic, imaging and moderate sedation monitoring equipment is positioned to provide access for the procedure. Appropriate protective attire is applied and verification that all others in the suite are properly protected including the patient. Intravenous access is started and moderate sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide when indicated, and sequential non-invasive blood pressure measurements. Topical anesthesia is applied to the throat. A bite block is placed in the mouth.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard upper endoscope is inserted into the mouth and the oropharynx and advanced through the esophagus into the stomach. Residual

fluid is removed from the stomach. The endoscope is advanced through the pylorus into the duodenal bulb, and then around the bulb apex to the second portion of the duodenum. Examination is conducted of the duodenum, the entire stomach including the gastric cardia in a retroflexed scope position, and the entire esophagus, noting the abnormal area(s) to be evaluated by echoendoscopy and location as well as any other abnormalities present. The standard upper endoscope is withdrawn; the radial-view or linear-view echoendoscope is inserted into the mouth and the oropharynx and advanced through the esophagus into the stomach and to the duodenum or jejunum. Echoendoscopic evaluation is conducted of all abnormalities identified, correlating the endoscopic and ultrasonographic images. The locations of the findings are noted, as is the relationship of abnormalities to adjoining normal and abnormal structures including the GI tract wall as well as vascular and other structures of the mediastinum or abdomen/retroperitoneum. Multiple transducer frequencies are utilized as needed to fully visualize the area of interest. Doppler imaging of appropriate areas is completed when indicated. A determination of risk and benefit to sample (e.g. biopsy) the lesion is performed. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. Supervision of the level of sedation and vital signs is performed during the procedure with additional measures taken to maintain an appropriate level of sedation, vital signs, airway and oxygenation as indicated. At the conclusion of the procedure, the endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. The patient is assessed for physical signs and symptoms suggestive of complications, including abdominal pain, nausea/vomiting, respiratory distress, and bleeding. Post procedure orders are completed and discussed with staff. Photographs are reviewed and labeled. Radiographic images are reviewed with the technologist for entry into the image storing system. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to the referral source and other appropriate parties. Data is entered into the procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others including a discussion regarding potential procedure complications and follow-up plans or further treatments. Restrictions, prescriptions, follow-up tests, instructions and appointments are provided to the patient and pertinent others.



**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Bruce Cameron, MD (ACG), Joel Brill, MD (AGA), Shivan Mehta, MD (AGA), Nicholas Nickl, MD (ASGE)				
<b>Specialty(s):</b>	ACG, AGA, ASGE				
<b>CPT Code:</b>	43259				
<b>Sample Size:</b>	981	<b>Resp N:</b>	36	<b>Response:</b> 3.6 %	
<b>Description of Sample:</b>	The ACG, AGA and ASGE conducted an enhanced random sample as approved by the Research Subcommittee. The sampling methodology was a random sample of member gastroenterologists with the addition of ASGE Special Interest Group physicians identified as performers of EUS procedures and survey volunteers who responded to educational articles and identified themselves as EUS performers.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	25.00	<b>43.00</b>	106.00	350.00
<b>Survey RVW:</b>	2.30	4.74	<b>5.45</b>	6.13	12.50
<b>Pre-Service Evaluation Time:</b>			<b>35.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>10.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>10.00</b>		
<b>Intra-Service Time:</b>	15.00	30.00	<b>45.00</b>	56.00	135.00
<b>Immediate Post Service-Time:</b>	<b>20.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	43259	<b>Recommended Physician Work RVU: 4.74</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>33.00</b>	<b>33.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>3.00</b>	<b>1.00</b>	<b>2.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>5.00</b>	<b>5.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>45.00</b>		
<b>Immediate Post Service-Time:</b>	<b>20.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		

<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31631	000	4.36	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of tracheal stent(s) (includes tracheal/bronchial dilation as required)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
31628	000	3.80	RUC Time	38,792

CPT Descriptor 1 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 5      % of respondents: 13.8 %**

**TIME ESTIMATES (Median)**

	<b>CPT Code: 43259</b>	<b>Key Reference CPT Code: 31631</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	41.00	45.00	
Median Intra-Service Time	45.00	45.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>106.00</b>	<b>120.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.40
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.20	3.60
--	------	------

Urgency of medical decision making	3.80	3.60
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.40	4.00
--------------------------	------	------

Physical effort required	3.60	3.40
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.80	3.80
---	------	------

Outcome depends on the skill and judgment of physician	4.40	3.80
--	------	------

Estimated risk of malpractice suit with poor outcome	4.20	3.80
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.40	3.00
----------------------------------	------	------

Intra-Service intensity/complexity	4.20	3.60
------------------------------------	------	------

Post-Service intensity/complexity	3.80	3.20
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**43259 – Discussion and Recommendation**

Code 43259 *Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis* was identified as a family code through the MPC List screen. This service has been reviewed by the RUC three times. In 1993, the RUC reviewed the new code and recommended an RVW of 6.11 with survey intra-time of 55 minutes. CMS disagreed with this recommendation and assigned an RVW of 3.95 (a 35% reduction). Refinement resulted in an increase in 1995 to 4.89 (a 20% reduction from the RUC recommendation. The RUC again reviewed the code in 2000 during the second five-year-review and approved an RVW of 8.59 based on a calculated increment and 69 minutes of intra-service time. CMS disagreed and maintain the RVW of 4.89. The third review of 43259 occurred in 2003 in conjunction with creation of new ultrasound codes. At this review, the RUC determined that the CMS assigned RVW of 4.89 presented a rank order anomaly. The RUC crosswalked their recommendation to 45385 (5.30 RVU) with a slight reduction for reduced intensity and work neutrality within the family of new codes, resulting in a recommended RVU of 5.19. CMS accepted this RUC recommendation.

A survey was conducted and received 36 respondents. The expert panel noted that the median intraservice time was 45 minutes, which is 30 minutes above the IS time for the family base code, 43235, of 15 minutes. The 25th percentile survey RVW of 4.74 provides incremental work over the base code (43235, 2.36 RVU) of 2.48; this is appropriately comparable to the increment for 43237 / 43235 of 1.59, representing the additional work of endoscopic ultrasound of the entire esophagus, stomach, and duodenum compared to the esophagus alone. **We recommend the 25<sup>th</sup> percentile RVW of 4.74 which is less than the current value of 5.19.**

**Comparison to Key Ref 31631**

Key Reference code 31631 was surveyed and presented to the RUC in 2004. The RUC agreed with the specialty presentation that the work had not changed and maintained the RVW and accepted the survey times. Code 31631 does not include the additional work/intensity of physician administered moderate sedation. Code 43259 compares favorably with 31631; the additional work, intensity and time for moderate sedation is reflected in the difference in RVWs.

**43259 Comparison To MPC and Other RUC-Reviewed Codes with 40-45 Minutes Intra-Service Time**

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2010	<b>12018</b>	Rpr f/e/n/l/m >30.0 cm	3.61	0.071	64	8	2	1	<b>45</b>	8
MPC 2003	<b>31628</b>	Bronchoscopy/lung bx each	3.80	0.071	90	10	10	10	<b>40</b>	20
2009	<b>49411</b>	Ins mark abd/pel for rt perq	3.82	0.072	85	19	1	5	<b>40</b>	20
2009	<b>31626</b>	Bronchoscopy w/markers	4.16	0.074	85	19	1	5	<b>45</b>	15
1995	<b>93505</b>	Biopsy of heart lining	4.37	0.084	100	27		15	<b>38</b>	20
	<b>43259</b>	<b>EGD, EUS distal</b>	<b>4.74</b>	<b>0.077</b>	<b>106</b>	<b>33</b>	<b>3</b>	<b>5</b>	<b>45</b>	<b>20</b>
1997	<b>58558</b>	Hysteroscopy biopsy	4.74	0.091	90	30			<b>40</b>	20
2011	<b>52315</b>	Cystoscopy and treatment	5.20	0.093	94	19	5	5	<b>45</b>	20
2011	<b>36246</b>	Ins cath abd/l-ext art 2nd	5.27	0.088	106	33	3	5	<b>45</b>	20
2008	<b>52341</b>	Cysto w/ureter stricture tx	5.35	0.079	135	45	10	15	<b>45</b>	20

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.

- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43259

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology                      How often? Sometimes

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 105000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2011 ~ 35,000

Specialty Gastroenterology                      Frequency 96600                      Percentage 92.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 35,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2011 ~ 35,000

Specialty Gastroenterology                      Frequency 32200                      Percentage 92.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? No

## Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43259

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.



ISSUE: Esophagoscopy Gastroscopy Duodenoscopy (EGD)

SOURCE	CPT	DESC	Resp	IWP	RVW					Time	PRE	PRE			INTRA					POST	SURVEY EXPERIENCE					TYP	
					MIN	25th	MED	75th	MAX			EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX		P-SD	MIN	25th	MED	75th		MAX
REF	31622	Bronchoscopy, rigid or flexible, including fluoroscopy	98	0.069			2.78			65		10	5	5			30			15							
RUC-05	43235	Upper gastrointestinal endoscopy including esophagoscopy		0.075			2.39			63		18	5	5			20			15							
SVY	43235	Esophagogastroduodenoscopy, flexible, transoral; diagnostic	315	0.142	0.70	2.59	3.00	3.50	8.95	57		20	5	5	5	10	15	20	60	12	0	87	200	400	1500	98%	
REC	43235	EGD; DIAGNOSTIC		0.097			2.26			54	1b	19	3	5			15			12							
REF	31625	Bronchoscopy, rigid or flexible, including fluoroscopy	25	0.087			3.36			70		10	5	10			30			15							
RUC-02	43236	Upper gastrointestinal endoscopy including esophagoscopy		0.051			2.92			86		27					35			23.5							
SVY	43236	Esophagogastroduodenoscopy, flexible, transoral; with biopsy	78	0.129	1.50	3.21	3.62	4.35	7.17	70		25	5	5	12	18	20	30	60	15	0	5	10	24	400	91%	
REC	43236	EGD; INJECTION		0.085			2.57			62	1b	19	3	5			20			15							
REF	31625	Bronchoscopy, rigid or flexible, including fluoroscopy	8	0.087			3.36			70		10	5	10			30			15							
RUC-03	43237	Upper gastrointestinal endoscopy including esophagoscopy		0.055			3.98			113		31					45			36.5							
SVY	43237	Esophagogastroduodenoscopy, flexible, transoral; with biopsy	37	0.084	2.20	3.85	4.20	5.00	13.00	95		30	5	5	15	25	35	45	90	20	0	10	23	50	400		
REC	43237	EGD; EUS limited to esophagus		0.075			3.85			93	2b	30	3	5			35			20							
Rationale		25th pctl																									
REF	31638	Bronchoscopy, rigid or flexible, including fluoroscopy	5	0.055			4.88			140		20	15	15			60			30							
RUC-03	43238	Upper gastrointestinal endoscopy including esophagoscopy		0.049			5.02			143		31					70			41.5							
SVY	43238	Esophagogastroduodenoscopy, flexible, transoral; with biopsy	33	0.083	2.30	4.50	5.03	5.75	14.00	106		30	5	6	20	40	45	60	135	20	0	10	25	50	400		
REC	43238	EGD; US FNA, esophagus		0.073			4.50			103	2b	30	3	5			45			20							
Rationale		25th pctl																									
REF	31625	Bronchoscopy, rigid or flexible, including fluoroscopy	144	0.087			3.36			70		10	5	10			30			15							
RUC-00	43239	Upper gastrointestinal endoscopy including esophagoscopy		0.051			2.87			85		27					34			23.5							
SVY	43239	Esophagogastroduodenoscopy, flexible, transoral; with biopsy	310	0.166	0.80	3.00	3.36	3.90	10.35	57		20	5	5	5	12	15	20	60	12	0	200	300	500	1600	96%	
REC	43239	EGD; BIOPSY		0.117			2.56			54	1b	19	3	5			15			12							
REF	31600	Tracheostomy, planned (separate procedure)	6	0.114			7.17			156		50					40			66							
RUC-00	43240	Upper gastrointestinal endoscopy including esophagoscopy		0.066			6.85			130		20					90			20							
SVY	43240	Esophagogastroduodenoscopy, flexible, transoral; with biopsy	33	0.091	4.65	7.25	8.50	10.00	13.00	170		50	10	10	40	60	70	90	120	30	0	0	5	10	50		
REC	43240	EGD; pseudocyst w/ EUS		0.082			7.25			141	2b	33	3	5			70			30							
Rationale		25th percentile																									
REF	31631	Bronchoscopy, rigid or flexible, including fluoroscopy	8	0.064			4.36			120		20	10	15			45			30							
HVD	43241	Upper gastrointestinal endoscopy including esophagoscopy		0.049			2.59			93		16		25			33			19							
SVY	43241	Esophagogastroduodenoscopy, flexible, transoral; with biopsy	39	0.106	1.80	3.50	4.25	4.50	6.55	82		25	5	7	12	20	30	30	50	15	0	5	10	23	100	87%	
REC	43241	EGD; TUBE INSERTION		0.053			2.59			78	2b	25	3	5			30			15							
REF	31600	Tracheostomy, planned (separate procedure)	5	0.114			7.17			156		50					40			66							
RUC-03	43242	Esophagogastroduodenoscopy, flexible, transoral; with biopsy		0.071			7.30			130		20					90			20							
SVY	43242	Esophagogastroduodenoscopy, flexible, transoral; with biopsy	36	0.100	3.00	5.04	6.65	8.00	14.00	131		38	10	10	25	45	50	66	160	23	0	24	60	100	300		
REC	43242	EGD; US FNA, incl EUS		0.081			5.39			114	2b	33	3	5			50			23							
Rationale		Building block: 4.74 recommended RVW for 43259 + 0.65 (Increment for FNA [43237 and 43238 = 0.65], which compares to code 76942, US guidance for needle placement) = 5.39																									
REF	31631	Bronchoscopy, rigid or flexible, including fluoroscopy	14	0.064			4.36			120		20	10	15			45			30							
HVD	43243	Upper gastrointestinal endoscopy including esophagoscopy		0.110			4.56			95		18		25			32			20							

ISSUE: Esophagoscopy Gastroscopy Duodenoscopy (EGD)

SOURCE	CPT	DESC	Resp	IWPUT	RVW					Total Time	PRE PKG	PRE			INTRA					POST P-SD	SURVEY EXPERIENCE					TYP
					MIN	25th	MED	75th	MAX			EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX		MIN	25th	MED	75th	MAX	
SVY	43243	Esophagogastroduodenoscopy, flexible, transoral; v	58	0.117	2.25	4.37	4.89	5.60	12.00	95		35	5	5	15	25	30	40	60	20	0	4	10	15	100	88%
REC	43243	EGD; INJECT FOR BLEEDING		0.103			4.37			91	2b	33	3	5			30			20						
REF	31631	Bronchoscopy, rigid or flexible, including fluoroscop	16	0.064			4.36			120		20	10	15			45			30						
RUC-00	43244	Upper gastrointestinal endoscopy including esopha		0.055			5.04			147		57					54			36						
SVY	43244	Esophagogastroduodenoscopy, flexible, transoral; v	69	0.117	2.25	4.50	4.90	5.60	9.50	95		35	5	5	15	25	30	40	60	20	1	10	20	25	500	100%
REC	43244	EGD; BAND FOR BLEEDING		0.107			4.50			91	2b	33	3	5			30			20						
REF	52342	Cystourethroscopy; with treatment of ureteropelvic j	12	0.070			5.85			140		40	10	10			60			20						
RUC-02	43245	Upper gastrointestinal endoscopy including esopha		0.051			3.18			91		27					40			23.5						
SVY	43245	Esophagogastroduodenoscopy, flexible, transoral; v	56	0.137	1.80	3.58	4.13	5.16	7.50	73		25	5	5	10	18	23	30	75	15	0	6	21	71	500	98%
REC	43245	EGD; DILATE STRICTURES		0.097			3.18			71	2b	25	3	5			23			15						
REF	31600	Tracheostomy, planned (separate procedu	10	0.114			7.17			156		50					40			66						
RUC-05	43246	Upper gastrointestinal endoscopy including esc		0.075			4.32			106		35	8	5			38			20						
NEW SVY	43246	Esophagogastroduodenoscopy, flexible, tr	57	0.125	1.00	4.30	5.12	6.75	14.34	95		40	5	5	5	20	30	30	60	15	0	11	20	50	100	
OLD SVY	43246	Esophagogastroduodenoscopy, flexible, tr	68	0.148	2.30	4.24	4.55	5.98	11.00	80		33	5	5	8	20	23	30	60	15	0	15	25	50	200	



ISSUE: Esophagoscopy Gastroscopy Duodenoscopy (EGD)

SOURCE	CPT	DESC	Resp	IWP	RVW					Total Time	PRE PKG	PRE			INTRA					POST P-SD	SURVEY EXPERIENCE					TYP	
					MIN	25th	MED	75th	MAX			EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX		MIN	25th	MED	75th	MAX		
REC	43246	EGD; PEG		0.105	4.32					86	2b	33	3	5		30		15									
Rationale		current																									
REF	31638	Bronchoscopy, rigid or flexible, including fluoroscopy	14	0.055			4.88			140		20	15	15		60		30									
RUC-00	43247	Upper gastrointestinal endoscopy including esophagoscopy		0.034			3.38			122		42				54		26									
SVY	43247	Esophagogastroduodenoscopy, flexible, transoral; with biopsy	68	0.123	2.00	3.98	4.50	5.20	10.60	70		15	5	5	6	20	30	45	75	15	0	10	15	25	70	78%	
REC	43247	EGD; FOREIGN BODY REMOVAL		0.083			3.27			68	2b	15	3	5		30		15									
REF	31631	Bronchoscopy, rigid or flexible, including fluoroscopy	11	0.064			4.36			120		20	10	15		45		30									
RUC-93	43248	Upper gastrointestinal endoscopy including esophagoscopy		0.077			3.15			63		16				32		15									
SVY	43248	Esophagogastroduodenoscopy, flexible, transoral; with biopsy	50	0.158	1.60	3.64	4.10	4.88	8.00	65		20	5	5	10	15	20	30	60	15	0	31	50	100	500	96%	
REC	43248	EGD; GUIDE WIRE AND DILATOR		0.107			3.01			62	1b	19	3	5		20		15									
REF	31625	Bronchoscopy, rigid or flexible, including fluoroscopy	9	0.087			3.36			70		10	5	10		30		15									
RUC-00	43249	Upper gastrointestinal endoscopy including esophagoscopy		0.035			2.90			107		42				39		26									
SVY	43249	Esophagogastroduodenoscopy, flexible, transoral; with biopsy	56	0.157	1.60	3.36	4.07	4.82	6.55	65		20	5	5	10	15	20	30	60	15	0	15	30	79	500	96%	
REC	43249	EGD; BALLOON <30MM		0.095			2.77			62	1b	19	3	5		20		15									
REF	31638	Bronchoscopy, rigid or flexible, including fluoroscopy	8	0.055			4.88			140		20	15	15		60		30									
NEW										0																	
SVY	43233	Esophagogastroduodenoscopy, flexible, transoral; with biopsy	35	0.119	3.50	4.45	4.98	5.73	8.00	100		30	10	10	10	23	30	43	90	20	0	1	5	11	250	94%	
REC	43233	EGD; BALLOON >30MM W-FLUORO		0.107			4.45			88	2b	30	3	5		30		20									
REF	31625	Bronchoscopy, rigid or flexible, including fluoroscopy	23	0.087			3.36			70		10	5	10		30		15									
RUC-93	43250	Upper gastrointestinal endoscopy including esophagoscopy		0.120			3.20			51		15				21		15									
SVY	43250	Esophagogastroduodenoscopy, flexible, transoral; with biopsy	59	0.134	1.25	3.25	3.50	4.43	9.99	60		16	5	5	6	15	20	25	50	14	0	5	10	50	500	90%	
REC	43250	EGD; HOT BIOPSY LESION REMOVAL		0.115			3.07			58	1b	16	3	5		20		14									
REF	31625	Bronchoscopy, rigid or flexible, including fluoroscopy	10	0.087			3.36			70		10	5	10		30		15									
RUC-93	43251	Upper gastrointestinal endoscopy including esophagoscopy		0.091			3.69			67		20				32		15									
NEW SVY	43251	Esophagogastroduodenoscopy, flexible, transoral; with biopsy	39	0.143	1.00	3.36	3.80	4.68	10.08	65		25	5	5	9	15	20	28	35	10	0	10	25	63	800		
OLD SVY	43251	Esophagogastroduodenoscopy, flexible, transoral; with biopsy	67	0.157	1.50	3.69	4.00	4.69	9.99	62		20	5	5	8	17	20	30	80	12	0	8	20	50	500		
REC	43251	EGD; snare		0.134	3.57					63	2b	25	3	5		20		10									
Rationale		Building block: 43235 (2.26) + established incr. of esoph snare for Esoph (1.31) = 3.57																									
REF	91110	Gastrointestinal tract imaging, intraluminal (eg, capsule)	12	0.040			3.64			100		5				80		15									
NEW										0																	
SVY	43252	Esophagogastroduodenoscopy, flexible, transoral; with biopsy	26	0.087	1.50	3.66	4.00	4.65	10.00	98		30	10	8	15	20	30	43	60	20	2	11	28	43	300	77%	
REC	43252	EGD; optical endomicroscopy		0.069			3.06			77	1b	19	3	5		30		20									

## ISSUE: Esophagoscopy Gastroscopy Duodenoscopy (EGD)

					RVW					Total	PRE	PRE			INTRA					POST	SURVEY EXPERIENCE					TYP
SOURCE	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	PKG	Eval	POSIT	SDW	MIN	25th	MED	75th	MAX	P-SD	MIN	25th	MED	75th	MAX	
REF	31631	Bronchoscopy, rigid or flexible, including	9	0.064			4.36			120		20	10	15			45			30						
CURRENT	NEW									0																
SVY	43253	Esophagogastroduodenoscopy, flexible, tr	34	0.104	2.50	4.44	5.77	7.38	12.50	118		35	10	10	15	30	40	60	135	23	0	2	8	15	60	
REC	43253	EGD; fiducial marker inj w/ EUS		0.101			5.39			104	2b	33	3	5			40			23						

<b>Rationale</b>	Building block: 4.74 recommended RVW for 43259 + 0.65 (76942, US guidance for needle placement) = 5.41
------------------	--

REF	58561	Hysteroscopy, surgical; with removal of leiomyomat	9	0.112		9.99		145		40		75		30				
NEW								0										
SVY	43254	Esophagogastroduodenoscopy, flexible, transoral; v	43	0.122	3.20 5.25	6.90	8.40 15.85	115		30 10 10	20 35	45	60 90	20	0 5	10	25 250	95%
REC	43254	EGD; endoscopic mucosal resection		0.089		5.25		103	2b	30 3 5		45		20				

[illegible][illegible][illegible][illegible]

REF	31631	Bronchoscopy, rigid or flexible, including	5	0.064		4.36		120		20	10	15		45		30			
RUC-03	43259	Upper gastrointestinal endoscopy including esc	0.054			5.19		133		28				69		36			
SVY	43259	Esophagogastroduodenoscopy, flexible, tr	36	0.087	2.30 4.74	5.45	6.13 12.50	120		35	10	10	15 30	45	56 135	20	0 25	43	106 350
REC	43259	EGD; EUS esoph, stomach, and either duodenum d	0.077			4.74		106	2b	33	3	5		45		20			

<b>Rationale</b>	25th pctl
------------------	-----------

Code	Description	Current RVW	RUC Rec	Survey RVW Median	Survey 25%	Pre Pack	Pre	Intra	Post	Total	IWPUT	RUC Valuation Methodology
43235	Esophagogastroduodenoscopy, flexible, transoral; diagnostic, with collection of specimen(s) by brushing or washing, when performed	2.39	2.26	3.00	2.59	1b	27	15	12	54	0.097	Direct crosswalk to CPT code 31579 Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy (work RVU= 2.26, 15/15/15)
43236	Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal injection(s), any substance	2.92	2.57	3.62	3.21	1b	27	20	15	62	0.085	43235 (2.26) + increment of 43201-43200 (0.31)
43237	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination limited to the esophagus	3.98	3.85	4.20	3.85	2b	38	35	20	93	0.075	25th percentile. 3.98 current RVW - 0.13 (decrease in 43235 EGD base code (2.39 - 2.26 = 0.13) = 3.85 RVW
43238	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), esophagus (includes endoscopic ultrasound examination limited to the esophagus)	5.02	4.50	5.03	4.50	2b	38	45	20	104	0.073	25th percentile. 5.02 current RVW - 0.13 (decrease in 43235 EGD base code (2.39 - 2.26 = 0.13) = 4.89, which supports the 25th percentile 4.50 RVW. Increment for FNA between 43237 and 43238 is 0.65, which compares to code 76942, US guidance for needle placement, RVW = 0.67)
43239	Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple	2.87	2.56	3.36	3.00	1b	27	15	12	54	0.117	43235 (2.26) + increment of 43202-43200 (0.30)
43240	Esophagogastroduodenoscopy, flexible, transoral; with transmural drainage of pseudocyst (includes placement of transmural drainage catheter[s]/stent[s], when performed, and endoscopic ultrasound, when performed)	6.85	7.25	8.50	7.25	2b	41	70	30	153	0.082	25th percentile. Preserves rank order among the EGD EUS codes and within the EGD family
43241	Esophagogastroduodenoscopy, flexible, transoral; with insertion of intraluminal tube, or catheter	2.59	2.59	4.25	3.50	2b	33	30	15	78	0.053	No Esophagoscopy equivalent: the current value of 2.59 is recommended
43242	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)	7.30	5.39	6.65	5.04	2b	41	50	23	124	0.081	Building block: 4.74 recommended RVW for 43259 + 0.65 (Increment for FNA between 43237 and 43238 is 0.65, which compares to code 76942, US guidance for needle placement) = 5.39, which is greater than the survey 25th percentile but less than the current RVW. It maintains rank order in the EGD EUS procedures.
43243	Esophagogastroduodenoscopy, flexible, transoral; with injection sclerosis of esophageal / gastric varices	4.56	4.37	4.89	4.37	2b	41	30	20	91	0.103	No Esophagoscopy equivalent: the 25th percentile of 4.37 is recommended
43244	Esophagogastroduodenoscopy, flexible, transoral; with band ligation of esophageal / gastric varices	5.04	4.50	4.90	4.50	2b	41	30	20	91	0.107	No Esophagoscopy equivalent: the 25th percentile of 4.50 is recommended
43245	Esophagogastroduodenoscopy, flexible, transoral; with dilation of gastric / duodenal stricture(s) (eg, balloon, bougie)	3.18	3.18	4.13	3.58	2b	33	23	15	71	0.097	No Esophagoscopy equivalent: the current value of 3.18 is recommended
43246	Esophagogastroduodenoscopy, flexible, transoral; with directed placement of percutaneous gastrostomy tube	4.32	4.32	5.12	4.30	2b	41	30	15	86	0.105	Current
43247	Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body	3.38	3.27	4.50	3.98	2b	23	30	15	68	0.082	43235 (2.26)+ increment of 43215-43200 (1.01)
43248	Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by dilation of passage of dilator(s) through esophagus over guide wire	3.15	3.01	4.10	3.64	1b	27	20	15	62	0.107	43235 (2.26) + increment of 43226-43200 (0.75)
43249	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)	2.90	2.77	4.07	3.36	1b	27	20	15	62	0.095	43235 (2.26) + increment of 43220-43200 (0.51)
43233	Esophagogastroduodenoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)	NEW	4.45	4.98	4.45	2b	38	30	20	88	0.099	25th percentile work RVU of 4.45
43250	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	3.20	3.07	3.50	3.25	1b	24	20	14	58	0.115	43235 (2.26) + increment of 43216-43200 (0.81)
43251	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	3.69	3.57	3.80	3.36	2b	33	20	10	63	0.134	Increment: 43235 (2.26) + established incr. of esoph snare for EGD and Esoph (1.31) = 3.57
43252	Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy	NEW	3.06	4.00	3.66	1b	27	30	20	77	0.069	43235 (2.26) + increment of 431X1-43200 (0.80)
43253	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance(s) (eg, anesthetic, neurolytic agent) or fiducial marker(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)	NEW	5.39	5.77	4.44	2b	41	40	23	111	0.101	Increment: 4.74 recommended RVW for 43259 + 0.65 (Increment for FNA between 43237 and 43238), which is greater than the survey 25th percentile but less than the median RVW. It maintains rank order in the EGD EUS procedures. This is slightly higher than 43242 because the work of injection is higher than the work of FNA aspiration (43242).
43254	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic mucosal resection	NEW	5.25	6.90	5.25	2b	38	45	20	103	0.090	25th percentile work RVU of 5.25
43255	Esophagogastroduodenoscopy, flexible, transoral; with control of bleeding, any method	4.81	4.20	4.93	4.20	2b	41	30	20	91	0.097	No Esophagoscopy equivalent: the 25th percentile of 4.20 is recommended
43266	Esophagogastroduodenoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)	NEW	4.40	5.20	4.40	2b	41	40	20	101	0.078	25th percentile work RVU= 4.40
43257	Esophagogastroduodenoscopy, flexible, transoral; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease	5.50	4.25	5.10	4.25	2b	41	45	15	101	0.068	No Esophagoscopy equivalent: the 25th percentile of 4.25 is recommended
43270	Esophagogastroduodenoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)	NEW	4.39	5.75	4.39	2b	41	45	15	101	0.071	25th percentile work RVU= 4.39
43259	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)	5.19	4.74	5.45	4.74	2b	41	45	20	111	0.077	25th percentile. 43259 involves more work than 43237 (EGD with EUS limited to esoph = 3.85 RVW) because there is more to examine (stomach and either duodenum or surgically altered stomach). The 25th percentile RVW 4.74 maintains relativity to the other EGD with EUS codes

EGD Approved Increments				
EGD Code	Description	RUC RVU	Increment above base EGD Code (43235)	EGD Code Rationale
43239	biopsy	2.56	0.30	43235 (2.26) + increment of 43202-43200 (0.30)
43236	submucosal injection	2.57	0.31	43235 (2.26) + increment of 43201-43200 (0.31)
43249	balloon dilation > 30mm	2.77	0.51	43235 (2.26) + increment of 43220-43200 (0.51)
43242	FNA w EUS	5.39	0.65	43259 (4.74) + increment of 43238-43237 (0.65)
43248	guide wire insertion	3.01	0.75	43235 (2.26) + increment of 43226-43200 (0.75)
43252	optical endomicroscopy	3.06	0.80	43235 (2.26) + increment of 43206-43200 (0.80)
43250	hot biopsy	3.07	0.81	43235 (2.26) + increment of 43216-43200 (0.81)
43247	foreign body removal	3.27	1.01	43235 (2.26) + increment of 43215-43200 (1.01)
Esophagoscopy Approved Increments				
Esoph Code	Description	RUC RVU	Increment above base Esoph Code (43200)	Esophagoscopy Code Rationale
43202	biopsy	1.89	0.30	Current value
43201	submucosal injection	1.90	0.31	Direct crosswalk to MPC code 64483
43215	foreign body removal	2.60	1.01	Current value
43216	hot biopsy	2.40	0.81	Current value
43220	balloon dilation > 30mm	2.10	0.51	Current value
43226	guide wire insertion	2.34	0.75	Current value
43206	optical endomicroscopy	2.39	0.80	Direct crosswalk to code 12006
43217	removal of lesion by snare	2.90	1.31	Current value
Esoph Code	Description	RUC RVU	Increment above base Esoph Code (43200)	Esophagoscopy Code Rationale
43229	ablation (includes pre- and post-dilation)	3.72	2.13	43270 25th percentile (4.39)- 0.67 (diff 43235-43200) = 3.72
43212	endoscopic stent (includes pre- and post-dilation)	3.73	2.14	43266 25th percentile (4.40)- 0.67 (diff 43235-43200) = 3.73
43214	balloon dilation < 30mm	3.78	2.19	43233 25th percentile (4.45) - 0.67 (diff 43235-43200) = 3.78
43211	endoscopic mucosal resection	4.58	2.99	43254 25th percentile (5.25) - 0.78 = 4.58
ERCP Approved Increments				
ERCP Code	Description	RUC RVU	Increment above base ERCP Code (43260)	ERCP Code Rationale
43274	sphincterotomy	8.74	0.65	43260 (5.95) increment of 43262-43260 (0.65)

Date: January 8, 2013

To: Scott Manaker, MD, RUC Practice Expense Subcommittee Chair

From: Joel V. Brill, MD, RUC Advisor, AGA  
Nicholas J. Nickl III, MD, RUC Advisor, ASGE  
Edward S. Bentley, MD, RUC Alternate Advisor, ASGE  
Donald Selzer, MD, RUC Advisor, SAGES

Subject: Compelling Evidence for Practice Expense for Tab 8

---

The American Gastroenterological Association (AGA), American Society for Gastrointestinal Endoscopy (ASGE), and Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) are pleased to submit recommendations to the RUC regarding practice expense for Esophagogastroduodenoscopy (EGD) codes 43235-43270, tab 8, for discussion at the January 2013 RUC meeting.

We present the following arguments for compelling evidence for the procedures in tab 8:

- Changes in technology
- Changes in site of service
- Errors/omissions in previous valuation

When the Practice Expense Subcommittee reviewed tab 10, the esophagoscopy codes 43200-43232 in October 2012, they accepted that there was compelling evidence to review, change and update the practice expense staff, supplies and equipment inputs for all of the codes in the family since they were last evaluated for practice expense, based on changes in technology, site of service migration for several services not previously valued in the non-facility setting, changes in patient safety requirements, and the absence of scope cleaning supplies in non-facility setting.

The practice expense inputs being presented for the existing EGD codes in tab 8 correspond directly to the practice expense inputs that were approved for the similar esophagoscopy codes that the RUC approved in October 2012.



**AMA/Specialty Society Update Process**  
**Practice Expense Summary of Recommendation**  
**Non-Facility Direct Inputs**

**TAB 8 - CPT Code / Long Descriptor:**

<b>43235</b>	Esophagogastroduodenoscopy, flexible, transoral; diagnostic, with collection of specimen(s) by brushing or washing, when performed
<b>43236</b>	Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal injection(s), any substance
<b>43239</b>	Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple
<b>43241</b>	N/A – FACILITY ONLY
<b>43243</b>	N/A – FACILITY ONLY
<b>43244</b>	N/A – FACILITY ONLY
<b>43245</b>	Esophagogastroduodenoscopy, flexible, transoral; with dilation of gastric / duodenal stricture(s) (eg, balloon, bougie)
<b>43246</b>	N/A – FACILITY ONLY
<b>43247</b>	Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body
<b>43248</b>	Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by dilation of passage of dilator(s) through esophagus over guide wire
<b>43249</b>	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)
<b>43250</b>	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
<b>43251</b>	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
<b>43252</b>	Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy
<b>43255</b>	Esophagogastroduodenoscopy, flexible, transoral; with control of bleeding, any method
<b>43257</b>	N/A – FACILITY ONLY
<b>43254</b>	N/A – FACILITY ONLY
<b>43233</b>	N/A – FACILITY ONLY
<b>43266</b>	N/A – FACILITY ONLY
<b>43270</b>	Esophagogastroduodenoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)

**Global Period: 000**

**Meeting Date: January 2013**

**1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:**

The AGA, ASGE, and SAGES convened a group from a broad range of geographic locations with differing practice circumstances and settings - community, academic, teaching, and public; urban, suburban and rural; single and multi-specialty group; independent and employed - who typically perform these services. The committee served as the consensus panel to develop PE recommendations.

**2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

For codes previously priced in the office setting, the current PE times are shown, along with another crosswalk reference code for the matching esophagoscopy service - just reviewed by the PE Subcommittee in October 2012. For codes that were previously not priced in the office setting, reference codes were chosen that matched where possible to the similar service for esophagoscopy. All crosswalk reference codes were just reviewed and approved by the PE Subcommittee in October 2012.

**CPT Code: Tab 8 Esophagoscopy Gastroscopy Duodenoscopy (EGD)**  
**Specialty Society('s) AGA, ASGE, SAGES**

Current Time data (non-RN*)					Crosswalk Code Data (non-RN*)					Survey Code non-RN* Recommendation			
CPT	Source	Pre	Intra	Post	CPT	Source	Pre	Intra	Post	CPT	Pre	Intra	Post
43235	PEAC-02	9	62	3	43200	RUC-12	9	73	3	43235	9	73	3
43236	RUC-02	9	74	3	43201	RUC-12	9	76	3	43236	9	78	3
43239	PEAC-02	9	72	3	43202	RUC-12	9	78	3	43239	9	73	3
43245	PEAC-02	0	0	0	43215	RUC-12	9	78	3	43245	9	81	3
43247	PEAC-02	0	0	0	43215	RUC-12	9	78	3	43247	9	88	3
43248	PEAC-02	0	0	0	43226	RUC-12	9	83	3	43248	9	88	3
43249	PEAC-02	0	0	0	43220	RUC-12	9	78	3	43249	9	78	3
43250	PEAC-02	0	0	0	43216	RUC-12	9	80	3	43250	9	78	3
43251	PEAC-02	0	0	0	43217	RUC-12	9	88	3	43251	9	78	3
43252	NEW-13	--	--	--	43206	RUC-12	9	88	3	43252	9	88	3
43255	PEAC-02	0	0	0	43227		9	88	3	43255	9	88	3
					43228	RUC-12	9	93	3	43270	9	103	3

\* Note: RN time will be equal to 2 minutes (standard for sedate apply MS) PLUS 100% physician time for scope-in-scope out PLUS 15 minutes to monitor the patient after scope out during anesthesia reversal

**3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:**

For codes previously priced in the office:

- time was added to set up scope and to clean scope – both of these activities were not assigned time in the early PE review 2002
- time to obtain vitals was increased from 3 minutes to 5 minutes to account for 4-6 vitals taken before administration of moderate sedation

For codes NOT previously priced in the office, the recommended times are consistent with recently reviewed esophagoscopy codes.

**4. Please describe in detail the clinical activities of your staff:**

Pre-Service Clinical Labor Activities:

Three minutes to complete pre-service diagnostic and referral forms.  
Five minutes to coordinate pre-surgery services with other qualified healthcare providers  
Three minutes for pre-op prescriptions

Intra-Service Clinical Labor Activities:

Three minutes: Greet patient, provide gowning, ensure appropriate medical records are available  
Five minutes: 4-6 vitals  
Three minutes: Provide pre-service education/obtain consent  
Two minutes: Prepare room, equipment, supplies  
Five minutes: Setup scope (non facility setting only)  
Two minutes: Prepare and position patient/ monitor patient/ set up IV  
Minutes vary with procedure – 100% MD time to assist physician in performing procedure  
Three minutes: Clean room/equipment by physician staff  
Thirty minutes: Clean flexible scope  
Ten minutes: Clean Surgical Instrument Package (only code 43248)  
Two minutes: Complete diagnostic forms, lab & X-ray requisitions  
Three minutes: Check dressings & wound/ home care instructions /coordinate office visits /prescriptions

Post-Service Clinical Labor Activities: Three minutes for a follow-up phone call to patient

**AMA/Specialty Society Update Process**  
**Practice Expense Summary of Recommendation**  
**Facility Direct Inputs**

**CPT Code / Long Descriptor:**

<b>43235</b>	Esophagogastroduodenoscopy, flexible, transoral; diagnostic, with collection of specimen(s) by brushing or washing, when performed
<b>43236</b>	Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal injection(s), any substance
<b>43239</b>	Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple
<b>43241</b>	Esophagogastroduodenoscopy, flexible, transoral; with insertion of intraluminal tube, or catheter
<b>43243</b>	Esophagogastroduodenoscopy, flexible, transoral; with injection sclerosis of esophageal / gastric varices
<b>43244</b>	Esophagogastroduodenoscopy, flexible, transoral; with band ligation of esophageal / gastric varices
<b>43245</b>	Esophagogastroduodenoscopy, flexible, transoral; with dilation of gastric / duodenal stricture(s) (eg, balloon, bougie)
<b>43246</b>	Esophagogastroduodenoscopy, flexible, transoral; with directed placement of percutaneous gastrostomy tube
<b>43247</b>	Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body
<b>43248</b>	Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by dilation of passage of dilator(s) through esophagus over guide wire
<b>43249</b>	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)
<b>43250</b>	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
<b>43251</b>	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
<b>43252</b>	Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy
<b>43255</b>	Esophagogastroduodenoscopy, flexible, transoral; with control of bleeding, any method
<b>43257</b>	Esophagogastroduodenoscopy, flexible, transoral; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease
<b>43254</b>	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic mucosal resection
<b>43233</b>	Esophagogastroduodenoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)
<b>43266</b>	Esophagogastroduodenoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)
<b>43270</b>	Esophagogastroduodenoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)

**Global Period: 000**

**Meeting Date: January 2013**

**1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:**

The AGA, ASGE, and SAGES convened a group from a broad range of geographic locations with differing practice circumstances and settings - community, academic, teaching, and public; urban, suburban and rural; single and multi-specialty group; independent and employed - who typically perform these services. The committee served as the consensus panel to develop PE recommendations.



**CPT Code: Tab 8 Esophagoscopy Gastroscopy Duodenoscopy (EGD)**  
**Specialty Society('s) AGA, ASGE, SAGES**

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

Reference codes chosen are matched where possible with the similar service for esophagoscopy. Where this is not possible, Code 43205 (facility one service) was used for crosswalk reference. All crosswalk reference codes were just reviewed and approved by the PE Subcommittee in October 2012.

Current Time data					Crosswalk Code Data					Survey Code Recommendation			
CPT	Source	Pre	Intra	Post	CPT	Source	Pre	Intra	Post	CPT	Pre	Intra	Post
43235	PEAC-02	19	0	3	43200	RUC-12	19	0	3	43235	19	0	3
43236	RUC-02	19	0	3	43201	RUC-12	19	0	3	43236	19	0	3
43239	PEAC-02	19	0	3	43202	RUC-12	19	0	3	43239	19	0	3
43241	PEAC-02	19	0	3	43219	RUC-12	19	0	3	43241	19	0	0*
43243	PEAC-02	19	0	3	43204	RUC-12	19	0	3	43243	19	0	3
43244	PEAC-02	19	0	3	43205	RUC-12	19	0	3	43244	19	0	3
43245	PEAC-02	19	0	3	43215	RUC-12	19	0	3	43245	19	0	3
43246	PEAC-05	19	0	3	43205	RUC-12	19	0	3	43246	19	0	0*
43247	PEAC-02	19	0	3	43215	RUC-12	19	0	3	43247	19	0	3
43248	PEAC-02	19	0	3	43226	RUC-12	19	0	3	43248	19	0	3
43249	PEAC-02	19	0	3	43220	RUC-12	19	0	3	43249	19	0	3
43250	PEAC-02	19	0	3	43216	RUC-12	19	0	3	43250	19	0	3
43251	PEAC-02	19	0	3	43217	RUC-12	19	0	3	43251	19	0	3
43252	NEW-13	--	--	--	43206	RUC-12	19	0	3	43252	19	0	3
43255	PEAC-02	19	0	3	43227	RUC-12	19	0	3	43255	19	0	3
43257	RUC-03	19	0	6	43205	RUC-12	19	0	3	43257	19	0	3
43254	NEW	--	--	--	43217	RUC-12	19	0	3	43254	19	0	3
43458	PEAC-02	19	0	3	43205	RUC-12	19	0	3	43233	19	0	3
43256	PEAC-02	19	0	0*	43205	RUC-12	19	0	3	43266	19	0	0*
43458	PEAC-02	19	0	3	43228	RUC-12	19	0	3	43270	19	0	3

\*Typically inpatient

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time: N/A

4. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

For all codes shown above:

- Three minutes to complete pre-service diagnostic and referral forms.
- Five minutes to coordinate pre-surgery services with other qualified healthcare providers
- Three minutes for scheduling space and equipment in facility
- Five minutes to perform pre-service education/ obtain consent
- Three minutes for pre-op prescriptions

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

For all codes shown above EXCEPT 43241, 43246, 4326X8:

- Three minutes for a follow-up phone call to patient

## AMA/Specialty Society Update Process Practice Expense Summary of Recommendation Facility Direct Inputs

CPT Long Descriptor:

43246	Esophagogastroduodenoscopy, flexible, transoral; with directed placement of percutaneous gastrostomy tube
43251	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
43237	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination limited to the esophagus
43238	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), esophagus (includes endoscopic ultrasound examination limited to the esophagus)
43240	Esophagogastroduodenoscopy, flexible, transoral; with transmural drainage of pseudocyst (includes placement of transmural drainage catheter[s]/stent[s], when performed, and endoscopic ultrasound, when performed)
43242	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)
43259	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)
4325X3	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance(s) (eg, anesthetic, neurolytic agent) or fiducial marker(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)

Global Period: 000

Meeting Date: April 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The ACG, AGA, ASGE and SAGES convened a group from a broad range of geographic locations with differing practice circumstances and settings - community, academic, teaching, and public; urban, suburban and rural; single and multi-specialty group; independent and employed - who typically perform these services. The committee served as the consensus panel to develop PE recommendations.

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

Current Time data	Survey Code Recommendation
-------------------	----------------------------

**CPT Code: Tab 11 (EGD)**  
**Specialty Society('s) ACG, AGA, ASGE, SAGES**

CPT	Source	Pre	Intra	Post	CPT	Pre	Intra	Post
43246	PEAC-05	19	0	3	43246	19	0	0*
43251	PEAC-02	19	0	3	43251	19	0	3
43237	RUC-03	19	0	3	43237	19	0	3
43238	RUC-03	19	0	3	43238	19	0	3
43240	PEAC-03	19	0	3	43240	19	0	3
43242	RUC-03	19	0	3	43242	19	0	3
43259	RUC-03	19	0	3	43259	19	0	3
4325X3	NA	NA	NA	NA	4325X3	19	0	3

\*Typically inpatient

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:

We present the following arguments for compelling evidence for 43251:

- Changes in technology
- Changes in site of service
- Errors/omissions in previous valuation

When the Practice Expense Subcommittee reviewed the esophagoscopy codes 43200-43232 (Tab 10) in October 2012, they accepted that there was compelling evidence to review, change and update the practice expense staff, supplies and equipment inputs for all of the codes in the family since they were last evaluated for practice expense, based on changes in technology, site of service migration for several services not previously valued in the non-facility setting, changes in patient safety requirements, and the absence of scope cleaning supplies in non-facility setting.

The practice expense inputs being presented for 43251 correspond directly to the practice expense inputs that were approved for the similar esophagoscopy code 43217 that the RUC approved in October 2012.

5. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

For all codes shown above:

- Three minutes to complete pre-service diagnostic and referral forms.
- Five minutes to coordinate pre-surgery services with other qualified healthcare providers
- Three minutes for scheduling space and equipment in facility
- Five minutes to perform pre-service education/ obtain consent
- Three minutes for pre-op prescriptions

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

For all codes but 43246:

- Three minutes for a follow-up phone call to patient

	A	B	C	D	E	F	G	H	I
1				PEAC 2002		Crosswalk Code from RUC 10/2012		Recommendation (x-walk 43200, RUC 10/12)	
2				43235		43200		43235	
3	Meeting Date: January 2013 Tab: EGD Specialty: GI	CMS Code	Staff Type	EGD, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)		ESOPH, diagnostic, including collection of specimen(s) by brushing or washing when performed		EGD, diagnostic, with collection of specimen(s) by brushing or washing, when performed	
4	LOCATION			NF	FAC	NF	FAC	NF	FAC
5	GLOBAL PERIOD			000	000	000	000	000	000
6	TOTAL CLINICAL LABOR TIME	L051A	RN	37	0	32	0	32	0
7	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	74	22	85	22	85	22
8	PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	9	19	9	19	9	19
9	SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	37	0	32	0	32	0
10	SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	62	0	73	0	73	0
11	POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	3	3	3	3	3	3
12	PRE-SERVICE								
13	Start: Following visit when decision for surgery or procedure made								
14	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	3	3	3	3	3	3
15	Coordinate pre-surgery services	L037D	RN/LPN/MTA	3	5	3	5	3	5
16	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3		3
17	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5		5
18	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3	3	3	3	3	3
20	End: When patient enters office/facility for surgery/procedure								
21	SERVICE PERIOD								
22	Start: When patient enters office/facility for surgery/procedure:								
23	Review charts [N/A in 2012]	L037D	RN/LPN/MTA	2					
24	Review history, systems, and meds [N/A in 2012]	L037D	RN/LPN/MTA	3					
25	Greet patient, provide gowning, ensure appropriate	L037D	RN/LPN/MTA	3		3		3	
26	Obtain vital signs	L037D	RN/LPN/MTA	3		5		5	
27	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	5		3		3	
28	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2		2		2	
29	Setup scope (non facility setting only)	L037D	RN/LPN/MTA			5		5	
30	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	2		2		2	
31	Sedate/apply anesthesia	L051A	RN	2		2		2	
32	Intra-service								
33	Moderate sedation	L051A	RN	20		15		15	
34	Assist physician in performing procedure	L037D	RN/LPN/MTA	17		15		15	
35	Post-Service								
36	Monitor pt. following service/check tubes, monitors,	L051A	RN	15		15		15	
37	Monitor pt. following service/check tubes, monitors,	L037D	RN/LPN/MTA						
38	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	20		3		3	
39	Clean Scope	L037D	RN/LPN/MTA			30		30	
40	Clean Surgical Instrument Package	L037D	RN/LPN/MTA						
41	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA	2		2		2	
42	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA						
43	Check dressings & wound/ home care instructions	L037D	RN/LPN/MTA	3		3		3	
47	End: Patient leaves office								
48	POST-SERVICE Period								
49	Start: Patient leaves office/facility								
50	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	3	3	3	3	3	3
59	End: with last office visit before end of global period								
60	MEDICAL SUPPLIES	CODE	UNIT						
61	SCRUB, DRESS, DRAPE								
62	pack, minimum multi-specialty visit	SA048	pack	1		1		1	
63	gown, staff, impervious	SB027	item	3		2		2	
64	cap, surgical	SB001	item	3		3		3	
65	mask, surgical, with face shield	SB034	item	3		3		3	
66	shoe covers, surgical	SB039	pair	3		3		3	
67	scrub brush (impregnated)	SM023	item			3		3	
68	drape, non-sterile, sheet 40in x 60in	SB006	item			1		1	
69	basin, emesis	SJ010	item	1		1		1	
70	denture cup	SJ016	item			1		1	
71	MODERATE SEDATION								
72	pack, moderate sedation	SA044	pack	1		1		1	
73	electrode, ECG (single)	SD053	item						
74	nasal cannula	SD100	item	1					
75	bite block	SD006	item			1		1	
76	PROCEDURE INSTRUMENTS / SUPPLIES								
77	endoscope anti-fog solution	SM014	ml			1		1	
78	endoscopic cytology brush	SD067	item			1		1	
79	endoscopic biopsy forceps	SD066	item						
80	endoscopic polypectomy snare	SD068	item						
81	endosheath (proxy for endoscopic hood)	SD070	item						
82	endoscopic clip	NEW	item						
83	guidewire, STIFF	SD090	item						
84	endoscopic balloon, dilation	SD019	item						
86	needle, micropigmentation (tattoo)	SC079	item						
87	skin marking ink (tattoo)	SK073	ml						
88	needle, variceal injection	SC044	item						
89	syringe 5-6ml	SC057	item						
90	cautery, patient ground pad with cord	SF021	item						
91	cautery, bipolar cord	SF012	item						
92	cautery, bipolar, probe, endoscopy	NEW	item						
93	catheter, optical endomicroscopy	NEW	item						
94	kit, probe, radiofrequency, Xli-enhanced RF probe (proxy for catheter, RF ablation, endoscopic)	SA100	kit						
95	canister, suction	SD009	item	1		2		1	

	A	B	C	D	E	F	G	H	I
1				PEAC 2002		Crosswalk Code from RUC 10/2012		Recommendation (x-walk 43200, RUC 10/12)	
2				43235		43200		43235	
3	Meeting Date: January 2013 Tab: EGD Specialty: GI	CMS Code	Staff Type	EGD, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)		ESOPH, diagnostic, including collection of specimen(s) by brushing or washing when performed		EGD, diagnostic, with collection of specimen(s) by brushing or washing, when performed	
4	LOCATION			NF	FAC	NF	FAC	NF	FAC
5	GLOBAL PERIOD			000	000	000	000	000	000
96	tubing, suction, non-latex (6ft uou)	SD132	item			1		1	
97	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item	1		1		1	
98	syringe 50-60ml	SC056	item			1		1	
99	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item			1		1	
100	gauze, non-sterile 4in x 4in	SG051	item			1		1	
101	cup, biopsy-specimen non-sterile 4oz	SL035	item			1		1	
102	paper, photo printing (8.5 x 11)	SK058	item			1		1	
103	applicator, cotton-tipped, non-sterile 6in	SG008	item	3					
104	lubricating jelly (K-Y) (5gm uou)	SJ032	item	2		4		4	
106	gauze, non-sterile 2in x 2in	SG050	item	2					
107	iv tubing (extension)	SC019	item	1					
108	kit, needle - free injection system	SA021	item	1					
109	SCOPE CLEANING								
110	pack, cleaning and disinfecting, endoscope	SA042	pack			1		1	
111	pack, cleaning, surgical instruments	SA043	pack						
112	gloves, non-sterile	SB022	pair						
113	basin, irrigation	SJ009	item	1					
114	cleaning brush, endoscope	SM010	item	1					
115	enzymatic detergent	SM015	oz	1					
118	water, distilled	SK087	oz	6					
119	EQUIPMENT	CODE							
120	videoscope, gastroscopy	ES034		34		59		70	
121	stretcher	EF018				73		0	
122	IV infusion pump	EQ032		82		52		77	
123	table, power	EF031		34		29		43	
124	video system, endoscopy (processor, digital capture, monitor, printer, cart)	ES031		34		29		43	
125	suction machine (Gomco)	EQ235		34		29		43	
126	table, instrument, mobile	EF027		82		29		77	
127	radiofrequency generator (NEURO)	EQ214							
128	electrosurgical generator, gastrocautery	EQ113							
129	optical endomicroscope processor unit system	EQ355							
130	endoscope disinfectant, rigid or fiberoptic, w-cart	ES005		40		30		30	
131	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011		82		52		77	
132	light, surgical	EF014		34					
133	stretcher, endoscopy	EF020		60					
134	instrument pack, basic (\$500-\$1499)	EQ137							



	A	B	C	J	K	L	M	N	O
1				RUC 2002		Crosswalk Code from RUC 10/2012		Recommendation (x-walk 43201, RUC 10/12)	
2				43236		43201		43236	
3	Meeting Date: January 2013 Tab: EGD Specialty: GI	CMS Code	Staff Type	EGD, with directed submucosal injection(s), any substance		ESOPH, with directed submucosal injection(s), any substance		EGD, with directed submucosal injection(s), any substance	
4	LOCATION			NF	FAC	NF	FAC	NF	FAC
5	GLOBAL PERIOD			000	000	000	000	000	000
6	TOTAL CLINICAL LABOR TIME	L051A	RN	52	0	35	0	37	0
7	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	86	22	88	22	90	22
8	PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	9	19	9	19	9	19
9	SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	52	0	35	0	37	0
10	SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	74	0	76	0	78	0
11	POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	3	3	3	3	3	3
12	PRE-SERVICE								
13	Start: Following visit when decision for surgery or procedure made								
14	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	3	3	3	3	3	3
15	Coordinate pre-surgery services	L037D	RN/LPN/MTA	3	5	3	5	3	5
16	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3		3
17	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5		5
18	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3	3	3	3	3	3
20	End: When patient enters office/facility for surgery/procedure								
21	SERVICE PERIOD								
22	Start: When patient enters office/facility for surgery/procedure:								
23	Review charts [N/A in 2012]	L037D	RN/LPN/MTA	2					
24	Review history, systems, and meds [N/A in 2012]	L037D	RN/LPN/MTA	3					
25	Greet patient, provide gowning, ensure appropriate	L037D	RN/LPN/MTA	3		3		3	
26	Obtain vital signs	L037D	RN/LPN/MTA	3		5		5	
27	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	5		3		3	
28	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2		2		2	
29	Setup scope (non facility setting only)	L037D	RN/LPN/MTA			5		5	
30	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	2		2		2	
31	Sedate/apply anesthesia	L051A	RN	2		2		2	
32	Intra-service								
33	Moderate sedation	L051A	RN	35		18		20	
34	Assist physician in performing procedure	L037D	RN/LPN/MTA	17		18		20	
35	Post-Service								
36	Monitor pt. following service/check tubes, monitors,	L051A	RN	15		15		15	
37	Monitor pt. following service/check tubes, monitors,	L037D	RN/LPN/MTA	25					
38	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	7		3		3	
39	Clean Scope	L037D	RN/LPN/MTA			30		30	
40	Clean Surgical Instrument Package	L037D	RN/LPN/MTA						
41	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA	2		2		2	
42	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA						
43	Check dressings & wound/ home care instructions	L037D	RN/LPN/MTA	3		3		3	
47	End: Patient leaves office								
48	POST-SERVICE Period								
49	Start: Patient leaves office/facility								
50	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	3	3	3	3	3	3
59	End: with last office visit before end of global period								
60	MEDICAL SUPPLIES	CODE	UNIT						
61	SCRUB, DRESS, DRAPE								
62	pack, minimum multi-specialty visit	SA048	pack	1		1		1	
63	gown, staff, impervious	SB027	item			2		2	
64	cap, surgical	SB001	item	3		3		3	
65	mask, surgical, with face shield	SB034	item	3		3		3	
66	shoe covers, surgical	SB039	pair	3		3		3	
67	scrub brush (impregnated)	SM023	item	3		3		3	
68	drape, non-sterile, sheet 40in x 60in	SB006	item			1		1	
69	basin, emesis	SJ010	item	1		1		1	
70	denture cup	SJ016	item			1		1	
71	MODERATE SEDATION								
72	pack, moderate sedation	SA044	pack	1		1		1	
73	electrode, ECG (single)	SD053	item	1					
74	nasal cannula	SD100	item	1					
75	bite block	SD006	item	1		1		1	
76	PROCEDURE INSTRUMENTS / SUPPLIES								
77	endoscope anti-fog solution	SM014	ml			1		1	
78	endoscopic cytology brush	SD067	item						
79	endoscopic biopsy forceps	SD066	item						
80	endoscopic polypectomy snare	SD068	item						
81	endosheath (proxy for endoscopic hood)	SD070	item						
82	endoscopic clip	NEW	item						
83	guidewire, STIFF	SD090	item						
84	endoscopic balloon, dilation	SD019	item						
86	needle, micropigmentation (tattoo)	SC079	item			1		1	
87	skin marking ink (tattoo)	SK073	ml			2		2	
88	needle, variceal injection	SC044	item	1				1	
89	syringe 5-6ml	SC057	item	3		3		3	
90	cautery, patient ground pad with cord	SF021	item						
91	cautery, bipolar cord	SF012	item						
92	cautery, bipolar, probe, endoscopy	NEW	item						
93	catheter, optical endomicroscopy	NEW	item						
94	kit, probe, radiofrequency, Xli-enhanced RF probe (proxy for catheter, RF ablation, endoscopic)	SA100	kit						
95	canister, suction	SD009	item	1		2		1	

	A	B	C	J	K	L	M	N	O
1				RUC 2002		Crosswalk Code from RUC 10/2012		Recommendation (x-walk 43201, RUC 10/12)	
2				43236		43201		43236	
3	Meeting Date: January 2013 Tab: EGD Specialty: GI	CMS Code	Staff Type	EGD, with directed submucosal injection(s), any substance		ESOPH, with directed submucosal injection(s), any substance		EGD, with directed submucosal injection(s), any substance	
4	LOCATION			NF	FAC	NF	FAC	NF	FAC
5	GLOBAL PERIOD			000	000	000	000	000	000
96	tubing, suction, non-latex (6ft uou)	SD132	item			1		1	
97	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item			1		1	
98	syringe 50-60ml	SC056	item			1		1	
99	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item			1		1	
100	gauze, non-sterile 4in x 4in	SG051	item			1		1	
101	cup, biopsy-specimen non-sterile 4oz	SL035	item			1		1	
102	paper, photo printing (8.5 x 11)	SK058	item			1		1	
103	applicator, cotton-tipped, non-sterile 6in	SG008	item						
104	lubricating jelly (K-Y) (5gm uou)	SJ032	item	2		4		4	
106	gauze, non-sterile 2in x 2in	SG050	item						
107	iv tubing (extension)	SC019	item						
108	kit, needle - free injection system	SA021	item	1					
109	SCOPE CLEANING								
110	pack, cleaning and disinfecting, endoscope	SA042	pack			1		1	
111	pack, cleaning, surgical instruments	SA043	pack						
112	gloves, non-sterile	SB022	pair	1					
113	basin, irrigation	SJ009	item	1					
114	cleaning brush, endoscope	SM010	item	1					
115	enzymatic detergent	SM015	oz						
118	water, distilled	SK087	oz						
119	EQUIPMENT	CODE							
120	videoscope, gastroscopy	ES034		40		62		75	
121	stretcher	EF018				76		0	
122	IV infusion pump	EQ032		97		55		82	
123	table, power	EF031		40		32		48	
124	video system, endoscopy (processor, digital capture, monitor, printer, cart)	ES031		40		32		48	
125	suction machine (Gomco)	EQ235		40		32		48	
126	table, instrument, mobile	EF027		97		32		82	
127	radiofrequency generator (NEURO)	EQ214							
128	electrosurgical generator, gastrocautery	EQ113							
129	optical endomicroscope processor unit system	EQ355							
130	endoscope disinfectant, rigid or fiberoptic, w-cart	ES005		40		30		30	
131	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011		97		55		82	
132	light, surgical	EF014		40					
133	stretcher, endoscopy	EF020		60					
134	instrument pack, basic (\$500-\$1499)	EQ137							



	A	B	C	P	Q	R	S	T	U
1				PEAC 2002		Crosswalk Code from RUC 10/2012		Recommendation (x-walk 43202, RUC 10/12)	
2				43239		43202		43239	
3	Meeting Date: January 2013 Tab: EGD Specialty: GI	CMS Code	Staff Type	EGD, with biopsy, single or multiple		ESOPH, with biopsy, single or multiple		EGD, with biopsy, single or multiple	
4	LOCATION			NF	FAC	NF	FAC	NF	FAC
5	GLOBAL PERIOD			000	000	000	000	000	000
6	TOTAL CLINICAL LABOR TIME	L051A	RN	51	0	37	0	32	0
7	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	84	22	90	22	85	22
8	PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	9	19	9	19	9	19
9	SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	51	0	37	0	32	0
10	SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	72	0	78	0	73	0
11	POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	3	3	3	3	3	3
12	PRE-SERVICE								
13	Start: Following visit when decision for surgery or procedure made								
14	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	3	3	3	3	3	3
15	Coordinate pre-surgery services	L037D	RN/LPN/MTA	3	5	3	5	3	5
16	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3		3
17	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5		5
18	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3	3	3	3	3	3
20	End: When patient enters office/facility for surgery/procedure								
21	SERVICE PERIOD								
22	Start: When patient enters office/facility for surgery/procedure:								
23	Review charts [N/A in 2012]	L037D	RN/LPN/MTA	2					
24	Review history, systems, and meds [N/A in 2012]	L037D	RN/LPN/MTA	3					
25	Greet patient, provide gowning, ensure appropriate	L037D	RN/LPN/MTA	3		3		3	
26	Obtain vital signs	L037D	RN/LPN/MTA	3		5		5	
27	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	5		3		3	
28	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2		2		2	
29	Setup scope (non facility setting only)	L037D	RN/LPN/MTA			5		5	
30	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	2		2		2	
31	Sedate/apply anesthesia	L051A	RN	2		2		2	
32	Intra-service								
33	Moderate sedation	L051A	RN	34		20		15	
34	Assist physician in performing procedure	L037D	RN/LPN/MTA	22		20		15	
35	Post-Service								
36	Monitor pt. following service/check tubes, monitors,	L051A	RN	15		15		15	
37	Monitor pt. following service/check tubes, monitors,	L037D	RN/LPN/MTA						
38	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	25		3		3	
39	Clean Scope	L037D	RN/LPN/MTA			30		30	
40	Clean Surgical Instrument Package	L037D	RN/LPN/MTA						
41	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA	2		2		2	
42	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA						
43	Check dressings & wound/ home care instructions	L037D	RN/LPN/MTA	3		3		3	
47	End: Patient leaves office								
48	POST-SERVICE Period								
49	Start: Patient leaves office/facility								
50	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	3	3	3	3	3	3
59	End: with last office visit before end of global period								
60	MEDICAL SUPPLIES	CODE	UNIT						
61	SCRUB, DRESS, DRAPE								
62	pack, minimum multi-specialty visit	SA048	pack	1		1		1	
63	gown, staff, impervious	SB027	item	3		2		2	
64	cap, surgical	SB001	item	3		3		3	
65	mask, surgical, with face shield	SB034	item	3		3		3	
66	shoe covers, surgical	SB039	pair	3		3		3	
67	scrub brush (impregnated)	SM023	item			3		3	
68	drape, non-sterile, sheet 40in x 60in	SB006	item			1		1	
69	basin, emesis	SJ010	item	1		1		1	
70	denture cup	SJ016	item			1		1	
71	MODERATE SEDATION								
72	pack, moderate sedation	SA044	pack	1		1		1	
73	electrode, ECG (single)	SD053	item						
74	nasal cannula	SD100	item	1					
75	bite block	SD006	item			1		1	
76	PROCEDURE INSTRUMENTS / SUPPLIES								
77	endoscope anti-fog solution	SM014	ml			1		1	
78	endoscopic cytology brush	SD067	item			1		1	
79	endoscopic biopsy forceps	SD066	item			1		1	
80	endoscopic polypectomy snare	SD068	item						
81	endosheath (proxy for endoscopic hood)	SD070	item						
82	endoscopic clip	NEW	item						
83	guidewire, STIFF	SD090	item						
84	endoscopic balloon, dilation	SD019	item						
86	needle, micropigmentation (tattoo)	SC079	item						
87	skin marking ink (tattoo)	SK073	ml						
88	needle, variceal injection	SC044	item						
89	syringe 5-6ml	SC057	item						
90	cautery, patient ground pad with cord	SF021	item						
91	cautery, bipolar cord	SF012	item						
92	cautery, bipolar, probe, endoscopy	NEW	item						
93	catheter, optical endomicroscopy	NEW	item						
94	kit, probe, radiofrequency, Xli-enhanced RF probe (proxy for catheter, RF ablation, endoscopic)	SA100	kit						
95	canister, suction	SD009	item	1		2		1	

	A	B	C	P	Q	R	S	T	U
1				PEAC 2002		Crosswalk Code from RUC 10/2012		Recommendation (x-walk 43202, RUC 10/12)	
2				43239		43202		43239	
3	Meeting Date: January 2013 Tab: EGD Specialty: GI	CMS Code	Staff Type	EGD, with biopsy, single or multiple		ESOPH, with biopsy, single or multiple		EGD, with biopsy, single or multiple	
4	LOCATION			NF	FAC	NF	FAC	NF	FAC
5	GLOBAL PERIOD			000	000	000	000	000	000
96	tubing, suction, non-latex (6ft uou)	SD132	item			1		1	
97	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item	1		1		1	
98	syringe 50-60ml	SC056	item			1		1	
99	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item			1		1	
100	gauze, non-sterile 4in x 4in	SG051	item			1		1	
101	cup, biopsy-specimen non-sterile 4oz	SL035	item			1		1	
102	paper, photo printing (8.5 x 11)	SK058	item			1		1	
103	applicator, cotton-tipped, non-sterile 6in	SG008	item	3					
104	lubricating jelly (K-Y) (5gm uou)	SJ032	item	2		4		4	
106	gauze, non-sterile 2in x 2in	SG050	item	2					
107	iv tubing (extension)	SC019	item	1					
108	kit, needle - free injection system	SA021	item	1					
109	SCOPE CLEANING								
110	pack, cleaning and disinfecting, endoscope	SA042	pack			1		1	
111	pack, cleaning, surgical instruments	SA043	pack						
112	gloves, non-sterile	SB022	pair						
113	basin, irrigation	SJ009	item	1					
114	cleaning brush, endoscope	SM010	item	1					
115	enzymatic detergent	SM015	oz	1					
118	water, distilled	SK087	oz	6					
119	EQUIPMENT	CODE							
120	videoscope, gastroscopy	ES034		43		64		70	
121	stretcher	EF018				78		0	
122	IV infusion pump	EQ032		96		57		77	
123	table, power	EF031		43		34		43	
124	video system, endoscopy (processor, digital capture, monitor, printer, cart)	ES031		43		34		43	
125	suction machine (Gomco)	EQ235		43		34		43	
126	table, instrument, mobile	EF027		96		34		77	
127	radiofrequency generator (NEURO)	EQ214							
128	electrosurgical generator, gastrocautery	EQ113							
129	optical endomicroscope processor unit system	EQ355							
130	endoscope disinfectant, rigid or fiberoptic, w-cart	ES005		40		30		30	
131	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011		96		57		77	
132	light, surgical	EF014		43					
133	stretcher, endoscopy	EF020		60					
134	instrument pack, basic (\$500-\$1499)	EQ137							

	A	B	C	V	W	X	Y	Z	AA
1				PEAC 2002		Crosswalk Code from RUC 10/2012		Recommendation (x-walk 43219 RUC 10/12) <b>FAC ONLY</b>	
2				43241		43219		43241	
3	Meeting Date: January 2013 Tab: EGD Specialty: GI	CMS Code	Staff Type	EGD, with insertion of intraluminal tube or catheter		ESOPH, with insertion of plastic tube or stent		EGD, with insertion of intraluminal tube or catheter	
4	LOCATION			NF	FAC	NF	FAC	NF	FAC
5	GLOBAL PERIOD			000	000	000	000	000	000
6	TOTAL CLINICAL LABOR TIME	L051A	RN	0	0	0	0	n/a	0
7	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	22	0	19	n/a	19
8	PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	19	0	19	n/a	19
9	SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	0	0	0	0	n/a	0
10	SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	0	0	0	n/a	0
11	POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	3	0	0	n/a	0
12	PRE-SERVICE								
13	Start: Following visit when decision for surgery or procedure made								
14	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		3		3		3
15	Coordinate pre-surgery services	L037D	RN/LPN/MTA		5		5		5
16	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3		3
17	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5		5
18	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		3		3		3
20	End: When patient enters office/facility for surgery/procedure								
21	SERVICE PERIOD								
22	Start: When patient enters office/facility for surgery/procedure:								
23	Review charts [N/A in 2012]	L037D	RN/LPN/MTA						
24	Review history, systems, and meds [N/A in 2012]	L037D	RN/LPN/MTA						
25	Greet patient, provide gowning, ensure appropriate	L037D	RN/LPN/MTA						
26	Obtain vital signs	L037D	RN/LPN/MTA						
27	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA						
28	Prepare room, equipment, supplies	L037D	RN/LPN/MTA						
29	Setup scope (non facility setting only)	L037D	RN/LPN/MTA						
30	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA						
31	Sedate/apply anesthesia	L051A	RN						
32	Intra-service								
33	Moderate sedation	L051A	RN						
34	Assist physician in performing procedure	L037D	RN/LPN/MTA						
35	Post-Service								
36	Monitor pt. following service/check tubes, monitors,	L051A	RN						
37	Monitor pt. following service/check tubes, monitors,	L037D	RN/LPN/MTA						
38	Clean room/equipment by physician staff	L037D	RN/LPN/MTA						
39	Clean Scope	L037D	RN/LPN/MTA						
40	Clean Surgical Instrument Package	L037D	RN/LPN/MTA						
41	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA						
42	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA						
43	Check dressings & wound/ home care instructions	L037D	RN/LPN/MTA						
47	End: Patient leaves office								
48	POST-SERVICE Period								
49	Start: Patient leaves office/facility								
50	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA		3		0		0
59	End: with last office visit before end of global period								
60	MEDICAL SUPPLIES	CODE	UNIT						
61	SCRUB, DRESS, DRAPE								
62	pack, minimum multi-specialty visit	SA048	pack						
63	gown, staff, impervious	SB027	item						
64	cap, surgical	SB001	item						
65	mask, surgical, with face shield	SB034	item						
66	shoe covers, surgical	SB039	pair						
67	scrub brush (impregnated)	SM023	item						
68	drape, non-sterile, sheet 40in x 60in	SB006	item						
69	basin, emesis	SJ010	item						
70	denture cup	SJ016	item						
71	MODERATE SEDATION								
72	pack, moderate sedation	SA044	pack						
73	electrode, ECG (single)	SD053	item						
74	nasal cannula	SD100	item						
75	bite block	SD006	item						
76	PROCEDURE INSTRUMENTS / SUPPLIES								
77	endoscope anti-fog solution	SM014	ml						
78	endoscopic cytology brush	SD067	item						
79	endoscopic biopsy forceps	SD066	item						
80	endoscopic polypectomy snare	SD068	item						
81	endosheath (proxy for endoscopic hood)	SD070	item						
82	endoscopic clip	NEW	item						
83	guidewire, STIFF	SD090	item						
84	endoscopic balloon, dilation	SD019	item						
86	needle, micropigmentation (tattoo)	SC079	item						
87	skin marking ink (tattoo)	SK073	ml						
88	needle, variceal injection	SC044	item						
89	syringe 5-6ml	SC057	item						
90	cautery, patient ground pad with cord	SF021	item						
91	cautery, bipolar cord	SF012	item						
92	cautery, bipolar, probe, endoscopy	NEW	item						
93	catheter, optical endomicroscopy	NEW	item						
94	kit, probe, radiofrequency, Xli-enhanced RF probe (proxy for catheter, RF ablation, endoscopic)	SA100	kit						
95	canister, suction	SD009	item						



	A	B	C	V	W	X	Y	Z	AA
1				PEAC 2002		Crosswalk Code from RUC 10/2012		Recommendation (x-walk 43219 RUC 10/12) FAC ONLY	
2				43241		43219		43241	
3	Meeting Date: January 2013 Tab: EGD Specialty: GI	CMS Code	Staff Type	EGD, with insertion of intraluminal tube or catheter		ESOPH, with insertion of plastic tube or stent		EGD, with insertion of intraluminal tube or catheter	
4	LOCATION			NF	FAC	NF	FAC	NF	FAC
5	GLOBAL PERIOD			000	000	000	000	000	000
96	tubing, suction, non-latex (6ft uou)	SD132	item						
97	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item						
98	syringe 50-60ml	SC056	item						
99	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item						
100	gauze, non-sterile 4in x 4in	SG051	item						
101	cup, biopsy-specimen non-sterile 4oz	SL035	item						
102	paper, photo printing (8.5 x 11)	SK058	item						
103	applicator, cotton-tipped, non-sterile 6in	SG008	item						
104	lubricating jelly (K-Y) (5gm uou)	SJ032	item						
106	gauze, non-sterile 2in x 2in	SG050	item						
107	iv tubing (extension)	SC019	item						
108	kit, needle - free injection system	SA021	item						
109	SCOPE CLEANING								
110	pack, cleaning and disinfecting, endoscope	SA042	pack						
111	pack, cleaning, surgical instruments	SA043	pack						
112	gloves, non-sterile	SB022	pair						
113	basin, irrigation	SJ009	item						
114	cleaning brush, endoscope	SM010	item						
115	enzymatic detergent	SM015	oz						
118	water, distilled	SK087	oz						
119	EQUIPMENT	CODE							
120	videoscope, gastroscopy	ES034							
121	stretcher	EF018							
122	IV infusion pump	EQ032							
123	table, power	EF031							
124	video system, endoscopy (processor, digital capture, monitor, printer, cart)	ES031							
125	suction machine (Gomco)	EQ235							
126	table, instrument, mobile	EF027							
127	radiofrequency generator (NEURO)	EQ214							
128	electrosurgical generator, gastrocautery	EQ113							
129	optical endomicroscope processor unit system	EQ355							
130	endoscope disinfectant, rigid or fiberoptic, w-cart	ES005							
131	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011							
132	light, surgical	EF014							
133	stretcher, endoscopy	EF020							
134	instrument pack, basic (\$500-\$1499)	EQ137							

	A	B	C	AB	AC	AD	AE	AF	AG
1				PEAC 2002		Crosswalk Code from RUC 10/2012		Recommendation (x-walk 43204 RUC 10/12) FAC ONLY	
2				43243		43204		43243	
3	Meeting Date: January 2013 Tab: EGD Specialty: GI	CMS Code	Staff Type	EGD, injection sclerosis of esophageal / gastric varices		ESOPH, with injection sclerosis of esophageal varices		EGD, injection sclerosis of esophageal / gastric varices	
4	LOCATION			NF	FAC	NF	FAC	NF	FAC
5	GLOBAL PERIOD			000	000	000	000	000	000
6	TOTAL CLINICAL LABOR TIME	L051A	RN	0	0	0	0	n/a	0
7	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	22	0	22	n/a	19
8	PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	19	0	19	n/a	19
9	SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	0	0	0	0	n/a	0
10	SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	0	0	0	n/a	0
11	POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	3	0	3	n/a	0
12	PRE-SERVICE								
13	Start: Following visit when decision for surgery or procedure made								
14	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		3		3		3
15	Coordinate pre-surgery services	L037D	RN/LPN/MTA		5		5		5
16	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3		3
17	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5		5
18	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		3		3		3
20	End: When patient enters office/facility for surgery/procedure								
21	SERVICE PERIOD								
22	Start: When patient enters office/facility for surgery/procedure:								
23	Review charts [N/A in 2012]	L037D	RN/LPN/MTA						
24	Review history, systems, and meds [N/A in 2012]	L037D	RN/LPN/MTA						
25	Greet patient, provide gowning, ensure appropriate	L037D	RN/LPN/MTA						
26	Obtain vital signs	L037D	RN/LPN/MTA						
27	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA						
28	Prepare room, equipment, supplies	L037D	RN/LPN/MTA						
29	Setup scope (non facility setting only)	L037D	RN/LPN/MTA						
30	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA						
31	Sedate/apply anesthesia	L051A	RN						
32	Intra-service								
33	Moderate sedation	L051A	RN						
34	Assist physician in performing procedure	L037D	RN/LPN/MTA						
35	Post-Service								
36	Monitor pt. following service/check tubes, monitors,	L051A	RN						
37	Monitor pt. following service/check tubes, monitors,	L037D	RN/LPN/MTA						
38	Clean room/equipment by physician staff	L037D	RN/LPN/MTA						
39	Clean Scope	L037D	RN/LPN/MTA						
40	Clean Surgical Instrument Package	L037D	RN/LPN/MTA						
41	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA						
42	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA						
43	Check dressings & wound/ home care instructions	L037D	RN/LPN/MTA						
47	End: Patient leaves office								
48	POST-SERVICE Period								
49	Start: Patient leaves office/facility								
50	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA		3		3		0
59	End: with last office visit before end of global period								
60	MEDICAL SUPPLIES	CODE	UNIT						
61	SCRUB, DRESS, DRAPE								
62	pack, minimum multi-specialty visit	SA048	pack						
63	gown, staff, impervious	SB027	item						
64	cap, surgical	SB001	item						
65	mask, surgical, with face shield	SB034	item						
66	shoe covers, surgical	SB039	pair						
67	scrub brush (impregnated)	SM023	item						
68	drape, non-sterile, sheet 40in x 60in	SB006	item						
69	basin, emesis	SJ010	item						
70	denture cup	SJ016	item						
71	MODERATE SEDATION								
72	pack, moderate sedation	SA044	pack						
73	electrode, ECG (single)	SD053	item						
74	nasal cannula	SD100	item						
75	bite block	SD006	item						
76	PROCEDURE INSTRUMENTS / SUPPLIES								
77	endoscope anti-fog solution	SM014	ml						
78	endoscopic cytology brush	SD067	item						
79	endoscopic biopsy forceps	SD066	item						
80	endoscopic polypectomy snare	SD068	item						
81	endosheath (proxy for endoscopic hood)	SD070	item						
82	endoscopic clip	NEW	item						
83	guidewire, STIFF	SD090	item						
84	endoscopic balloon, dilation	SD019	item						
86	needle, micropigmentation (tattoo)	SC079	item						
87	skin marking ink (tattoo)	SK073	ml						
88	needle, variceal injection	SC044	item						
89	syringe 5-6ml	SC057	item						
90	cautery, patient ground pad with cord	SF021	item						
91	cautery, bipolar cord	SF012	item						
92	cautery, bipolar, probe, endoscopy	NEW	item						
93	catheter, optical endomicroscopy	NEW	item						
94	kit, probe, radiofrequency, Xli-enhanced RF probe (proxy for catheter, RF ablation, endoscopic)	SA100	kit						
95	canister, suction	SD009	item						

	A	B	C	AB	AC	AD	AE	AF	AG
1				PEAC 2002		Crosswalk Code from RUC 10/2012		Recommendation (x-walk 43204 RUC 10/12) FAC ONLY	
2				43243		43204		43243	
3	Meeting Date: January 2013 Tab: EGD Specialty: GI	CMS Code	Staff Type	EGD, injection sclerosis of esophageal / gastric varices		ESOPH, with injection sclerosis of esophageal varices		EGD, injection sclerosis of esophageal / gastric varices	
4	LOCATION			NF	FAC	NF	FAC	NF	FAC
5	GLOBAL PERIOD			000	000	000	000	000	000
96	tubing, suction, non-latex (6ft uou)	SD132	item						
97	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item						
98	syringe 50-60ml	SC056	item						
99	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item						
100	gauze, non-sterile 4in x 4in	SG051	item						
101	cup, biopsy-specimen non-sterile 4oz	SL035	item						
102	paper, photo printing (8.5 x 11)	SK058	item						
103	applicator, cotton-tipped, non-sterile 6in	SG008	item						
104	lubricating jelly (K-Y) (5gm uou)	SJ032	item						
106	gauze, non-sterile 2in x 2in	SG050	item						
107	iv tubing (extension)	SC019	item						
108	kit, needle - free injection system	SA021	item						
109	SCOPE CLEANING								
110	pack, cleaning and disinfecting, endoscope	SA042	pack						
111	pack, cleaning, surgical instruments	SA043	pack						
112	gloves, non-sterile	SB022	pair						
113	basin, irrigation	SJ009	item						
114	cleaning brush, endoscope	SM010	item						
115	enzymatic detergent	SM015	oz						
118	water, distilled	SK087	oz						
119	EQUIPMENT	CODE							
120	videoscope, gastroscopy	ES034							
121	stretcher	EF018							
122	IV infusion pump	EQ032							
123	table, power	EF031							
124	video system, endoscopy (processor, digital capture, monitor, printer, cart)	ES031							
125	suction machine (Gomco)	EQ235							
126	table, instrument, mobile	EF027							
127	radiofrequency generator (NEURO)	EQ214							
128	electrosurgical generator, gastrocautery	EQ113							
129	optical endomicroscope processor unit system	EQ355							
130	endoscope disinfectant, rigid or fiberoptic, w-cart	ES005							
131	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011							
132	light, surgical	EF014							
133	stretcher, endoscopy	EF020							
134	instrument pack, basic (\$500-\$1499)	EQ137							



	A	B	C	AH	AI	AJ	AK	AL	AM
1				PEAC 2002		Crosswalk Code from RUC 10/2012		Recommendation (x-walk 43205 RUC 10/12) <b>FAC ONLY</b>	
2				43244		43205		43244	
3	Meeting Date: January 2013 Tab: EGD Specialty: GI	CMS Code	Staff Type	EGD, with band ligation of esophageal / gastric varices		ESOPH, with band ligation of esophageal varices		EGD, with band ligation of esophageal / gastric varices	
4	LOCATION			NF	FAC	NF	FAC	NF	FAC
5	GLOBAL PERIOD			000	000	000	000	000	000
6	TOTAL CLINICAL LABOR TIME	L051A	RN	0	0	0	0	n/a	0
7	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	22	0	22	n/a	22
8	PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	19	0	19	n/a	19
9	SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	0	0	0	0	n/a	0
10	SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	0	0	0	n/a	0
11	POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	3	0	3	n/a	3
12	PRE-SERVICE								
13	Start: Following visit when decision for surgery or procedure made								
14	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		3		3		3
15	Coordinate pre-surgery services	L037D	RN/LPN/MTA		5		5		5
16	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3		3
17	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5		5
18	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		3		3		3
20	End: When patient enters office/facility for surgery/procedure								
21	SERVICE PERIOD								
22	Start: When patient enters office/facility for surgery/procedure:								
23	Review charts [N/A in 2012]	L037D	RN/LPN/MTA						
24	Review history, systems, and meds [N/A in 2012]	L037D	RN/LPN/MTA						
25	Greet patient, provide gowning, ensure appropriate	L037D	RN/LPN/MTA						
26	Obtain vital signs	L037D	RN/LPN/MTA						
27	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA						
28	Prepare room, equipment, supplies	L037D	RN/LPN/MTA						
29	Setup scope (non facility setting only)	L037D	RN/LPN/MTA						
30	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA						
31	Sedate/apply anesthesia	L051A	RN						
32	Intra-service								
33	Moderate sedation	L051A	RN						
34	Assist physician in performing procedure	L037D	RN/LPN/MTA						
35	Post-Service								
36	Monitor pt. following service/check tubes, monitors,	L051A	RN						
37	Monitor pt. following service/check tubes, monitors,	L037D	RN/LPN/MTA						
38	Clean room/equipment by physician staff	L037D	RN/LPN/MTA						
39	Clean Scope	L037D	RN/LPN/MTA						
40	Clean Surgical Instrument Package	L037D	RN/LPN/MTA						
41	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA						
42	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA						
43	Check dressings & wound/ home care instructions	L037D	RN/LPN/MTA						
47	End: Patient leaves office								
48	POST-SERVICE Period								
49	Start: Patient leaves office/facility								
50	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA		3		3		3
59	End: with last office visit before end of global period								
60	MEDICAL SUPPLIES	CODE	UNIT						
61	SCRUB, DRESS, DRAPE								
62	pack, minimum multi-specialty visit	SA048	pack						
63	gown, staff, impervious	SB027	item						
64	cap, surgical	SB001	item						
65	mask, surgical, with face shield	SB034	item						
66	shoe covers, surgical	SB039	pair						
67	scrub brush (impregnated)	SM023	item						
68	drape, non-sterile, sheet 40in x 60in	SB006	item						
69	basin, emesis	SJ010	item						
70	denture cup	SJ016	item						
71	MODERATE SEDATION								
72	pack, moderate sedation	SA044	pack						
73	electrode, ECG (single)	SD053	item						
74	nasal cannula	SD100	item						
75	bite block	SD006	item						
76	PROCEDURE INSTRUMENTS / SUPPLIES								
77	endoscope anti-fog solution	SM014	ml						
78	endoscopic cytology brush	SD067	item						
79	endoscopic biopsy forceps	SD066	item						
80	endoscopic polypectomy snare	SD068	item						
81	endosheath (proxy for endoscopic hood)	SD070	item						
82	endoscopic clip	NEW	item						
83	guidewire, STIFF	SD090	item						
84	endoscopic balloon, dilation	SD019	item						
86	needle, micropigmentation (tattoo)	SC079	item						
87	skin marking ink (tattoo)	SK073	ml						
88	needle, variceal injection	SC044	item						
89	syringe 5-6ml	SC057	item						
90	cautery, patient ground pad with cord	SF021	item						
91	cautery, bipolar cord	SF012	item						
92	cautery, bipolar, probe, endoscopy	NEW	item						
93	catheter, optical endomicroscopy	NEW	item						
94	kit, probe, radiofrequency, Xli-enhanced RF probe (proxy for catheter, RF ablation, endoscopic)	SA100	kit						
95	canister, suction	SD009	item						

	A	B	C	AH	AI	AJ	AK	AL	AM
1				PEAC 2002		Crosswalk Code from RUC 10/2012		Recommendation (x-walk 43205 RUC 10/12) FAC ONLY	
2				43244		43205		43244	
3	Meeting Date: January 2013 Tab: EGD Specialty: GI	CMS Code	Staff Type	EGD, with band ligation of esophageal / gastric varices		ESOPH, with band ligation of esophageal varices		EGD, with band ligation of esophageal / gastric varices	
4	LOCATION			NF	FAC	NF	FAC	NF	FAC
5	GLOBAL PERIOD			000	000	000	000	000	000
96	tubing, suction, non-latex (6ft uou)	SD132	item						
97	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item						
98	syringe 50-60ml	SC056	item						
99	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item						
100	gauze, non-sterile 4in x 4in	SG051	item						
101	cup, biopsy-specimen non-sterile 4oz	SL035	item						
102	paper, photo printing (8.5 x 11)	SK058	item						
103	applicator, cotton-tipped, non-sterile 6in	SG008	item						
104	lubricating jelly (K-Y) (5gm uou)	SJ032	item						
106	gauze, non-sterile 2in x 2in	SG050	item						
107	iv tubing (extension)	SC019	item						
108	kit, needle - free injection system	SA021	item						
109	SCOPE CLEANING								
110	pack, cleaning and disinfecting, endoscope	SA042	pack						
111	pack, cleaning, surgical instruments	SA043	pack						
112	gloves, non-sterile	SB022	pair						
113	basin, irrigation	SJ009	item						
114	cleaning brush, endoscope	SM010	item						
115	enzymatic detergent	SM015	oz						
118	water, distilled	SK087	oz						
119	EQUIPMENT	CODE							
120	videoscope, gastroscopy	ES034							
121	stretcher	EF018							
122	IV infusion pump	EQ032							
123	table, power	EF031							
124	video system, endoscopy (processor, digital capture, monitor, printer, cart)	ES031							
125	suction machine (Gomco)	EQ235							
126	table, instrument, mobile	EF027							
127	radiofrequency generator (NEURO)	EQ214							
128	electrosurgical generator, gastrocautery	EQ113							
129	optical endomicroscope processor unit system	EQ355							
130	endoscope disinfectant, rigid or fiberoptic, w-cart	ES005							
131	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011							
132	light, surgical	EF014							
133	stretcher, endoscopy	EF020							
134	instrument pack, basic (\$500-\$1499)	EQ137							



	A	B	C	AN	AO	AP	AQ	AR	AS
1				PEAC 2002		Crosswalk Code from RUC 10/2012		Recommendation (x-walk 43215 RUC 10/12)	
2				43245		43215		43245	
3	Meeting Date: January 2013 Tab: EGD Specialty: GI	CMS Code	Staff Type	EGD, with dilation of gastric /duodenal stricture(s) (eg, balloon, bougie)		ESOPH, with removal of foreign body		EGD, with dilation of gastric /duodenal stricture(s) (eg, balloon, bougie)	
4	LOCATION			NF	FAC	NF	FAC	NF	FAC
5	GLOBAL PERIOD			000	000	000	000	000	000
6	TOTAL CLINICAL LABOR TIME	L051A	RN	0	0	37	0	40	0
7	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	22	90	22	93	22
8	PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	19	9	19	9	19
9	SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	0	0	37	0	40	0
10	SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	0	78	0	81	0
11	POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	3	3	3	3	3
12	PRE-SERVICE								
13	Start: Following visit when decision for surgery or procedure made								
14	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		3	3	3	3	3
15	Coordinate pre-surgery services	L037D	RN/LPN/MTA		5	3	5	3	5
16	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3		3
17	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5		5
18	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		3	3	3	3	3
20	End: When patient enters office/facility for surgery/procedure								
21	SERVICE PERIOD								
22	Start: When patient enters office/facility for surgery/procedure:								
23	Review charts [N/A in 2012]	L037D	RN/LPN/MTA						
24	Review history, systems, and meds [N/A in 2012]	L037D	RN/LPN/MTA						
25	Greet patient, provide gowning, ensure appropriate	L037D	RN/LPN/MTA			3		3	
26	Obtain vital signs	L037D	RN/LPN/MTA			5		5	
27	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA			3		3	
28	Prepare room, equipment, supplies	L037D	RN/LPN/MTA			2		2	
29	Setup scope (non facility setting only)	L037D	RN/LPN/MTA			5		5	
30	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA			2		2	
31	Sedate/apply anesthesia	L051A	RN			2		2	
32	Intra-service								
33	Moderate sedation	L051A	RN			20		23	
34	Assist physician in performing procedure	L037D	RN/LPN/MTA			20		23	
35	Post-Service								
36	Monitor pt. following service/check tubes, monitors,	L051A	RN			15		15	
37	Monitor pt. following service/check tubes, monitors,	L037D	RN/LPN/MTA						
38	Clean room/equipment by physician staff	L037D	RN/LPN/MTA			3		3	
39	Clean Scope	L037D	RN/LPN/MTA			30		30	
40	Clean Surgical Instrument Package	L037D	RN/LPN/MTA						
41	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA			2		2	
42	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA						
43	Check dressings & wound/ home care instructions	L037D	RN/LPN/MTA			3		3	
47	End: Patient leaves office								
48	POST-SERVICE Period								
49	Start: Patient leaves office/facility								
50	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA		3	3	3	3	3
59	End: with last office visit before end of global period								
60	MEDICAL SUPPLIES	CODE	UNIT						
61	SCRUB, DRESS, DRAPE								
62	pack, minimum multi-specialty visit	SA048	pack			1		1	
63	gown, staff, impervious	SB027	item			2		2	
64	cap, surgical	SB001	item			3		3	
65	mask, surgical, with face shield	SB034	item			3		3	
66	shoe covers, surgical	SB039	pair			3		3	
67	scrub brush (impregnated)	SM023	item			3		3	
68	drape, non-sterile, sheet 40in x 60in	SB006	item			1		1	
69	basin, emesis	SJ010	item			1		1	
70	denture cup	SJ016	item			1		1	
71	MODERATE SEDATION								
72	pack, moderate sedation	SA044	pack			1		1	
73	electrode, ECG (single)	SD053	item						
74	nasal cannula	SD100	item						
75	bite block	SD006	item			1		1	
76	PROCEDURE INSTRUMENTS / SUPPLIES								
77	endoscope anti-fog solution	SM014	ml			1		1	
78	endoscopic cytology brush	SD067	item			1		1	
79	endoscopic biopsy forceps	SD066	item						
80	endoscopic polypectomy snare	SD068	item			1			
81	endosheath (proxy for endoscopic hood)	SD070	item			1			
82	endoscopic clip	NEW	item						
83	guidewire, STIFF	SD090	item						
84	endoscopic balloon, dilation	SD019	item					1	
86	needle, micropigmentation (tattoo)	SC079	item						
87	skin marking ink (tattoo)	SK073	ml						
88	needle, variceal injection	SC044	item						
89	syringe 5-6ml	SC057	item						
90	cautery, patient ground pad with cord	SF021	item						
91	cautery, bipolar cord	SF012	item						
92	cautery, bipolar, probe, endoscopy	NEW	item						
93	catheter, optical endomicroscopy	NEW	item						
94	kit, probe, radiofrequency, Xli-enhanced RF probe (proxy for catheter, RF ablation, endoscopic)	SA100	kit						
95	canister, suction	SD009	item			2		1	

	A	B	C	AN	AO	AP	AQ	AR	AS
1				PEAC 2002		Crosswalk Code from RUC 10/2012		Recommendation (x-walk 43215 RUC 10/12)	
2				43245		43215		43245	
3	Meeting Date: January 2013 Tab: EGD Specialty: GI	CMS Code	Staff Type	EGD, with dilation of gastric /duodenal stricture(s) (eg, balloon, bougie)		ESOPH, with removal of foreign body		EGD, with dilation of gastric /duodenal stricture(s) (eg, balloon, bougie)	
4	LOCATION			NF	FAC	NF	FAC	NF	FAC
5	GLOBAL PERIOD			000	000	000	000	000	000
96	tubing, suction, non-latex (6ft uou)	SD132	item			1		1	
97	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item			1		1	
98	syringe 50-60ml	SC056	item			1		1	
99	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item			1		1	
100	gauze, non-sterile 4in x 4in	SG051	item			1		1	
101	cup, biopsy-specimen non-sterile 4oz	SL035	item			1		1	
102	paper, photo printing (8.5 x 11)	SK058	item			1		1	
103	applicator, cotton-tipped, non-sterile 6in	SG008	item						
104	lubricating jelly (K-Y) (5gm uou)	SJ032	item			4		4	
106	gauze, non-sterile 2in x 2in	SG050	item						
107	iv tubing (extension)	SC019	item						
108	kit, needle - free injection system	SA021	item						
109	SCOPE CLEANING								
110	pack, cleaning and disinfecting, endoscope	SA042	pack			1		1	
111	pack, cleaning, surgical instruments	SA043	pack						
112	gloves, non-sterile	SB022	pair						
113	basin, irrigation	SJ009	item						
114	cleaning brush, endoscope	SM010	item						
115	enzymatic detergent	SM015	oz						
118	water, distilled	SK087	oz						
119	EQUIPMENT	CODE							
120	videoscope, gastroscopy	ES034				64		78	
121	stretcher	EF018				78		0	
122	IV infusion pump	EQ032				57		85	
123	table, power	EF031				34		51	
124	video system, endoscopy (processor, digital capture, monitor, printer, cart)	ES031				34		51	
125	suction machine (Gomco)	EQ235				34		51	
126	table, instrument, mobile	EF027				34		85	
127	radiofrequency generator (NEURO)	EQ214							
128	electrosurgical generator, gastrocautery	EQ113							
129	optical endomicroscope processor unit system	EQ355							
130	endoscope disinfectant, rigid or fiberoptic, w-cart	ES005				30		30	
131	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011				57		85	
132	light, surgical	EF014							
133	stretcher, endoscopy	EF020							
134	instrument pack, basic (\$500-\$1499)	EQ137							

	A	B	C	AT	AU	AV	AW	AX	AY
1				PEAC 2002		Crosswalk Code from RUC 10/2012		Recommendation (x-walk 43215 RUC 10/12)	
2				43247		43215		43247	
3	Meeting Date: January 2013 Tab: EGD Specialty: GI	CMS Code	Staff Type	EGD, with removal of foreign body		ESOPH, with removal of foreign body		EGD, with removal of foreign body	
4	LOCATION			NF	FAC	NF	FAC	NF	FAC
5	GLOBAL PERIOD			000	000	000	000	000	000
6	TOTAL CLINICAL LABOR TIME	L051A	RN	0	0	37	0	47	0
7	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	22	90	22	100	22
8	PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	19	9	19	9	19
9	SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	0	0	37	0	47	0
10	SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	0	78	0	88	0
11	POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	3	3	3	3	3
12	PRE-SERVICE								
13	Start: Following visit when decision for surgery or procedure made								
14	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		3	3	3	3	3
15	Coordinate pre-surgery services	L037D	RN/LPN/MTA		5	3	5	3	5
16	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3		3
17	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5		5
18	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		3	3	3	3	3
20	End: When patient enters office/facility for surgery/procedure								
21	SERVICE PERIOD								
22	Start: When patient enters office/facility for surgery/procedure:								
23	Review charts [N/A in 2012]	L037D	RN/LPN/MTA						
24	Review history, systems, and meds [N/A in 2012]	L037D	RN/LPN/MTA						
25	Greet patient, provide gowning, ensure appropriate	L037D	RN/LPN/MTA			3		3	
26	Obtain vital signs	L037D	RN/LPN/MTA			5		5	
27	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA			3		3	
28	Prepare room, equipment, supplies	L037D	RN/LPN/MTA			2		2	
29	Setup scope (non facility setting only)	L037D	RN/LPN/MTA			5		5	
30	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA			2		2	
31	Sedate/apply anesthesia	L051A	RN			2		2	
32	Intra-service								
33	Moderate sedation	L051A	RN			20		30	
34	Assist physician in performing procedure	L037D	RN/LPN/MTA			20		30	
35	Post-Service								
36	Monitor pt. following service/check tubes, monitors,	L051A	RN			15		15	
37	Monitor pt. following service/check tubes, monitors,	L037D	RN/LPN/MTA						
38	Clean room/equipment by physician staff	L037D	RN/LPN/MTA			3		3	
39	Clean Scope	L037D	RN/LPN/MTA			30		30	
40	Clean Surgical Instrument Package	L037D	RN/LPN/MTA						
41	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA			2		2	
42	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA						
43	Check dressings & wound/ home care instructions	L037D	RN/LPN/MTA			3		3	
47	End: Patient leaves office								
48	POST-SERVICE Period								
49	Start: Patient leaves office/facility								
50	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA		3	3	3	3	3
59	End: with last office visit before end of global period								
60	MEDICAL SUPPLIES	CODE	UNIT						
61	SCRUB, DRESS, DRAPE								
62	pack, minimum multi-specialty visit	SA048	pack			1		1	
63	gown, staff, impervious	SB027	item			2		2	
64	cap, surgical	SB001	item			3		3	
65	mask, surgical, with face shield	SB034	item			3		3	
66	shoe covers, surgical	SB039	pair			3		3	
67	scrub brush (impregnated)	SM023	item			3		3	
68	drape, non-sterile, sheet 40in x 60in	SB006	item			1		1	
69	basin, emesis	SJ010	item			1		1	
70	denture cup	SJ016	item			1		1	
71	MODERATE SEDATION								
72	pack, moderate sedation	SA044	pack			1		1	
73	electrode, ECG (single)	SD053	item						
74	nasal cannula	SD100	item						
75	bite block	SD006	item			1		1	
76	PROCEDURE INSTRUMENTS / SUPPLIES								
77	endoscope anti-fog solution	SM014	ml			1		1	
78	endoscopic cytology brush	SD067	item			1		1	
79	endoscopic biopsy forceps	SD066	item						
80	endoscopic polypectomy snare	SD068	item			1		1	
81	endosheath (proxy for endoscopic hood)	SD070	item			1		1	
82	endoscopic clip	NEW	item						
83	guidewire, STIFF	SD090	item						
84	endoscopic balloon, dilation	SD019	item						
86	needle, micropigmentation (tattoo)	SC079	item						
87	skin marking ink (tattoo)	SK073	ml						
88	needle, variceal injection	SC044	item						
89	syringe 5-6ml	SC057	item						
90	cautery, patient ground pad with cord	SF021	item						
91	cautery, bipolar cord	SF012	item						
92	cautery, bipolar, probe, endoscopy	NEW	item						
93	catheter, optical endomicroscopy	NEW	item						
94	kit, probe, radiofrequency, Xli-enhanced RF probe (proxy for catheter, RF ablation, endoscopic)	SA100	kit						
95	canister, suction	SD009	item			2		1	



	A	B	C	AT	AU	AV	AW	AX	AY
1				PEAC 2002		Crosswalk Code from RUC 10/2012		Recommendation (x-walk 43215 RUC 10/12)	
2				43247		43215		43247	
3	Meeting Date: January 2013 Tab: EGD Specialty: GI	CMS Code	Staff Type	EGD, with removal of foreign body		ESOPH, with removal of foreign body		EGD, with removal of foreign body	
4	LOCATION			NF	FAC	NF	FAC	NF	FAC
5	GLOBAL PERIOD			000	000	000	000	000	000
96	tubing, suction, non-latex (6ft uou)	SD132	item			1		1	
97	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item			1		1	
98	syringe 50-60ml	SC056	item			1		1	
99	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item			1		1	
100	gauze, non-sterile 4in x 4in	SG051	item			1		1	
101	cup, biopsy-specimen non-sterile 4oz	SL035	item			1		1	
102	paper, photo printing (8.5 x 11)	SK058	item			1		1	
103	applicator, cotton-tipped, non-sterile 6in	SG008	item						
104	lubricating jelly (K-Y) (5gm uou)	SJ032	item			4		4	
106	gauze, non-sterile 2in x 2in	SG050	item						
107	iv tubing (extension)	SC019	item						
108	kit, needle - free injection system	SA021	item						
109	SCOPE CLEANING								
110	pack, cleaning and disinfecting, endoscope	SA042	pack			1		1	
111	pack, cleaning, surgical instruments	SA043	pack						
112	gloves, non-sterile	SB022	pair						
113	basin, irrigation	SJ009	item						
114	cleaning brush, endoscope	SM010	item						
115	enzymatic detergent	SM015	oz						
118	water, distilled	SK087	oz						
119	EQUIPMENT	CODE							
120	videoscope, gastroscopy	ES034				64		85	
121	stretcher	EF018				78		0	
122	IV infusion pump	EQ032				57		92	
123	table, power	EF031				34		58	
124	video system, endoscopy (processor, digital capture, monitor, printer, cart)	ES031				34		58	
125	suction machine (Gomco)	EQ235				34		58	
126	table, instrument, mobile	EF027				34		92	
127	radiofrequency generator (NEURO)	EQ214							
128	electrosurgical generator, gastrocautery	EQ113							
129	optical endomicroscope processor unit system	EQ355							
130	endoscope disinfectant, rigid or fiberoptic, w-cart	ES005				30		30	
131	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011				57		92	
132	light, surgical	EF014							
133	stretcher, endoscopy	EF020							
134	instrument pack, basic (\$500-\$1499)	EQ137							

	A	B	C	AZ	BA	BB	BC	BD	BE
1				PEAC 2002		Crosswalk Code from RUC 10/2012		Recommendation (x-walk 43226 RUC 10/12)	
2				43248		43226		43248	
3	Meeting Date: January 2013 Tab: EGD Specialty: GI	CMS Code	Staff Type	EGD, with insertion of guide wire followed by passage of dilator(s) through esophagus over guide wire		ESOPH, with insertion of guide wire followed by dilation over guide wire		EGD, with insertion of guide wire followed by passage of dilator(s) through esophagus over guide wire	
4	LOCATION			NF	FAC	NF	FAC	NF	FAC
5	GLOBAL PERIOD			000	000	000	000	000	000
6	TOTAL CLINICAL LABOR TIME	L051A	RN	0	0	42	0	37	0
7	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	22	95	22	100	22
8	PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	19	9	19	9	19
9	SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	0	0	42	0	37	0
10	SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	0	83	0	88	0
11	POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	3	3	3	3	3
12	PRE-SERVICE								
13	Start: Following visit when decision for surgery or procedure made								
14	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		3	3	3	3	3
15	Coordinate pre-surgery services	L037D	RN/LPN/MTA		5	3	5	3	5
16	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3		3
17	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5		5
18	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		3	3	3	3	3
20	End: When patient enters office/facility for surgery/procedure								
21	SERVICE PERIOD								
22	Start: When patient enters office/facility for surgery/procedure:								
23	Review charts [N/A in 2012]	L037D	RN/LPN/MTA						
24	Review history, systems, and meds [N/A in 2012]	L037D	RN/LPN/MTA						
25	Greet patient, provide gowning, ensure appropriate	L037D	RN/LPN/MTA			3		3	
26	Obtain vital signs	L037D	RN/LPN/MTA			5		5	
27	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA			3		3	
28	Prepare room, equipment, supplies	L037D	RN/LPN/MTA			2		2	
29	Setup scope (non facility setting only)	L037D	RN/LPN/MTA			5		5	
30	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA			2		2	
31	Sedate/apply anesthesia	L051A	RN			2		2	
32	Intra-service								
33	Moderate sedation	L051A	RN			25		20	
34	Assist physician in performing procedure	L037D	RN/LPN/MTA			25		20	
35	Post-Service								
36	Monitor pt. following service/check tubes, monitors,	L051A	RN			15		15	
37	Monitor pt. following service/check tubes, monitors,	L037D	RN/LPN/MTA						
38	Clean room/equipment by physician staff	L037D	RN/LPN/MTA			3		3	
39	Clean Scope	L037D	RN/LPN/MTA			30		30	
40	Clean Surgical Instrument Package	L037D	RN/LPN/MTA					10	
41	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA			2		2	
42	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA						
43	Check dressings & wound/ home care instructions	L037D	RN/LPN/MTA			3		3	
47	End: Patient leaves office								
48	POST-SERVICE Period								
49	Start: Patient leaves office/facility								
50	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA		3	3	3	3	3
59	End: with last office visit before end of global period								
60	MEDICAL SUPPLIES	CODE	UNIT						
61	SCRUB, DRESS, DRAPE								
62	pack, minimum multi-specialty visit	SA048	pack			1		1	
63	gown, staff, impervious	SB027	item			2		2	
64	cap, surgical	SB001	item			3		3	
65	mask, surgical, with face shield	SB034	item			3		3	
66	shoe covers, surgical	SB039	pair			3		3	
67	scrub brush (impregnated)	SM023	item			3		3	
68	drape, non-sterile, sheet 40in x 60in	SB006	item			1		1	
69	basin, emesis	SJ010	item			1		1	
70	denture cup	SJ016	item			1		1	
71	MODERATE SEDATION								
72	pack, moderate sedation	SA044	pack			1		1	
73	electrode, ECG (single)	SD053	item						
74	nasal cannula	SD100	item						
75	bite block	SD006	item			1		1	
76	PROCEDURE INSTRUMENTS / SUPPLIES								
77	endoscope anti-fog solution	SM014	ml			1		1	
78	endoscopic cytology brush	SD067	item			1		1	
79	endoscopic biopsy forceps	SD066	item						
80	endoscopic polypectomy snare	SD068	item						
81	endosheath (proxy for endoscopic hood)	SD070	item						
82	endoscopic clip	NEW	item						
83	guidewire, STIFF	SD090	item			1		1	
84	endoscopic balloon, dilation	SD019	item						
86	needle, micropigmentation (tattoo)	SC079	item						
87	skin marking ink (tattoo)	SK073	ml						
88	needle, variceal injection	SC044	item						
89	syringe 5-6ml	SC057	item						
90	cautery, patient ground pad with cord	SF021	item						
91	cautery, bipolar cord	SF012	item						
92	cautery, bipolar, probe, endoscopy	NEW	item						
93	catheter, optical endomicroscopy	NEW	item						
94	kit, probe, radiofrequency, Xli-enhanced RF probe (proxy for catheter, RF ablation, endoscopic)	SA100	kit						
95	canister, suction	SD009	item			2		1	

	A	B	C	AZ	BA	BB	BC	BD	BE
1				PEAC 2002		Crosswalk Code from RUC 10/2012		Recommendation (x-walk 43226 RUC 10/12)	
2				43248		43226		43248	
3	Meeting Date: January 2013 Tab: EGD Specialty: GI	CMS Code	Staff Type	EGD, with insertion of guide wire followed by passage of dilator(s) through esophagus over guide wire		ESOPH, with insertion of guide wire followed by dilation over guide wire		EGD, with insertion of guide wire followed by passage of dilator(s) through esophagus over guide wire	
4	LOCATION			NF	FAC	NF	FAC	NF	FAC
5	GLOBAL PERIOD			000	000	000	000	000	000
96	tubing, suction, non-latex (6ft uou)	SD132	item			1		1	
97	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item			1		1	
98	syringe 50-60ml	SC056	item			1		1	
99	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item			1		1	
100	gauze, non-sterile 4in x 4in	SG051	item			1		1	
101	cup, biopsy-specimen non-sterile 4oz	SL035	item			1		1	
102	paper, photo printing (8.5 x 11)	SK058	item			1		1	
103	applicator, cotton-tipped, non-sterile 6in	SG008	item						
104	lubricating jelly (K-Y) (5gm uou)	SJ032	item			4		4	
106	gauze, non-sterile 2in x 2in	SG050	item						
107	iv tubing (extension)	SC019	item						
108	kit, needle - free injection system	SA021	item						
109	SCOPE CLEANING								
110	pack, cleaning and disinfecting, endoscope	SA042	pack			1		1	
111	pack, cleaning, surgical instruments	SA043	pack					1	
112	gloves, non-sterile	SB022	pair						
113	basin, irrigation	SJ009	item						
114	cleaning brush, endoscope	SM010	item						
115	enzymatic detergent	SM015	oz						
118	water, distilled	SK087	oz						
119	EQUIPMENT	CODE							
120	videoscope, gastroscopy	ES034				69		75	
121	stretcher	EF018				83		0	
122	IV infusion pump	EQ032				62		82	
123	table, power	EF031				39		48	
124	video system, endoscopy (processor, digital capture, monitor, printer, cart)	ES031				39		48	
125	suction machine (Gomco)	EQ235				39		48	
126	table, instrument, mobile	EF027				39		82	
127	radiofrequency generator (NEURO)	EQ214							
128	electrosurgical generator, gastrocautery	EQ113							
129	optical endomicroscope processor unit system	EQ355							
130	endoscope disinfectant, rigid or fiberoptic, w-cart	ES005				30		30	
131	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011				62		82	
132	light, surgical	EF014							
133	stretcher, endoscopy	EF020							
134	instrument pack, basic (\$500-\$1499)	EQ137						55	



	A	B	C	BF	BG	BH	BI	BJ	BK
1				PEAC 2002		Crosswalk Code from RUC 10/2012		Recommendation (x-walk 43220 RUC 10/12)	
2				43249		43220		43249	
3	Meeting Date: January 2013 Tab: EGD Specialty: GI	CMS Code	Staff Type	EGD, with balloon dilation of esophagus (less than 30 mm diameter)		ESOPH, with balloon dilation (less than 30 mm diameter)		EGD, with balloon dilation of esophagus (less than 30 mm diameter)	
4	LOCATION			NF	FAC	NF	FAC	NF	FAC
5	GLOBAL PERIOD			000	000	000	000	000	000
6	TOTAL CLINICAL LABOR TIME	L051A	RN	0	0	37	0	37	0
7	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	22	90	22	90	22
8	PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	19	9	19	9	19
9	SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	0	0	37	0	37	0
10	SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	0	78	0	78	0
11	POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	3	3	3	3	3
12	PRE-SERVICE								
13	Start: Following visit when decision for surgery or procedure made								
14	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		3	3	3	3	3
15	Coordinate pre-surgery services	L037D	RN/LPN/MTA		5	3	5	3	5
16	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3		3
17	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5		5
18	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		3	3	3	3	3
20	End: When patient enters office/facility for surgery/procedure								
21	SERVICE PERIOD								
22	Start: When patient enters office/facility for surgery/procedure:								
23	Review charts [N/A in 2012]	L037D	RN/LPN/MTA						
24	Review history, systems, and meds [N/A in 2012]	L037D	RN/LPN/MTA						
25	Greet patient, provide gowning, ensure appropriate	L037D	RN/LPN/MTA			3		3	
26	Obtain vital signs	L037D	RN/LPN/MTA			5		5	
27	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA			3		3	
28	Prepare room, equipment, supplies	L037D	RN/LPN/MTA			2		2	
29	Setup scope (non facility setting only)	L037D	RN/LPN/MTA			5		5	
30	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA			2		2	
31	Sedate/apply anesthesia	L051A	RN			2		2	
32	Intra-service								
33	Moderate sedation	L051A	RN			20		20	
34	Assist physician in performing procedure	L037D	RN/LPN/MTA			20		20	
35	Post-Service								
36	Monitor pt. following service/check tubes, monitors,	L051A	RN			15		15	
37	Monitor pt. following service/check tubes, monitors,	L037D	RN/LPN/MTA						
38	Clean room/equipment by physician staff	L037D	RN/LPN/MTA			3		3	
39	Clean Scope	L037D	RN/LPN/MTA			30		30	
40	Clean Surgical Instrument Package	L037D	RN/LPN/MTA						
41	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA			2		2	
42	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA						
43	Check dressings & wound/ home care instructions	L037D	RN/LPN/MTA			3		3	
47	End: Patient leaves office								
48	POST-SERVICE Period								
49	Start: Patient leaves office/facility								
50	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA		3	3	3	3	3
59	End: with last office visit before end of global period								
60	MEDICAL SUPPLIES	CODE	UNIT						
61	SCRUB, DRESS, DRAPE								
62	pack, minimum multi-specialty visit	SA048	pack			1		1	
63	gown, staff, impervious	SB027	item			2		2	
64	cap, surgical	SB001	item			3		3	
65	mask, surgical, with face shield	SB034	item			3		3	
66	shoe covers, surgical	SB039	pair			3		3	
67	scrub brush (impregnated)	SM023	item			3		3	
68	drape, non-sterile, sheet 40in x 60in	SB006	item			1		1	
69	basin, emesis	SJ010	item			1		1	
70	denture cup	SJ016	item			1		1	
71	MODERATE SEDATION								
72	pack, moderate sedation	SA044	pack			1		1	
73	electrode, ECG (single)	SD053	item						
74	nasal cannula	SD100	item						
75	bite block	SD006	item			1		1	
76	PROCEDURE INSTRUMENTS / SUPPLIES								
77	endoscope anti-fog solution	SM014	ml			1		1	
78	endoscopic cytology brush	SD067	item			1		1	
79	endoscopic biopsy forceps	SD066	item						
80	endoscopic polypectomy snare	SD068	item						
81	endosheath (proxy for endoscopic hood)	SD070	item						
82	endoscopic clip	NEW	item						
83	guidewire, STIFF	SD090	item			1		0	
84	endoscopic balloon, dilation	SD019	item			3		3	
86	needle, micropigmentation (tattoo)	SC079	item						
87	skin marking ink (tattoo)	SK073	ml						
88	needle, variceal injection	SC044	item						
89	syringe 5-6ml	SC057	item						
90	cautery, patient ground pad with cord	SF021	item						
91	cautery, bipolar cord	SF012	item						
92	cautery, bipolar, probe, endoscopy	NEW	item						
93	catheter, optical endomicroscopy	NEW	item						
94	kit, probe, radiofrequency, Xli-enhanced RF probe (proxy for catheter, RF ablation, endoscopic)	SA100	kit						
95	canister, suction	SD009	item			2		1	

	A	B	C	BF	BG	BH	BI	BJ	BK
1				PEAC 2002		Crosswalk Code from RUC 10/2012		Recommendation (x-walk 43220 RUC 10/12)	
2				43249		43220		43249	
3	Meeting Date: January 2013 Tab: EGD Specialty: GI	CMS Code	Staff Type	EGD, with balloon dilation of esophagus (less than 30 mm diameter)		ESOPH, with balloon dilation (less than 30 mm diameter)		EGD, with balloon dilation of esophagus (less than 30 mm diameter)	
4	LOCATION			NF	FAC	NF	FAC	NF	FAC
5	GLOBAL PERIOD			000	000	000	000	000	000
96	tubing, suction, non-latex (6ft uou)	SD132	item			1		1	
97	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item			1		1	
98	syringe 50-60ml	SC056	item			1		1	
99	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item			1		1	
100	gauze, non-sterile 4in x 4in	SG051	item			1		1	
101	cup, biopsy-specimen non-sterile 4oz	SL035	item			1		1	
102	paper, photo printing (8.5 x 11)	SK058	item			1		1	
103	applicator, cotton-tipped, non-sterile 6in	SG008	item						
104	lubricating jelly (K-Y) (5gm uou)	SJ032	item			4		4	
106	gauze, non-sterile 2in x 2in	SG050	item						
107	iv tubing (extension)	SC019	item						
108	kit, needle - free injection system	SA021	item						
109	SCOPE CLEANING								
110	pack, cleaning and disinfecting, endoscope	SA042	pack			1		1	
111	pack, cleaning, surgical instruments	SA043	pack						
112	gloves, non-sterile	SB022	pair						
113	basin, irrigation	SJ009	item						
114	cleaning brush, endoscope	SM010	item						
115	enzymatic detergent	SM015	oz						
118	water, distilled	SK087	oz						
119	EQUIPMENT	CODE							
120	videoscope, gastroscopy	ES034				64		75	
121	stretcher	EF018				78		0	
122	IV infusion pump	EQ032				57		82	
123	table, power	EF031				34		48	
124	video system, endoscopy (processor, digital capture, monitor, printer, cart)	ES031				34		48	
125	suction machine (Gomco)	EQ235				34		48	
126	table, instrument, mobile	EF027				34		82	
127	radiofrequency generator (NEURO)	EQ214							
128	electrosurgical generator, gastrocautery	EQ113							
129	optical endomicroscope processor unit system	EQ355							
130	endoscope disinfectant, rigid or fiberoptic, w-cart	ES005				30		30	
131	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011				57		82	
132	light, surgical	EF014							
133	stretcher, endoscopy	EF020							
134	instrument pack, basic (\$500-\$1499)	EQ137							



	A	B	C	BL	BM	BN	BO	BP	BQ
1				<b>PEAC 2002 TO BE DELETED</b>		<b>Crosswalk Code from RUC 10/2012</b>		<b>Recommendation (x-walk 43205 RUC 10/12) FAC ONLY</b>	
2				<b>43458 (deleted)</b>		<b>43205</b>		<b>43233 NEW</b>	
3	<b>Meeting Date: January 2013 Tab: EGD Specialty: GI</b>	<b>CMS Code</b>	<b>Staff Type</b>	Dilation of esophagus, by balloon or dilator, retrograde		ESOPH, with band ligation of esophageal varices		EGD, with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance,	
4	<b>LOCATION</b>			<b>NF</b>	<b>FAC</b>	<b>NF</b>	<b>FAC</b>	<b>NF</b>	<b>FAC</b>
5	<b>GLOBAL PERIOD</b>			<b>000</b>	<b>000</b>	<b>000</b>	<b>000</b>	<b>000</b>	<b>000</b>
6	<b>TOTAL CLINICAL LABOR TIME</b>	<b>L051A</b>	<b>RN</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>n/a</b>	<b>0</b>
7	<b>TOTAL CLINICAL LABOR TIME</b>	<b>L037D</b>	<b>RN/LPN/MTA</b>	<b>0</b>	<b>22</b>	<b>0</b>	<b>22</b>	<b>n/a</b>	<b>22</b>
8	<b>PRE-SERV CLINICAL LABOR TIME</b>	<b>L037D</b>	<b>RN/LPN/MTA</b>	<b>0</b>	<b>19</b>	<b>0</b>	<b>19</b>	<b>n/a</b>	<b>19</b>
9	<b>SERVICE PERIOD CLINICAL LABOR TIME</b>	<b>L051A</b>	<b>RN</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>n/a</b>	<b>0</b>
10	<b>SERVICE PERIOD CLINICAL LABOR TIME</b>	<b>L037D</b>	<b>RN/LPN/MTA</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>n/a</b>	<b>0</b>
11	<b>POST-SERV CLINICAL LABOR TIME</b>	<b>L037D</b>	<b>RN/LPN/MTA</b>	<b>0</b>	<b>3</b>	<b>0</b>	<b>3</b>	<b>n/a</b>	<b>3</b>
12	<b>PRE-SERVICE</b>								
13	<b>Start: Following visit when decision for surgery or procedure made</b>								
14	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		3		3		3
15	Coordinate pre-surgery services	L037D	RN/LPN/MTA		5		5		5
16	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3		3
17	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5		5
18	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		3		3		3
20	<b>End: When patient enters office/facility for surgery/procedure</b>								
21	<b>SERVICE PERIOD</b>								
22	<b>Start: When patient enters office/facility for surgery/procedure:</b>								
23	Review charts [N/A in 2012]	L037D	RN/LPN/MTA						
24	Review history, systems, and meds [N/A in 2012]	L037D	RN/LPN/MTA						
25	Greet patient, provide gowning, ensure appropriate	L037D	RN/LPN/MTA						
26	Obtain vital signs	L037D	RN/LPN/MTA						
27	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA						
28	Prepare room, equipment, supplies	L037D	RN/LPN/MTA						
29	Setup scope (non facility setting only)	L037D	RN/LPN/MTA						
30	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA						
31	Sedate/apply anesthesia	L051A	RN						
32	<b>Intra-service</b>								
33	Moderate sedation	L051A	RN						
34	Assist physician in performing procedure	L037D	RN/LPN/MTA						
35	<b>Post-Service</b>								
36	Monitor pt. following service/check tubes, monitors,	L051A	RN						
37	Monitor pt. following service/check tubes, monitors,	L037D	RN/LPN/MTA						
38	Clean room/equipment by physician staff	L037D	RN/LPN/MTA						
39	Clean Scope	L037D	RN/LPN/MTA						
40	Clean Surgical Instrument Package	L037D	RN/LPN/MTA						
41	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA						
42	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA						
43	Check dressings & wound/ home care instructions	L037D	RN/LPN/MTA						
47	<b>End: Patient leaves office</b>								
48	<b>POST-SERVICE Period</b>								
49	<b>Start: Patient leaves office/facility</b>								
50	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA		3		3		3
59	<b>End: with last office visit before end of global period</b>								
60	<b>MEDICAL SUPPLIES</b>	<b>CODE</b>	<b>UNIT</b>						
61	<b>SCRUB, DRESS, DRAPE</b>								
62	pack, minimum multi-specialty visit	SA048	pack						
63	gown, staff, impervious	SB027	item						
64	cap, surgical	SB001	item						
65	mask, surgical, with face shield	SB034	item						
66	shoe covers, surgical	SB039	pair						
67	scrub brush (impregnated)	SM023	item						
68	drape, non-sterile, sheet 40in x 60in	SB006	item						
69	basin, emesis	SJ010	item						
70	denture cup	SJ016	item						
71	<b>MODERATE SEDATION</b>								
72	pack, moderate sedation	SA044	pack						
73	electrode, ECG (single)	SD053	item						
74	nasal cannula	SD100	item						
75	bite block	SD006	item						
76	<b>PROCEDURE INSTRUMENTS / SUPPLIES</b>								
77	endoscope anti-fog solution	SM014	ml						
78	endoscopic cytology brush	SD067	item						
79	endoscopic biopsy forceps	SD066	item						
80	endoscopic polypectomy snare	SD068	item						
81	endosheath (proxy for endoscopic hood)	SD070	item						
82	endoscopic clip	NEW	item						
83	guidewire, STIFF	SD090	item						
84	endoscopic balloon, dilation	SD019	item						
86	needle, micropigmentation (tattoo)	SC079	item						
87	skin marking ink (tattoo)	SK073	ml						
88	needle, variceal injection	SC044	item						
89	syringe 5-6ml	SC057	item						
90	cautery, patient ground pad with cord	SF021	item						
91	cautery, bipolar cord	SF012	item						
92	cautery, bipolar, probe, endoscopy	NEW	item						
93	catheter, optical endomicroscopy	NEW	item						
94	kit, probe, radiofrequency, Xli-enhanced RF probe (proxy for catheter, RF ablation, endoscopic)	SA100	kit						
95	canister, suction	SD009	item						

	A	B	C	BL	BM	BN	BO	BP	BQ
1				PEAC 2002 TO BE DELETED		Crosswalk Code from RUC 10/2012		Recommendation (x-walk 43205 RUC 10/12) FAC ONLY	
2				43458 (deleted)		43205		43233 NEW	
3	Meeting Date: January 2013 Tab: EGD Specialty: GI	CMS Code	Staff Type	Dilation of esophagus, by balloon or dilator, retrograde		ESOPH, with band ligation of esophageal varices		EGD, with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance,	
4	LOCATION			NF	FAC	NF	FAC	NF	FAC
5	GLOBAL PERIOD			000	000	000	000	000	000
96	tubing, suction, non-latex (6ft uou)	SD132	item						
97	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item						
98	syringe 50-60ml	SC056	item						
99	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item						
100	gauze, non-sterile 4in x 4in	SG051	item						
101	cup, biopsy-specimen non-sterile 4oz	SL035	item						
102	paper, photo printing (8.5 x 11)	SK058	item						
103	applicator, cotton-tipped, non-sterile 6in	SG008	item						
104	lubricating jelly (K-Y) (5gm uou)	SJ032	item						
106	gauze, non-sterile 2in x 2in	SG050	item						
107	iv tubing (extension)	SC019	item						
108	kit, needle - free injection system	SA021	item						
109	SCOPE CLEANING								
110	pack, cleaning and disinfecting, endoscope	SA042	pack						
111	pack, cleaning, surgical instruments	SA043	pack						
112	gloves, non-sterile	SB022	pair						
113	basin, irrigation	SJ009	item						
114	cleaning brush, endoscope	SM010	item						
115	enzymatic detergent	SM015	oz						
118	water, distilled	SK087	oz						
119	EQUIPMENT	CODE							
120	videoscope, gastroscopy	ES034							
121	stretcher	EF018							
122	IV infusion pump	EQ032							
123	table, power	EF031							
124	video system, endoscopy (processor, digital capture, monitor, printer, cart)	ES031							
125	suction machine (Gomco)	EQ235							
126	table, instrument, mobile	EF027							
127	radiofrequency generator (NEURO)	EQ214							
128	electrosurgical generator, gastrocautery	EQ113							
129	optical endomicroscope processor unit system	EQ355							
130	endoscope disinfectant, rigid or fiberoptic, w-cart	ES005							
131	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011							
132	light, surgical	EF014							
133	stretcher, endoscopy	EF020							
134	instrument pack, basic (\$500-\$1499)	EQ137							

	A	B	C	BR	BS	BT	BU	BV	BW
1				PEAC 2002		Crosswalk Code from RUC 10/2012		Recommendation (x-walk 43216 RUC 10/12)	
2				43250		43216		43250	
3	Meeting Date: January 2013 Tab: EGD Specialty: GI	CMS Code	Staff Type	EGD, with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery		ESOPH, with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery		EGD, with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	
4	LOCATION			NF	FAC	NF	FAC	NF	FAC
5	GLOBAL PERIOD			000	000	000	000	000	000
6	TOTAL CLINICAL LABOR TIME	L051A	RN	0	0	39	0	37	0
7	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	22	92	22	90	22
8	PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	19	9	19	9	19
9	SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	0	0	39	0	37	0
10	SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	0	80	0	78	0
11	POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	3	3	3	3	3
12	PRE-SERVICE								
13	Start: Following visit when decision for surgery or procedure made								
14	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		3	3	3	3	3
15	Coordinate pre-surgery services	L037D	RN/LPN/MTA		5	3	5	3	5
16	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3		3
17	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5		5
18	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		3	3	3	3	3
20	End: When patient enters office/facility for surgery/procedure								
21	SERVICE PERIOD								
22	Start: When patient enters office/facility for surgery/procedure:								
23	Review charts [N/A in 2012]	L037D	RN/LPN/MTA						
24	Review history, systems, and meds [N/A in 2012]	L037D	RN/LPN/MTA						
25	Greet patient, provide gowning, ensure appropriate	L037D	RN/LPN/MTA			3		3	
26	Obtain vital signs	L037D	RN/LPN/MTA			5		5	
27	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA			3		3	
28	Prepare room, equipment, supplies	L037D	RN/LPN/MTA			2		2	
29	Setup scope (non facility setting only)	L037D	RN/LPN/MTA			5		5	
30	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA			2		2	
31	Sedate/apply anesthesia	L051A	RN			2		2	
32	Intra-service								
33	Moderate sedation	L051A	RN			22		20	
34	Assist physician in performing procedure	L037D	RN/LPN/MTA			22		20	
35	Post-Service								
36	Monitor pt. following service/check tubes, monitors,	L051A	RN			15		15	
37	Monitor pt. following service/check tubes, monitors,	L037D	RN/LPN/MTA						
38	Clean room/equipment by physician staff	L037D	RN/LPN/MTA			3		3	
39	Clean Scope	L037D	RN/LPN/MTA			30		30	
40	Clean Surgical Instrument Package	L037D	RN/LPN/MTA						
41	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA			2		2	
42	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA						
43	Check dressings & wound/ home care instructions	L037D	RN/LPN/MTA			3		3	
47	End: Patient leaves office								
48	POST-SERVICE Period								
49	Start: Patient leaves office/facility								
50	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA		3	3	3	3	3
59	End: with last office visit before end of global period								
60	MEDICAL SUPPLIES	CODE	UNIT						
61	SCRUB, DRESS, DRAPE								
62	pack, minimum multi-specialty visit	SA048	pack			1		1	
63	gown, staff, impervious	SB027	item			2		2	
64	cap, surgical	SB001	item			3		3	
65	mask, surgical, with face shield	SB034	item			3		3	
66	shoe covers, surgical	SB039	pair			3		3	
67	scrub brush (impregnated)	SM023	item			3		3	
68	drape, non-sterile, sheet 40in x 60in	SB006	item			1		1	
69	basin, emesis	SJ010	item			1		1	
70	denture cup	SJ016	item			1		1	
71	MODERATE SEDATION								
72	pack, moderate sedation	SA044	pack			1		1	
73	electrode, ECG (single)	SD053	item						
74	nasal cannula	SD100	item						
75	bite block	SD006	item			1		1	
76	PROCEDURE INSTRUMENTS / SUPPLIES								
77	endoscope anti-fog solution	SM014	ml			1		1	
78	endoscopic cytology brush	SD067	item			1		1	
79	endoscopic biopsy forceps	SD066	item			1		1	
80	endoscopic polypectomy snare	SD068	item						
81	endosheath (proxy for endoscopic hood)	SD070	item						
82	endoscopic clip	NEW	item						
83	guidewire, STIFF	SD090	item						
84	endoscopic balloon, dilation	SD019	item						
86	needle, micropigmentation (tattoo)	SC079	item						
87	skin marking ink (tattoo)	SK073	ml						
88	needle, variceal injection	SC044	item						
89	syringe 5-6ml	SC057	item						
90	cautery, patient ground pad with cord	SF021	item			1		1	
91	cautery, bipolar cord	SF012	item			1		1	
92	cautery, bipolar, probe, endoscopy	NEW	item						
93	catheter, optical endomicroscopy	NEW	item						
94	kit, probe, radiofrequency, XLI-enhanced RF probe (proxy for catheter, RF ablation, endoscopic)	SA100	kit						
95	canister, suction	SD009	item			2		1	



	A	B	C	BR	BS	BT	BU	BV	BW
1				PEAC 2002		Crosswalk Code from RUC 10/2012		Recommendation (x-walk 43216 RUC 10/12)	
2				43250		43216		43250	
3	Meeting Date: January 2013 Tab: EGD Specialty: GI	CMS Code	Staff Type	EGD, with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery		ESOPH, with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery		EGD, with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	
4	LOCATION			NF	FAC	NF	FAC	NF	FAC
5	GLOBAL PERIOD			000	000	000	000	000	000
96	tubing, suction, non-latex (6ft uou)	SD132	item			1		1	
97	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item			1		1	
98	syringe 50-60ml	SC056	item			1		1	
99	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item			1		1	
100	gauze, non-sterile 4in x 4in	SG051	item			1		1	
101	cup, biopsy-specimen non-sterile 4oz	SL035	item			1		1	
102	paper, photo printing (8.5 x 11)	SK058	item			1		1	
103	applicator, cotton-tipped, non-sterile 6in	SG008	item						
104	lubricating jelly (K-Y) (5gm uou)	SJ032	item			4		4	
106	gauze, non-sterile 2in x 2in	SG050	item						
107	iv tubing (extension)	SC019	item						
108	kit, needle - free injection system	SA021	item						
109	SCOPE CLEANING								
110	pack, cleaning and disinfecting, endoscope	SA042	pack			1		1	
111	pack, cleaning, surgical instruments	SA043	pack						
112	gloves, non-sterile	SB022	pair						
113	basin, irrigation	SJ009	item						
114	cleaning brush, endoscope	SM010	item						
115	enzymatic detergent	SM015	oz						
118	water, distilled	SK087	oz						
119	EQUIPMENT	CODE							
120	videoscope, gastroscopy	ES034				66		75	
121	stretcher	EF018				80		0	
122	IV infusion pump	EQ032				59		82	
123	table, power	EF031				36		48	
124	video system, endoscopy (processor, digital capture, monitor, printer, cart)	ES031				36		48	
125	suction machine (Gomco)	EQ235				36		48	
126	table, instrument, mobile	EF027				36		82	
127	radiofrequency generator (NEURO)	EQ214							
128	electrosurgical generator, gastrocautery	EQ113				36		48	
129	optical endomicroscope processor unit system	EQ355							
130	endoscope disinfectant, rigid or fiberoptic, w-cart	ES005				30		30	
131	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011				59		82	
132	light, surgical	EF014							
133	stretcher, endoscopy	EF020							
134	instrument pack, basic (\$500-\$1499)	EQ137							

	A	B	C	BX	BY	BZ	CA
1				<b>Crosswalk Code from RUC 10/2012</b>		<b>Recommendation (x-walk 43206 RUC 10/12)</b>	
2				<b>43206 NEW</b>		<b>43252 NEW</b>	
3	Meeting Date: January 2013 Tab: EGD Specialty: GI	CMS Code	Staff Type	ESOPH, with optical endomicroscopy		EGD, with optical endomicroscopy	
4	LOCATION			NF	FAC	NF	FAC
5	GLOBAL PERIOD			000	000	000	000
6	TOTAL CLINICAL LABOR TIME	L051A	RN	47	0	47	0
7	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	103	22	103	22
8	PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	9	19	9	19
9	SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	47	0	47	0
10	SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	91	0	91	0
11	POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	3	3	3	3
12	PRE-SERVICE						
13	Start: Following visit when decision for surgery or procedure made						
14	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	3	3	3	3
15	Coordinate pre-surgery services	L037D	RN/LPN/MTA	3	5	3	5
16	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3
17	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5
18	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3	3	3	3
20	End: When patient enters office/facility for surgery/procedure						
21	SERVICE PERIOD						
22	Start: When patient enters office/facility for surgery/procedure:						
23	Review charts [N/A in 2012]	L037D	RN/LPN/MTA				
24	Review history, systems, and meds [N/A in 2012]	L037D	RN/LPN/MTA				
25	Greet patient, provide gowning, ensure appropriate	L037D	RN/LPN/MTA	3		3	
26	Obtain vital signs	L037D	RN/LPN/MTA	5		5	
27	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	3		3	
28	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	5		5	
29	Setup scope (non facility setting only)	L037D	RN/LPN/MTA	5		5	
30	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	2		2	
31	Sedate/apply anesthesia	L051A	RN	2		2	
32	Intra-service						
33	Moderate sedation	L051A	RN	30		30	
34	Assist physician in performing procedure	L037D	RN/LPN/MTA	30		30	
35	Post-Service						
36	Monitor pt. following service/check tubes, monitors,	L051A	RN	15		15	
37	Monitor pt. following service/check tubes, monitors,	L037D	RN/LPN/MTA				
38	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	3		3	
39	Clean Scope	L037D	RN/LPN/MTA	30		30	
40	Clean Surgical Instrument Package	L037D	RN/LPN/MTA				
41	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA	2		2	
42	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA				
43	Check dressings & wound/ home care instructions	L037D	RN/LPN/MTA	3		3	
47	End: Patient leaves office						
48	POST-SERVICE Period						
49	Start: Patient leaves office/facility						
50	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	3	3	3	3
59	End: with last office visit before end of global period						
60	MEDICAL SUPPLIES	CODE	UNIT				
61	SCRUB, DRESS, DRAPE						
62	pack, minimum multi-specialty visit	SA048	pack	1		1	
63	gown, staff, impervious	SB027	item	2		2	
64	cap, surgical	SB001	item	3		3	
65	mask, surgical, with face shield	SB034	item	3		3	
66	shoe covers, surgical	SB039	pair	3		3	
67	scrub brush (impregnated)	SM023	item	3		3	
68	drape, non-sterile, sheet 40in x 60in	SB006	item	1		1	
69	basin, emesis	SJ010	item	1		1	
70	denture cup	SJ016	item	1		1	
71	MODERATE SEDATION						
72	pack, moderate sedation	SA044	pack	1		1	
73	electrode, ECG (single)	SD053	item				
74	nasal cannula	SD100	item				
75	bite block	SD006	item	1		1	
76	PROCEDURE INSTRUMENTS / SUPPLIES						
77	endoscope anti-fog solution	SM014	ml	1		1	
78	endoscopic cytology brush	SD067	item				
79	endoscopic biopsy forceps	SD066	item				
80	endoscopic polypectomy snare	SD068	item				
81	endosheath (proxy for endoscopic hood)	SD070	item				
82	endoscopic clip	NEW	item				
83	guidewire, STIFF	SD090	item				
84	endoscopic balloon, dilation	SD019	item				
86	needle, micropigmentation (tattoo)	SC079	item				
87	skin marking ink (tattoo)	SK073	ml				
88	needle, variceal injection	SC044	item				
89	syringe 5-6ml	SC057	item				
90	cautery, patient ground pad with cord	SF021	item				
91	cautery, bipolar cord	SF012	item				
92	cautery, bipolar, probe, endoscopy	NEW	item				
93	catheter, optical endomicroscopy	NEW	item	1		1	
94	kit, probe, radiofrequency, Xli-enhanced RF probe (proxy for catheter, RF ablation, endoscopic)	SA100	kit				
95	canister, suction	SD009	item	2		2	

	A	B	C	BX	BY	BZ	CA
1				<b>Crosswalk Code from RUC 10/2012</b>		<b>Recommendation (x-walk 43206 RUC 10/12)</b>	
2				<b>43206 NEW</b>		<b>43252 NEW</b>	
3	<b>Meeting Date: January 2013 Tab: EGD Specialty: GI</b>	<b>CMS Code</b>	<b>Staff Type</b>	ESOPH, with optical endomicroscopy		EGD, with optical endomicroscopy	
4	<b>LOCATION</b>			<b>NF</b>	<b>FAC</b>	<b>NF</b>	<b>FAC</b>
5	<b>GLOBAL PERIOD</b>			<b>000</b>	<b>000</b>	<b>000</b>	<b>000</b>
96	tubing, suction, non-latex (6ft uou)	SD132	item	1		1	
97	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item	1		1	
98	syringe 50-60ml	SC056	item	1		1	
99	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item	1		1	
100	gauze, non-sterile 4in x 4in	SG051	item	1		1	
101	cup, biopsy-specimen non-sterile 4oz	SL035	item	1		1	
102	paper, photo printing (8.5 x 11)	SK058	item	1		1	
103	applicator, cotton-tipped, non-sterile 6in	SG008	item				
104	lubricating jelly (K-Y) (5gm uou)	SJ032	item	4		4	
106	gauze, non-sterile 2in x 2in	SG050	item				
107	iv tubing (extension)	SC019	item				
108	kit, needle - free injection system	SA021	item				
109	<b>SCOPE CLEANING</b>						
110	pack, cleaning and disinfecting, endoscope	SA042	pack	1		1	
111	pack, cleaning, surgical instruments	SA043	pack				
112	gloves, non-sterile	SB022	pair				
113	basin, irrigation	SJ009	item				
114	cleaning brush, endoscope	SM010	item				
115	enzymatic detergent	SM015	oz				
118	water, distilled	SK087	oz				
119	<b>EQUIPMENT</b>	<b>CODE</b>					
120	videoscope, gastroscopy	ES034		77		88	
121	stretcher	EF018		91		0	
122	IV infusion pump	EQ032		70		92	
123	table, power	EF031		47		61	
124	video system, endoscopy (processor, digital capture, monitor, printer, cart)	ES031		47		61	
125	suction machine (Gomco)	EQ235		47		61	
126	table, instrument, mobile	EF027		47		92	
127	radiofrequency generator (NEURO)	<b>EQ214</b>					
128	electrosurgical generator, gastrocautery	EQ113					
129	optical endomicroscope processor unit system	<b>EQ355</b>		77		61	
130	endoscope disinfectant, rigid or fiberoptic, w-cart	ES005		30		30	
131	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011		70		92	
132	light, surgical	EF014					
133	stretcher, endoscopy	EF020					
134	instrument pack, basic (\$500-\$1499)	EQ137					

	A	B	C	CB	CC	CD	CE
1				<b>Crosswalk Code from RUC 10/2012</b>		<b>Recommendation (x-walk 43205 RUC 10/12)</b>	
2				<b>43205</b>		<b>43254 NEW</b>	
3	<b>Meeting Date: January 2013</b> <b>Tab: EGD</b> <b>Specialty: GI</b>	<b>CMS Code</b>	<b>Staff Type</b>	ESOPH, with band ligation of esophageal varices		EGD, with endoscopic mucosal resection	
4	<b>LOCATION</b>			<b>NF</b>	<b>FAC</b>	<b>NF</b>	<b>FAC</b>
5	<b>GLOBAL PERIOD</b>			<b>000</b>	<b>000</b>	<b>000</b>	<b>000</b>
6	<b>TOTAL CLINICAL LABOR TIME</b>	<b>L051A</b>	<b>RN</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
7	<b>TOTAL CLINICAL LABOR TIME</b>	<b>L037D</b>	<b>RN/LPN/MTA</b>	<b>0</b>	<b>22</b>	<b>0</b>	<b>22</b>
8	<b>PRE-SERV CLINICAL LABOR TIME</b>	<b>L037D</b>	<b>RN/LPN/MTA</b>	<b>0</b>	<b>19</b>	<b>0</b>	<b>19</b>
9	<b>SERVICE PERIOD CLINICAL LABOR TIME</b>	<b>L051A</b>	<b>RN</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
10	<b>SERVICE PERIOD CLINICAL LABOR TIME</b>	<b>L037D</b>	<b>RN/LPN/MTA</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
11	<b>POST-SERV CLINICAL LABOR TIME</b>	<b>L037D</b>	<b>RN/LPN/MTA</b>	<b>0</b>	<b>3</b>	<b>0</b>	<b>3</b>
12	<b>PRE-SERVICE</b>						
13	<b>Start: Following visit when decision for surgery or procedure made</b>						
14	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		3		3
15	Coordinate pre-surgery services	L037D	RN/LPN/MTA		5		5
16	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3
17	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5
18	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		3		3
20	<b>End: When patient enters office/facility for surgery/procedure</b>						
21	<b>SERVICE PERIOD</b>						
22	<b>Start: When patient enters office/facility for surgery/procedure:</b>						
23	Review charts [N/A in 2012]	L037D	RN/LPN/MTA				
24	Review history, systems, and meds [N/A in 2012]	L037D	RN/LPN/MTA				
25	Greet patient, provide gowning, ensure appropriate	L037D	RN/LPN/MTA				
26	Obtain vital signs	L037D	RN/LPN/MTA				
27	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA				
28	Prepare room, equipment, supplies	L037D	RN/LPN/MTA				
29	Setup scope (non facility setting only)	L037D	RN/LPN/MTA				
30	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA				
31	Sedate/apply anesthesia	L051A	RN				
32	<b>Intra-service</b>						
33	Moderate sedation	L051A	RN				
34	Assist physician in performing procedure	L037D	RN/LPN/MTA				
35	<b>Post-Service</b>						
36	Monitor pt. following service/check tubes, monitors,	L051A	RN				
37	Monitor pt. following service/check tubes, monitors,	L037D	RN/LPN/MTA				
38	Clean room/equipment by physician staff	L037D	RN/LPN/MTA				
39	Clean Scope	L037D	RN/LPN/MTA				
40	Clean Surgical Instrument Package	L037D	RN/LPN/MTA				
41	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA				
42	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA				
43	Check dressings & wound/ home care instructions	L037D	RN/LPN/MTA				
47	<b>End: Patient leaves office</b>						
48	<b>POST-SERVICE Period</b>						
49	<b>Start: Patient leaves office/facility</b>						
50	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA		3		3
59	<b>End: with last office visit before end of global period</b>						
60	<b>MEDICAL SUPPLIES</b>	<b>CODE</b>	<b>UNIT</b>				
61	<b>SCRUB, DRESS, DRAPE</b>						
62	pack, minimum multi-specialty visit	SA048	pack				
63	gown, staff, impervious	SB027	item				
64	cap, surgical	SB001	item				
65	mask, surgical, with face shield	SB034	item				
66	shoe covers, surgical	SB039	pair				
67	scrub brush (impregnated)	SM023	item				
68	drape, non-sterile, sheet 40in x 60in	SB006	item				
69	basin, emesis	SJ010	item				
70	denture cup	SJ016	item				
71	<b>MODERATE SEDATION</b>						
72	pack, moderate sedation	SA044	pack				
73	electrode, ECG (single)	SD053	item				
74	nasal cannula	SD100	item				
75	bite block	SD006	item				
76	<b>PROCEDURE INSTRUMENTS / SUPPLIES</b>						
77	endoscope anti-fog solution	SM014	ml				
78	endoscopic cytology brush	SD067	item				
79	endoscopic biopsy forceps	SD066	item				
80	endoscopic polypectomy snare	SD068	item				
81	endosheath (proxy for endoscopic hood)	SD070	item				
82	endoscopic clip	NEW	item				
83	guidewire, STIFF	SD090	item				
84	endoscopic balloon, dilation	SD019	item				
86	needle, micropigmentation (tattoo)	SC079	item				
87	skin marking ink (tattoo)	SK073	ml				
88	needle, variceal injection	SC044	item				
89	syringe 5-6ml	SC057	item				
90	cautery, patient ground pad with cord	SF021	item				
91	cautery, bipolar cord	SF012	item				
92	cautery, bipolar, probe, endoscopy	NEW	item				
93	catheter, optical endomicroscopy	NEW	item				
94	kit, probe, radiofrequency, Xli-enhanced RF probe (proxy for catheter, RF ablation, endoscopic)	SA100	kit				
95	canister, suction	SD009	item				



	A	B	C	CB	CC	CD	CE
1				<b>Crosswalk Code from RUC 10/2012</b>		<b>Recommendation (x-walk 43205 RUC 10/12)</b>	
2				<b>43205</b>		<b>43254 NEW</b>	
3	<b>Meeting Date: January 2013 Tab: EGD Specialty: GI</b>	<b>CMS Code</b>	<b>Staff Type</b>	ESOPH, with band ligation of esophageal varices		EGD, with endoscopic mucosal resection	
4	<b>LOCATION</b>			<b>NF</b>	<b>FAC</b>	<b>NF</b>	<b>FAC</b>
5	<b>GLOBAL PERIOD</b>			<b>000</b>	<b>000</b>	<b>000</b>	<b>000</b>
96	tubing, suction, non-latex (6ft uou)	SD132	item				
97	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item				
98	syringe 50-60ml	SC056	item				
99	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item				
100	gauze, non-sterile 4in x 4in	SG051	item				
101	cup, biopsy-specimen non-sterile 4oz	SL035	item				
102	paper, photo printing (8.5 x 11)	SK058	item				
103	applicator, cotton-tipped, non-sterile 6in	SG008	item				
104	lubricating jelly (K-Y) (5gm uou)	SJ032	item				
106	gauze, non-sterile 2in x 2in	SG050	item				
107	iv tubing (extension)	SC019	item				
108	kit, needle - free injection system	SA021	item				
109	<b>SCOPE CLEANING</b>						
110	pack, cleaning and disinfecting, endoscope	SA042	pack				
111	pack, cleaning, surgical instruments	SA043	pack				
112	gloves, non-sterile	SB022	pair				
113	basin, irrigation	SJ009	item				
114	cleaning brush, endoscope	SM010	item				
115	enzymatic detergent	SM015	oz				
118	water, distilled	SK087	oz				
119	<b>EQUIPMENT</b>	<b>CODE</b>					
120	videoscope, gastroscopy	ES034					
121	stretcher	EF018					
122	IV infusion pump	EQ032					
123	table, power	EF031					
124	video system, endoscopy (processor, digital capture, monitor, printer, cart)	ES031					
125	suction machine (Gomco)	EQ235					
126	table, instrument, mobile	EF027					
127	radiofrequency generator (NEURO)	<b>EQ214</b>					
128	electrosurgical generator, gastrocautery	EQ113					
129	optical endomicroscope processor unit system	<b>EQ355</b>					
130	endoscope disinfectant, rigid or fiberoptic, w-cart	ES005					
131	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011					
132	light, surgical	EF014					
133	stretcher, endoscopy	EF020					
134	instrument pack, basic (\$500-\$1499)	EQ137					



	A	B	C	CF	CG	CH	CI	CJ	CK
1				PEAC 2002		Crosswalk Code from RUC 10/2012		Recommendation (x-walk 43227 RUC 10/12)	
2				43255		43227		43255	
3	Meeting Date: January 2013 Tab: EGD Specialty: GI	CMS Code	Staff Type	EGD, with control of bleeding, any method		ESOPH, with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma		EGD, with control of bleeding, any method	
4	LOCATION			NF	FAC	NF	FAC	NF	FAC
5	GLOBAL PERIOD			000	000	000	000	000	000
6	TOTAL CLINICAL LABOR TIME	L051A	RN	0	0	47	0	47	0
7	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	22	100	22	100	22
8	PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	19	9	19	9	19
9	SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	0	0	47	0	47	0
10	SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	0	88	0	88	0
11	POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	3	3	3	3	3
12	PRE-SERVICE								
13	Start: Following visit when decision for surgery or procedure made								
14	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		3	3	3	3	3
15	Coordinate pre-surgery services	L037D	RN/LPN/MTA		5	3	5	3	5
16	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3		3
17	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5		5
18	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		3	3	3	3	3
20	End: When patient enters office/facility for surgery/procedure								
21	SERVICE PERIOD								
22	Start: When patient enters office/facility for surgery/procedure:								
23	Review charts [N/A in 2012]	L037D	RN/LPN/MTA						
24	Review history, systems, and meds [N/A in 2012]	L037D	RN/LPN/MTA						
25	Greet patient, provide gowning, ensure appropriate	L037D	RN/LPN/MTA			3		3	
26	Obtain vital signs	L037D	RN/LPN/MTA			5		5	
27	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA			3		3	
28	Prepare room, equipment, supplies	L037D	RN/LPN/MTA			2		2	
29	Setup scope (non facility setting only)	L037D	RN/LPN/MTA			5		5	
30	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA			2		2	
31	Sedate/apply anesthesia	L051A	RN			2		2	
32	Intra-service								
33	Moderate sedation	L051A	RN			30		30	
34	Assist physician in performing procedure	L037D	RN/LPN/MTA			30		30	
35	Post-Service								
36	Monitor pt. following service/check tubes, monitors,	L051A	RN			15		15	
37	Monitor pt. following service/check tubes, monitors,	L037D	RN/LPN/MTA						
38	Clean room/equipment by physician staff	L037D	RN/LPN/MTA			3		3	
39	Clean Scope	L037D	RN/LPN/MTA			30		30	
40	Clean Surgical Instrument Package	L037D	RN/LPN/MTA						
41	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA			2		2	
42	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA						
43	Check dressings & wound/ home care instructions	L037D	RN/LPN/MTA			3		3	
47	End: Patient leaves office								
48	POST-SERVICE Period								
49	Start: Patient leaves office/facility								
50	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA		3	3	3	3	3
59	End: with last office visit before end of global period								
60	MEDICAL SUPPLIES	CODE	UNIT						
61	SCRUB, DRESS, DRAPE								
62	pack, minimum multi-specialty visit	SA048	pack			1		1	
63	gown, staff, impervious	SB027	item			2		2	
64	cap, surgical	SB001	item			3		3	
65	mask, surgical, with face shield	SB034	item			3		3	
66	shoe covers, surgical	SB039	pair			3		3	
67	scrub brush (impregnated)	SM023	item			3		3	
68	drape, non-sterile, sheet 40in x 60in	SB006	item			1		1	
69	basin, emesis	SJ010	item			1		1	
70	denture cup	SJ016	item			1		1	
71	MODERATE SEDATION								
72	pack, moderate sedation	SA044	pack			1		1	
73	electrode, ECG (single)	SD053	item						
74	nasal cannula	SD100	item						
75	bite block	SD006	item			1		1	
76	PROCEDURE INSTRUMENTS / SUPPLIES								
77	endoscope anti-fog solution	SM014	ml			1		1	
78	endoscopic cytology brush	SD067	item			1		1	
79	endoscopic biopsy forceps	SD066	item						
80	endoscopic polypectomy snare	SD068	item						
81	endosheath (proxy for endoscopic hood)	SD070	item						
82	endoscopic clip	NEW	item			1		1	
83	guidewire, STIFF	SD090	item						
84	endoscopic balloon, dilation	SD019	item						
86	needle, micropigmentation (tattoo)	SC079	item						
87	skin marking ink (tattoo)	SK073	ml						
88	needle, variceal injection	SC044	item						
89	syringe 5-6ml	SC057	item						
90	cautery, patient ground pad with cord	SF021	item			1		1	
91	cautery, bipolar cord	SF012	item			1		1	
92	cautery, bipolar, probe, endoscopy	NEW	item			1		1	
93	catheter, optical endomicroscopy	NEW	item						
94	kit, probe, radiofrequency, Xli-enhanced RF probe (proxy for catheter, RF ablation, endoscopic)	SA100	kit						
95	canister, suction	SD009	item			2		1	

	A	B	C	CF	CG	CH	CI	CJ	CK
1				PEAC 2002		Crosswalk Code from RUC 10/2012		Recommendation (x-walk 43227 RUC 10/12)	
2				43255		43227		43255	
3	Meeting Date: January 2013 Tab: EGD Specialty: GI	CMS Code	Staff Type	EGD, with control of bleeding, any method		ESOPH, with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma		EGD, with control of bleeding, any method	
4	LOCATION			NF	FAC	NF	FAC	NF	FAC
5	GLOBAL PERIOD			000	000	000	000	000	000
96	tubing, suction, non-latex (6ft uou)	SD132	item			1		1	
97	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item			1		1	
98	syringe 50-60ml	SC056	item			1		1	
99	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item			1		1	
100	gauze, non-sterile 4in x 4in	SG051	item			1		1	
101	cup, biopsy-specimen non-sterile 4oz	SL035	item			1		1	
102	paper, photo printing (8.5 x 11)	SK058	item			1		1	
103	applicator, cotton-tipped, non-sterile 6in	SG008	item						
104	lubricating jelly (K-Y) (5gm uou)	SJ032	item			4		4	
106	gauze, non-sterile 2in x 2in	SG050	item						
107	iv tubing (extension)	SC019	item						
108	kit, needle - free injection system	SA021	item						
109	SCOPE CLEANING								
110	pack, cleaning and disinfecting, endoscope	SA042	pack			1		1	
111	pack, cleaning, surgical instruments	SA043	pack						
112	gloves, non-sterile	SB022	pair						
113	basin, irrigation	SJ009	item						
114	cleaning brush, endoscope	SM010	item						
115	enzymatic detergent	SM015	oz						
118	water, distilled	SK087	oz						
119	EQUIPMENT	CODE							
120	videoscope, gastroscopy	ES034				74		85	
121	stretcher	EF018				88		0	
122	IV infusion pump	EQ032				67		92	
123	table, power	EF031				44		58	
124	video system, endoscopy (processor, digital capture, monitor, printer, cart)	ES031				44		58	
125	suction machine (Gomco)	EQ235				44		58	
126	table, instrument, mobile	EF027				44		92	
127	radiofrequency generator (NEURO)	EQ214							
128	electrosurgical generator, gastrocautery	EQ113				44		58	
129	optical endomicroscope processor unit system	EQ355							
130	endoscope disinfectant, rigid or fiberoptic, w-cart	ES005				30		30	
131	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011				67		92	
132	light, surgical	EF014							
133	stretcher, endoscopy	EF020							
134	instrument pack, basic (\$500-\$1499)	EQ137							

	A	B	C	CL	CM	CN	CO	CP	CQ
1				<b>PEAC 2002 43256 TO BE DELETED</b>		<b>Crosswalk Code from RUC 10/2012</b>		<b>Recommendation (x-walk 43205 RUC 10/12) FAC ONLY</b>	
2				<b>43256 (deleted)</b>		<b>43205</b>		<b>43266 NEW</b>	
3	<b>Meeting Date: January 2013 Tab: EGD Specialty: GI</b>	<b>CMS Code</b>	<b>Staff Type</b>	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as		ESOPH, with band ligation of esophageal varices		EGD, with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when	
4	<b>LOCATION</b>			<b>NF</b>	<b>FAC</b>	<b>NF</b>	<b>FAC</b>	<b>NF</b>	<b>FAC</b>
5	<b>GLOBAL PERIOD</b>			<b>000</b>	<b>000</b>	<b>000</b>	<b>000</b>	<b>000</b>	<b>000</b>
6	<b>TOTAL CLINICAL LABOR TIME</b>	<b>L051A</b>	<b>RN</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>n/a</b>	<b>0</b>
7	<b>TOTAL CLINICAL LABOR TIME</b>	<b>L037D</b>	<b>RN/LPN/MTA</b>	<b>0</b>	<b>19</b>	<b>0</b>	<b>22</b>	<b>n/a</b>	<b>19</b>
8	<b>PRE-SERV CLINICAL LABOR TIME</b>	<b>L037D</b>	<b>RN/LPN/MTA</b>	<b>0</b>	<b>19</b>	<b>0</b>	<b>19</b>	<b>n/a</b>	<b>19</b>
9	<b>SERVICE PERIOD CLINICAL LABOR TIME</b>	<b>L051A</b>	<b>RN</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>n/a</b>	<b>0</b>
10	<b>SERVICE PERIOD CLINICAL LABOR TIME</b>	<b>L037D</b>	<b>RN/LPN/MTA</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>n/a</b>	<b>0</b>
11	<b>POST-SERV CLINICAL LABOR TIME</b>	<b>L037D</b>	<b>RN/LPN/MTA</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>3</b>	<b>n/a</b>	<b>0</b>
12	<b>PRE-SERVICE</b>								
13	<b>Start: Following visit when decision for surgery or procedure made</b>								
14	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		3		3		3
15	Coordinate pre-surgery services	L037D	RN/LPN/MTA		5		5		5
16	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3		3
17	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5		5
18	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		3		3		3
20	<b>End: When patient enters office/facility for surgery/procedure</b>								
21	<b>SERVICE PERIOD</b>								
22	<b>Start: When patient enters office/facility for surgery/procedure:</b>								
23	Review charts [N/A in 2012]	L037D	RN/LPN/MTA						
24	Review history, systems, and meds [N/A in 2012]	L037D	RN/LPN/MTA						
25	Greet patient, provide gowning, ensure appropriate	L037D	RN/LPN/MTA						
26	Obtain vital signs	L037D	RN/LPN/MTA						
27	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA						
28	Prepare room, equipment, supplies	L037D	RN/LPN/MTA						
29	Setup scope (non facility setting only)	L037D	RN/LPN/MTA						
30	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA						
31	Sedate/apply anesthesia	L051A	RN						
32	<b>Intra-service</b>								
33	Moderate sedation	L051A	RN						
34	Assist physician in performing procedure	L037D	RN/LPN/MTA						
35	<b>Post-Service</b>								
36	Monitor pt. following service/check tubes, monitors,	L051A	RN						
37	Monitor pt. following service/check tubes, monitors,	L037D	RN/LPN/MTA						
38	Clean room/equipment by physician staff	L037D	RN/LPN/MTA						
39	Clean Scope	L037D	RN/LPN/MTA						
40	Clean Surgical Instrument Package	L037D	RN/LPN/MTA						
41	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA						
42	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA						
43	Check dressings & wound/ home care instructions	L037D	RN/LPN/MTA						
47	<b>End: Patient leaves office</b>								
48	<b>POST-SERVICE Period</b>								
49	<b>Start: Patient leaves office/facility</b>								
50	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA				3		0
59	<b>End: with last office visit before end of global period</b>								
60	<b>MEDICAL SUPPLIES</b>								
61	<b>CODE UNIT</b>								
61	<b>SCRUB, DRESS, DRAPE</b>								
62	pack, minimum multi-specialty visit	SA048	pack						
63	gown, staff, impervious	SB027	item						
64	cap, surgical	SB001	item						
65	mask, surgical, with face shield	SB034	item						
66	shoe covers, surgical	SB039	pair						
67	scrub brush (impregnated)	SM023	item						
68	drape, non-sterile, sheet 40in x 60in	SB006	item						
69	basin, emesis	SJ010	item						
70	denture cup	SJ016	item						
71	<b>MODERATE SEDATION</b>								
72	pack, moderate sedation	SA044	pack						
73	electrode, ECG (single)	SD053	item						
74	nasal cannula	SD100	item						
75	bite block	SD006	item						
76	<b>PROCEDURE INSTRUMENTS / SUPPLIES</b>								
77	endoscope anti-fog solution	SM014	ml						
78	endoscopic cytology brush	SD067	item						
79	endoscopic biopsy forceps	SD066	item						
80	endoscopic polypectomy snare	SD068	item						
81	endosheath (proxy for endoscopic hood)	SD070	item						
82	endoscopic clip	NEW	item						
83	guidewire, STIFF	SD090	item						
84	endoscopic balloon, dilation	SD019	item						
86	needle, micropigmentation (tattoo)	SC079	item						
87	skin marking ink (tattoo)	SK073	ml						
88	needle, variceal injection	SC044	item						
89	syringe 5-6ml	SC057	item						
90	cautery, patient ground pad with cord	SF021	item						
91	cautery, bipolar cord	SF012	item						
92	cautery, bipolar, probe, endoscopy	NEW	item						
93	catheter, optical endomicroscopy	NEW	item						
94	kit, probe, radiofrequency, Xli-enhanced RF probe (proxy for catheter, RF ablation, endoscopic)	SA100	kit						
95	canister, suction	SD009	item						



	A	B	C	CL	CM	CN	CO	CP	CQ
1				<b>PEAC 2002 43256 TO BE DELETED</b>		<b>Crosswalk Code from RUC 10/2012</b>		<b>Recommendation (x-walk 43205 RUC 10/12) FAC ONLY</b>	
2				<b>43256 (deleted)</b>		<b>43205</b>		<b>43266 NEW</b>	
3	<b>Meeting Date: January 2013 Tab: EGD Specialty: GI</b>	<b>CMS Code</b>	<b>Staff Type</b>	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as		ESOPH, with band ligation of esophageal varices		EGD, with placement of endoscopic stent (includes pre- and post- dilation and guide wire passage, when	
4	<b>LOCATION</b>			<b>NF</b>	<b>FAC</b>	<b>NF</b>	<b>FAC</b>	<b>NF</b>	<b>FAC</b>
5	<b>GLOBAL PERIOD</b>			<b>000</b>	<b>000</b>	<b>000</b>	<b>000</b>	<b>000</b>	<b>000</b>
96	tubing, suction, non-latex (6ft uou)	SD132	item						
97	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item						
98	syringe 50-60ml	SC056	item						
99	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item						
100	gauze, non-sterile 4in x 4in	SG051	item						
101	cup, biopsy-specimen non-sterile 4oz	SL035	item						
102	paper, photo printing (8.5 x 11)	SK058	item						
103	applicator, cotton-tipped, non-sterile 6in	SG008	item						
104	lubricating jelly (K-Y) (5gm uou)	SJ032	item						
106	gauze, non-sterile 2in x 2in	SG050	item						
107	iv tubing (extension)	SC019	item						
108	kit, needle - free injection system	SA021	item						
109	<b>SCOPE CLEANING</b>								
110	pack, cleaning and disinfecting, endoscope	SA042	pack						
111	pack, cleaning, surgical instruments	SA043	pack						
112	gloves, non-sterile	SB022	pair						
113	basin, irrigation	SJ009	item						
114	cleaning brush, endoscope	SM010	item						
115	enzymatic detergent	SM015	oz						
118	water, distilled	SK087	oz						
119	<b>EQUIPMENT</b>	<b>CODE</b>							
120	videoscope, gastroscopy	ES034							
121	stretcher	EF018							
122	IV infusion pump	EQ032							
123	table, power	EF031							
124	video system, endoscopy (processor, digital capture, monitor, printer, cart)	ES031							
125	suction machine (Gomco)	EQ235							
126	table, instrument, mobile	EF027							
127	radiofrequency generator (NEURO)	<b>EQ214</b>							
128	electrosurgical generator, gastrocautery	EQ113							
129	optical endomicroscope processor unit system	<b>EQ355</b>							
130	endoscope disinfectant, rigid or fiberoptic, w-cart	ES005							
131	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011							
132	light, surgical	EF014							
133	stretcher, endoscopy	EF020							
134	instrument pack, basic (\$500-\$1499)	EQ137							

	A	B	C	CR	CS	CT	CU	CV	CW
1				RUC 2003		Crosswalk Code from RUC 10/2012		Recommendation (x-walk 43205 RUC 10/12) FAC ONLY	
2				43257		43205		43257	
3	Meeting Date: January 2013 Tab: EGD Specialty: GI	CMS Code	Staff Type	EGD, with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for		ESOPH, with band ligation of esophageal varices		EGD, with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for	
4	LOCATION			NF	FAC	NF	FAC	NF	FAC
5	GLOBAL PERIOD			000	000	000	000	000	000
6	TOTAL CLINICAL LABOR TIME	L051A	RN	0	0	0	0	n/a	0
7	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	25	0	22	n/a	22
8	PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	19	0	19	n/a	19
9	SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	0	0	0	0	n/a	0
10	SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	0	0	0	n/a	0
11	POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	6	0	3	n/a	3
12	PRE-SERVICE								
13	Start: Following visit when decision for surgery or procedure made								
14	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		3		3		3
15	Coordinate pre-surgery services	L037D	RN/LPN/MTA		5		5		5
16	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3		3
17	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5		5
18	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		3		3		3
20	End: When patient enters office/facility for surgery/procedure								
21	SERVICE PERIOD								
22	Start: When patient enters office/facility for surgery/procedure:								
23	Review charts [N/A in 2012]	L037D	RN/LPN/MTA						
24	Review history, systems, and meds [N/A in 2012]	L037D	RN/LPN/MTA						
25	Greet patient, provide gowning, ensure appropriate	L037D	RN/LPN/MTA						
26	Obtain vital signs	L037D	RN/LPN/MTA						
27	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA						
28	Prepare room, equipment, supplies	L037D	RN/LPN/MTA						
29	Setup scope (non facility setting only)	L037D	RN/LPN/MTA						
30	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA						
31	Sedate/apply anesthesia	L051A	RN						
32	Intra-service								
33	Moderate sedation	L051A	RN						
34	Assist physician in performing procedure	L037D	RN/LPN/MTA						
35	Post-Service								
36	Monitor pt. following service/check tubes, monitors,	L051A	RN						
37	Monitor pt. following service/check tubes, monitors,	L037D	RN/LPN/MTA						
38	Clean room/equipment by physician staff	L037D	RN/LPN/MTA						
39	Clean Scope	L037D	RN/LPN/MTA						
40	Clean Surgical Instrument Package	L037D	RN/LPN/MTA						
41	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA						
42	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA						
43	Check dressings & wound/ home care instructions	L037D	RN/LPN/MTA						
47	End: Patient leaves office								
48	POST-SERVICE Period								
49	Start: Patient leaves office/facility								
50	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA		6		3		3
59	End: with last office visit before end of global period								
60	MEDICAL SUPPLIES	CODE	UNIT						
61	SCRUB, DRESS, DRAPE								
62	pack, minimum multi-specialty visit	SA048	pack						
63	gown, staff, impervious	SB027	item						
64	cap, surgical	SB001	item						
65	mask, surgical, with face shield	SB034	item						
66	shoe covers, surgical	SB039	pair						
67	scrub brush (impregnated)	SM023	item						
68	drape, non-sterile, sheet 40in x 60in	SB006	item						
69	basin, emesis	SJ010	item						
70	denture cup	SJ016	item						
71	MODERATE SEDATION								
72	pack, moderate sedation	SA044	pack						
73	electrode, ECG (single)	SD053	item						
74	nasal cannula	SD100	item						
75	bite block	SD006	item						
76	PROCEDURE INSTRUMENTS / SUPPLIES								
77	endoscope anti-fog solution	SM014	ml						
78	endoscopic cytology brush	SD067	item						
79	endoscopic biopsy forceps	SD066	item						
80	endoscopic polypectomy snare	SD068	item						
81	endosheath (proxy for endoscopic hood)	SD070	item						
82	endoscopic clip	NEW	item						
83	guidewire, STIFF	SD090	item						
84	endoscopic balloon, dilation	SD019	item						
86	needle, micropigmentation (tattoo)	SC079	item						
87	skin marking ink (tattoo)	SK073	ml						
88	needle, variceal injection	SC044	item						
89	syringe 5-6ml	SC057	item						
90	cautery, patient ground pad with cord	SF021	item						
91	cautery, bipolar cord	SF012	item						
92	cautery, bipolar, probe, endoscopy	NEW	item						
93	catheter, optical endomicroscopy	NEW	item						
94	kit, probe, radiofrequency, Xli-enhanced RF probe (proxy for catheter, RF ablation, endoscopic)	SA100	kit						
95	canister, suction	SD009	item						

	A	B	C	CR	CS	CT	CU	CV	CW
1				RUC 2003		Crosswalk Code from RUC 10/2012		Recommendation (x-walk 43205 RUC 10/12) FAC ONLY	
2				43257		43205		43257	
3	Meeting Date: January 2013 Tab: EGD Specialty: GI	CMS Code	Staff Type	EGD, with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for		ESOPH, with band ligation of esophageal varices		EGD, with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for	
4	LOCATION			NF	FAC	NF	FAC	NF	FAC
5	GLOBAL PERIOD			000	000	000	000	000	000
96	tubing, suction, non-latex (6ft uou)	SD132	item						
97	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item						
98	syringe 50-60ml	SC056	item						
99	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item						
100	gauze, non-sterile 4in x 4in	SG051	item						
101	cup, biopsy-specimen non-sterile 4oz	SL035	item						
102	paper, photo printing (8.5 x 11)	SK058	item						
103	applicator, cotton-tipped, non-sterile 6in	SG008	item						
104	lubricating jelly (K-Y) (5gm uou)	SJ032	item						
106	gauze, non-sterile 2in x 2in	SG050	item						
107	iv tubing (extension)	SC019	item						
108	kit, needle - free injection system	SA021	item						
109	SCOPE CLEANING								
110	pack, cleaning and disinfecting, endoscope	SA042	pack						
111	pack, cleaning, surgical instruments	SA043	pack						
112	gloves, non-sterile	SB022	pair						
113	basin, irrigation	SJ009	item						
114	cleaning brush, endoscope	SM010	item						
115	enzymatic detergent	SM015	oz						
118	water, distilled	SK087	oz						
119	EQUIPMENT	CODE							
120	videoscope, gastroscopy	ES034							
121	stretcher	EF018							
122	IV infusion pump	EQ032							
123	table, power	EF031							
124	video system, endoscopy (processor, digital capture, monitor, printer, cart)	ES031							
125	suction machine (Gomco)	EQ235							
126	table, instrument, mobile	EF027							
127	radiofrequency generator (NEURO)	EQ214							
128	electrosurgical generator, gastrocautery	EQ113							
129	optical endomicroscope processor unit system	EQ355							
130	endoscope disinfectant, rigid or fiberoptic, w-cart	ES005							
131	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011							
132	light, surgical	EF014							
133	stretcher, endoscopy	EF020							
134	instrument pack, basic (\$500-\$1499)	EQ137							



	A	B	C	CX	CY	CZ	DA	DB	DC
1				<b>PEAC 2002 43258 TO BE DELETED</b>		<b>Crosswalk Code from RUC 10/2012</b>		<b>Recommendation (x-walk 43228 RUC 10/12)</b>	
2				<b>43258 (deleted)</b>		<b>43228</b>		<b>43270 NEW</b>	
3	<b>Meeting Date: January 2013 Tab: EGD Specialty: GI</b>	<b>CMS Code</b>	<b>Staff Type</b>	Upper gi endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate;		Esophagoscopy, flexible, transoral: with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by		EGD, with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when	
4	<b>LOCATION</b>			<b>NF</b>	<b>FAC</b>	<b>NF</b>	<b>FAC</b>	<b>NF</b>	<b>FAC</b>
5	<b>GLOBAL PERIOD</b>			<b>000</b>	<b>000</b>	<b>000</b>	<b>000</b>	<b>000</b>	<b>000</b>
6	<b>TOTAL CLINICAL LABOR TIME</b>	<b>L051A</b>	<b>RN</b>	<b>0</b>	<b>0</b>	<b>52</b>	<b>0</b>	<b>62</b>	<b>0</b>
7	<b>TOTAL CLINICAL LABOR TIME</b>	<b>L037D</b>	<b>RN/LPN/MTA</b>	<b>0</b>	<b>22</b>	<b>105</b>	<b>22</b>	<b>115</b>	
8	<b>PRE-SERV CLINICAL LABOR TIME</b>	<b>L037D</b>	<b>RN/LPN/MTA</b>	<b>0</b>	<b>19</b>	<b>9</b>	<b>19</b>	<b>9</b>	<b>19</b>
9	<b>SERVICE PERIOD CLINICAL LABOR TIME</b>	<b>L051A</b>	<b>RN</b>	<b>0</b>	<b>0</b>	<b>52</b>	<b>0</b>	<b>62</b>	<b>0</b>
10	<b>SERVICE PERIOD CLINICAL LABOR TIME</b>	<b>L037D</b>	<b>RN/LPN/MTA</b>	<b>0</b>	<b>0</b>	<b>93</b>	<b>0</b>	<b>103</b>	<b>0</b>
11	<b>POST-SERV CLINICAL LABOR TIME</b>	<b>L037D</b>	<b>RN/LPN/MTA</b>	<b>0</b>	<b>3</b>	<b>3</b>	<b>3</b>	<b>3</b>	<b>3</b>
12	<b>PRE-SERVICE</b>								
13	<b>Start: Following visit when decision for surgery or procedure made</b>								
14	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		3	3	3	3	3
15	Coordinate pre-surgery services	L037D	RN/LPN/MTA		5	3	5	3	5
16	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3		3
17	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5		5
18	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		3	3	3	3	3
20	<b>End: When patient enters office/facility for surgery/procedure</b>								
21	<b>SERVICE PERIOD</b>								
22	<b>Start: When patient enters office/facility for surgery/procedure:</b>								
23	Review charts [N/A in 2012]	L037D	RN/LPN/MTA						
24	Review history, systems, and meds [N/A in 2012]	L037D	RN/LPN/MTA						
25	Greet patient, provide gowning, ensure appropriate	L037D	RN/LPN/MTA			3		3	
26	Obtain vital signs	L037D	RN/LPN/MTA			5		5	
27	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA			3		3	
28	Prepare room, equipment, supplies	L037D	RN/LPN/MTA			2		2	
29	Setup scope (non facility setting only)	L037D	RN/LPN/MTA			5		5	
30	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA			2		2	
31	Sedate/apply anesthesia	L051A	RN			2		2	
32	<b>Intra-service</b>								
33	Moderate sedation	L051A	RN			35		45	
34	Assist physician in performing procedure	L037D	RN/LPN/MTA			35		45	
35	<b>Post-Service</b>								
36	Monitor pt. following service/check tubes, monitors,	L051A	RN			15		15	
37	Monitor pt. following service/check tubes, monitors,	L037D	RN/LPN/MTA						
38	Clean room/equipment by physician staff	L037D	RN/LPN/MTA			3		3	
39	Clean Scope	L037D	RN/LPN/MTA			30		30	
40	Clean Surgical Instrument Package	L037D	RN/LPN/MTA						
41	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA			2		2	
42	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA						
43	Check dressings & wound/ home care instructions	L037D	RN/LPN/MTA			3		3	
47	<b>End: Patient leaves office</b>								
48	<b>POST-SERVICE Period</b>								
49	<b>Start: Patient leaves office/facility</b>								
50	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA		3	3	3	3	3
59	<b>End: with last office visit before end of global period</b>								
60	<b>MEDICAL SUPPLIES</b>								
61	<b>CODE UNIT</b>								
61	<b>SCRUB, DRESS, DRAPE</b>								
62	pack, minimum multi-specialty visit	SA048	pack			1		1	
63	gown, staff, impervious	SB027	item			2		2	
64	cap, surgical	SB001	item			3		3	
65	mask, surgical, with face shield	SB034	item			3		3	
66	shoe covers, surgical	SB039	pair			3		3	
67	scrub brush (impregnated)	SM023	item			3		3	
68	drape, non-sterile, sheet 40in x 60in	SB006	item			1		1	
69	basin, emesis	SJ010	item			1		1	
70	denture cup	SJ016	item			1		1	
71	<b>MODERATE SEDATION</b>								
72	pack, moderate sedation	SA044	pack			1		1	
73	electrode, ECG (single)	SD053	item						
74	nasal cannula	SD100	item						
75	bite block	SD006	item			1		1	
76	<b>PROCEDURE INSTRUMENTS / SUPPLIES</b>								
77	endoscope anti-fog solution	SM014	ml			1		1	
78	endoscopic cytology brush	SD067	item			1		1	
79	endoscopic biopsy forceps	SD066	item						
80	endoscopic polypectomy snare	SD068	item						
81	endosheath (proxy for endoscopic hood)	SD070	item						
82	endoscopic clip	NEW	item						
83	guidewire, STIFF	SD090	item			1		0	
84	endoscopic balloon, dilation	SD019	item			1		1	
86	needle, micropigmentation (tattoo)	SC079	item						
87	skin marking ink (tattoo)	SK073	ml						
88	needle, variceal injection	SC044	item						
89	syringe 5-6ml	SC057	item						
90	cautery, patient ground pad with cord	SF021	item						
91	cautery, bipolar cord	SF012	item						
92	cautery, bipolar, probe, endoscopy	NEW	item						
93	catheter, optical endomicroscopy	NEW	item						
94	kit, probe, radiofrequency, Xli-enhanced RF probe (proxy for catheter, RF ablation, endoscopic)	SA100	kit			1		0	
95	canister, suction	SD009	item			2		1	

	A	B	C	CX	CY	CZ	DA	DB	DC
1				<b>PEAC 2002 43258 TO BE DELETED</b>		<b>Crosswalk Code from RUC 10/2012</b>		<b>Recommendation (x-walk 43228 RUC 10/12)</b>	
2				<b>43258 (deleted)</b>		<b>43228</b>		<b>43270 NEW</b>	
3	<b>Meeting Date: January 2013 Tab: EGD Specialty: GI</b>	<b>CMS Code</b>	<b>Staff Type</b>	Upper gi endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate;		Esophagoscopy, flexible, transoral: with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by		EGD, with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when	
4	<b>LOCATION</b>			<b>NF</b>	<b>FAC</b>	<b>NF</b>	<b>FAC</b>	<b>NF</b>	<b>FAC</b>
5	<b>GLOBAL PERIOD</b>			<b>000</b>	<b>000</b>	<b>000</b>	<b>000</b>	<b>000</b>	<b>000</b>
96	tubing, suction, non-latex (6ft uou)	SD132	item			1		1	
97	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item			1		1	
98	syringe 50-60ml	SC056	item			1		1	
99	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item			1		1	
100	gauze, non-sterile 4in x 4in	SG051	item			1		1	
101	cup, biopsy-specimen non-sterile 4oz	SL035	item			1		1	
102	paper, photo printing (8.5 x 11)	SK058	item			1		1	
103	applicator, cotton-tipped, non-sterile 6in	SG008	item						
104	lubricating jelly (K-Y) (5gm uou)	SJ032	item			4		4	
106	gauze, non-sterile 2in x 2in	SG050	item						
107	iv tubing (extension)	SC019	item						
108	kit, needle - free injection system	SA021	item						
109	<b>SCOPE CLEANING</b>								
110	pack, cleaning and disinfecting, endoscope	SA042	pack			1		1	
111	pack, cleaning, surgical instruments	SA043	pack						
112	gloves, non-sterile	SB022	pair						
113	basin, irrigation	SJ009	item						
114	cleaning brush, endoscope	SM010	item						
115	enzymatic detergent	SM015	oz						
118	water, distilled	SK087	oz						
119	<b>EQUIPMENT</b>	<b>CODE</b>							
120	videoscope, gastroscopy	ES034				79		100	
121	stretcher	EF018				93		0	
122	IV infusion pump	EQ032				72		107	
123	table, power	EF031				49		73	
124	video system, endoscopy (processor, digital capture, monitor, printer, cart)	ES031				49		73	
125	suction machine (Gomco)	EQ235				49		73	
126	table, instrument, mobile	EF027				49		107	
127	radiofrequency generator (NEURO)	<b>EQ214</b>				49		73	
128	electrosurgical generator, gastrocautery	EQ113				49		73	
129	optical endomicroscope processor unit system	<b>EQ355</b>							
130	endoscope disinfectant, rigid or fiberoptic, w-cart	ES005				30		30	
131	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011				72		107	
132	light, surgical	EF014							
133	stretcher, endoscopy	EF020							
134	instrument pack, basic (\$500-\$1499)	EQ137							



	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1				REFERENCE CODE											
2	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.			43246 PEAC 2005	43205 Crosswalk Code from RUC 10/2012	43246 FACILITY ONLY	43251 PEAC 2002	43217 Crosswalk Code from RUC 10/2012	43251						
3	Meeting Date: April 2013 Tab: 11 (EGD) Specialty: Gastroenterology	CMS Code	Staff Type	EGD, with directed placement of percutaneous gastrostomy tube	ESOPH, with band ligation of esophageal varices	EGD, with directed placement of percutaneous gastrostomy tube	EGD, with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	ESOPH, with removal of tumor(s), polyp(s), or other lesion(s) by snare	EGD, with removal of tumor(s), polyp(s), or other lesion(s) by snare technique						
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	000	000	000	000	000	000	000	000
6	TOTAL CLINICAL LABOR TIME	L051A	RN	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	47.0	0.0	20.0	0.0
7	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	22.0	0.0	22.0	0.0	19.0	0.0	22.0	100.0	22.0	90.0	22.0
8	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	19.0	0.0	19.0	0.0	19.0	0.0	19.0	9.0	19.0	9.0	19.0
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	47.0	0.0	20.0	0.0
10	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	88.0	0.0	78.0	0.0
11	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	3.0	0.0	3.0	0.0	0.0	0.0	3.0	3.0	3.0	3.0	3.0
12	PRE-SERVICE														
13	Start: Following visit when decision for surgery or procedure made														
14	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		3		3		3		3	3	3	3	3
15	Coordinate pre-surgery services	L037D	RN/LPN/MTA		5		5		5		5	3	5	3	5
16	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3		3		3		3		3
17	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5		5		5		5		5
18	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		3		3		3		3	3	3	3	3
19	*Other Clinical Activity - specify:														
20	End: When patient enters office/facility for surgery/procedure														
21	SERVICE PERIOD														
22	Start: When patient enters office/facility for surgery/procedure:														
23	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA									3		3	
24	Obtain vital signs	L037D	RN/LPN/MTA									5		5	
25	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA									3		3	
26	Prepare room, equipment, supplies	L037D	RN/LPN/MTA									2		2	
27	Setup scope (non facility setting only)	L037D	RN/LPN/MTA									5		5	
28	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA									2		2	
29	Sedate/apply anesthesia	L051A	RN									2		2	
30	*Other Clinical Activity - specify:														
31	Intra-service														
32	Moderate sedation	L051A	RN									30		20	
33	Assist physician in performing procedure	L037D	RN/LPN/MTA									30		20	

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1				REFERENCE CODE											
2	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.			43246 PEAC 2005	43205 Crosswalk Code from RUC 10/2012	43246 FACILITY ONLY				43251 PEAC 2002	43217 Crosswalk Code from RUC 10/2012			43251	
3	Meeting Date: April 2013 Tab: 11 (EGD) Specialty: Gastroenterology	CMS Code	Staff Type	EGD, with directed placement of percutaneous gastrostomy tube	ESOPH, with band ligation of esophageal varices	EGD, with directed placement of percutaneous gastrostomy tube	EGD, with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	ESOPH, with removal of tumor(s), polyp(s), or other lesion(s) by snare	EGD, with removal of tumor(s), polyp(s), or other lesion(s) by snare technique						
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	000	000	000	000	000	000	000	000
34	Post-Service														
35	Monitor pt. following service/check tubes, monitors, drains	L051A	RN									15		15	
36	Clean room/equipment by physician staff	L037D	RN/LPN/MTA									3		3	
37	Clean Scope	L037D	RN/LPN/MTA									30		30	
38	Clean Surgical Instrument Package	L037D	RN/LPN/MTA												
39	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA									2		2	
40	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA												
41	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA									3		3	
42	*Other Clinical Activity - <i>specify</i> :														
43	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			n/a		n/a		n/a		n/a		n/a		n/a	
44	Dischrg mgmt (1.0 x 99238) (enter 12 min)			n/a		n/a		n/a		n/a		n/a		n/a	
45	Dischrg mgmt (1.0 x 99239) (enter 15 min)			n/a		n/a		n/a		n/a		n/a		n/a	
46	End: Patient leaves office														
47	POST-SERVICE Period														
48	Start: Patient leaves office/facility														
49	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA		3		3		0		3	3	3	3	3
50	Office visits: List Number and Level of Office Visits			# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits
51	99211 16 minutes		16												
52	99212 27 minutes		27												
53	99213 36 minutes		36												
54	99214 53 minutes		53												
55	99215 63 minutes		63												
56	Total Office Visit Time			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
57	*Other Clinical Activity - <i>specify</i> :														
58	End: with last office visit before end of global period														

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1				REFERENCE CODE											
2	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.			43246 PEAC 2005	43205 Crosswalk Code from RUC 10/2012	43246 FACILITY ONLY	43251 PEAC 2002	43217 Crosswalk Code from RUC 10/2012	43251						
3	Meeting Date: April 2013 Tab: 11 (EGD) Specialty: Gastroenterology	CMS Code	Staff Type	EGD, with directed placement of percutaneous gastrostomy tube	ESOPH, with band ligation of esophageal varices	EGD, with directed placement of percutaneous gastrostomy tube	EGD, with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	ESOPH, with removal of tumor(s), polyp(s), or other lesion(s) by snare	EGD, with removal of tumor(s), polyp(s), or other lesion(s) by snare technique						
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	000	000	000	000	000	000	000	000
59	MEDICAL SUPPLIES**	CODE	UNIT												
60	SCRUB, DRESS, DRAPE														
61	pack, minimum multi-specialty visit	SA048	pack									1		1	
62	gown, staff, impervious	SB027	item									2		2	
63	cap, surgical	SB001	item									3		3	
64	mask, surgical, with face shield	SB034	item									3		3	
65	shoe covers, surgical	SB039	pair									3		3	
66	scrub brush (impregnated)	SM023	item									3		3	
67	drape, non-sterile, sheet 40in x 60in	SB006	item									1		1	
68	basin, emesis	SJ010	item									1		1	
69	denture cup	SJ016	item									1		1	
70	MODERATE SEDATION														
71	pack, moderate sedation	SA044	pack									1		1	
72	bite block	SD006	item									1		1	
73	PROCEDURE INSTRUMENTS / SUPPLIES														
74	endoscope anti-fog solution	SM014	ml									1		1	
75	endoscopic cytology brush	SD067	item									1		1	
76	endoscopic polypectomy snare	SD068	item									1		1	
77	cautery, patient ground pad with cord	SF021	item									1		1	
78	cautery, bipolar cord	SF012	item									1			
79	canister, suction	SD009	item									2		1	
80	tubing, suction, non-latex (6ft uou)	SD132	item									1		1	
81	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item									1		1	
82	syringe 50-60ml	SC056	item									1		1	
83	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item									1		1	
84	gauze, non-sterile 4in x 4in	SG051	item									1		1	
85	cup, biopsy-specimen non-sterile 4oz	SL035	item									1		1	
86	paper, photo printing (8.5 x 11)	SK058	item									1		1	
87	lubricating jelly (K-Y) (5gm uou)	SJ032	item									4		4	
88	pack, cleaning and disinfecting, endoscope	SA042	pack									1		1	

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1				REFERENCE CODE											
2	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.			43246 PEAC 2005	43205 Crosswalk Code from RUC 10/2012	43246 FACILITY ONLY		43251 PEAC 2002	43217 Crosswalk Code from RUC 10/2012	43251					
3	Meeting Date: April 2013 Tab: 11 (EGD) Specialty: Gastroenterology	CMS Code	Staff Type	EGD, with directed placement of percutaneous gastrostomy tube	ESOPH, with band ligation of esophageal varices	EGD, with directed placement of percutaneous gastrostomy tube		EGD, with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	ESOPH, with removal of tumor(s), polyp(s), or other lesion(s) by snare	EGD, with removal of tumor(s), polyp(s), or other lesion(s) by snare technique					
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	000	000	000	000	000	000	000	000
89	EQUIPMENT	CODE													
90	videoscope, gastroscopy	ES034										74		75	
91	stretcher	EF018										88		0	
92	IV infusion pump	EQ032										67		82	
93	table, power	EF031										44		48	
94	video system, endoscopy (processor, digital capture, monitor, printer, cart)	ES031										44		48	
95	suction machine (Gomco)	EQ235										44		48	
96	table, instrument, mobile	EF027										44		82	
97	electrosurgical generator, gastrocautery	EQ113										44		48	
98	endoscope disinfecter, rigid or fiberoptic, w-cart	ES005										30		30	
99	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011										67		82	

	A	B	C	P	Q	R	S	T	U	V	W	X	Y	Z	AA
1				REFERENCE CODE				REFERENCE CODE				REFERENCE CODE			
2	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.			43237 RUC 2003	43237 FACILITY ONLY	43238 RUC 2003	43238 FACILITY ONLY	43240 PEAC 2003	43240 FACILITY ONLY						
3	Meeting Date: April 2013 Tab: 11 (EGD) Specialty: Gastroenterology	CMS Code	Staff Type	EGD; EUS exam limited to the esophagus	EGD; EUS exam limited to the esophagus	EGD; EUS exam limited to the esophagus with FNA	EGD; EUS exam limited to the esophagus with FNA	EGD; EUS exam with transmural drainage of pseudocyst	EGD; EUS exam with transmural drainage of pseudocyst						
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	000	000	000	000	000	000	000	000
6	TOTAL CLINICAL LABOR TIME	L051A	RN	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
7	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	19.0	0.0	22.0	0.0	19.0	0.0	22.0	0.0	19.0	0.0	22.0
8	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	19.0	0.0	19.0	0.0	19.0	0.0	19.0	0.0	19.0	0.0	19.0
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
10	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
11	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	0.0	0.0	3.0	0.0	0.0	0.0	3.0	0.0	0.0	0.0	3.0
12	PRE-SERVICE														
13	Start: Following visit when decision for surgery or procedure made														
14	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		3		3		3		3		3		3
15	Coordinate pre-surgery services	L037D	RN/LPN/MTA		5		5		5		5		5		5
16	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3		3		3		3		3
17	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5		5		5		5		5
18	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		3		3		3		3		3		3
19	*Other Clinical Activity - specify:														
20	End: When patient enters office/facility for surgery/procedure														
21	SERVICE PERIOD														
22	Start: When patient enters office/facility for surgery/procedure:														
23	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA												
24	Obtain vital signs	L037D	RN/LPN/MTA												
25	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA												
26	Prepare room, equipment, supplies	L037D	RN/LPN/MTA												
27	Setup scope (non facility setting only)	L037D	RN/LPN/MTA												
28	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA												
29	Sedate/apply anesthesia	L051A	RN												
30	*Other Clinical Activity - specify:														
31	Intra-service														
32	Moderate sedation	L051A	RN												
33	Assist physician in performing procedure	L037D	RN/LPN/MTA												



	A	B	C	P	Q	R	S	T	U	V	W	X	Y	Z	AA
1				REFERENCE CODE				REFERENCE CODE				REFERENCE CODE			
2	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.			43237 RUC 2003		43237 FACILITY ONLY		43238 RUC 2003		43238 FACILITY ONLY		43240 PEAC 2003		43240 FACILITY ONLY	
3	Meeting Date: April 2013 Tab: 11 (EGD) Specialty: Gastroenterology	CMS Code	Staff Type	EGD; EUS exam limited to the esophagus		EGD; EUS exam limited to the esophagus		EGD; EUS exam limited to the esophagus with FNA		EGD; EUS exam limited to the esophagus with FNA		EGD; EUS exam with transmural drainage of pseudocyst		EGD; EUS exam with transmural drainage of pseudocyst	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	000	000	000	000	000	000	000	000
34	Post-Service														
35	Monitor pt. following service/check tubes, monitors, drains	L051A	RN												
36	Clean room/equipment by physician staff	L037D	RN/LPN/MTA												
37	Clean Scope	L037D	RN/LPN/MTA												
38	Clean Surgical Instrument Package	L037D	RN/LPN/MTA												
39	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA												
40	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA												
41	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA												
42	*Other Clinical Activity - specify:			n/a		n/a		n/a		n/a		n/a		n/a	
43	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			n/a		n/a		n/a		n/a		n/a		n/a	
44	Dischrg mgmt (1.0 x 99238) (enter 12 min)			n/a		n/a		n/a		n/a		n/a		n/a	
45	Dischrg mgmt (1.0 x 99239) (enter 15 min)														
46	End: Patient leaves office														
47	POST-SERVICE Period														
48	Start: Patient leaves office/facility														
49	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA				3				3				3
50	Office visits: List Number and Level of Office Visits			# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits
51	99211 16 minutes		16												
52	99212 27 minutes		27												
53	99213 36 minutes		36												
54	99214 53 minutes		53												
55	99215 63 minutes		63												
56	Total Office Visit Time			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
57	*Other Clinical Activity - specify:														
58	End: with last office visit before end of global period														

	A	B	C	P	Q	R	S	T	U	V	W	X	Y	Z	AA
1				REFERENCE CODE				REFERENCE CODE				REFERENCE CODE			
	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.			43237 RUC 2003		43237 FACILITY ONLY		43238 RUC 2003		43238 FACILITY ONLY		43240 PEAC 2003		43240 FACILITY ONLY	
2															
3	Meeting Date: April 2013 Tab: 11 (EGD) Specialty: Gastroenterology	CMS Code	Staff Type	EGD; EUS exam limited to the esophagus		EGD; EUS exam limited to the esophagus		EGD; EUS exam limited to the esophagus with FNA		EGD; EUS exam limited to the esophagus with FNA		EGD; EUS exam with transmural drainage of pseudocyst		EGD; EUS exam with transmural drainage of pseudocyst	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	000	000	000	000	000	000	000	000
59	MEDICAL SUPPLIES**	CODE UNIT													
60	SCRUB, DRESS, DRAPE														
61	pack, minimum multi-specialty visit	SA048	pack												
62	gown, staff, impervious	SB027	item												
63	cap, surgical	SB001	item												
64	mask, surgical, with face shield	SB034	item												
65	shoe covers, surgical	SB039	pair												
66	scrub brush (impregnated)	SM023	item												
67	drape, non-sterile, sheet 40in x 60in	SB006	item												
68	basin, emesis	SJ010	item												
69	denture cup	SJ016	item												
70	MODERATE SEDATION														
71	pack, moderate sedation	SA044	pack												
72	bite block	SD006	item												
73	PROCEDURE INSTRUMENTS / SUPPLIES														
74	endoscope anti-fog solution	SM014	ml												
75	endoscopic cytology brush	SD067	item												
76	endoscopic polypectomy snare	SD068	item												
77	cautery, patient ground pad with cord	SF021	item												
78	cautery, bipolar cord	SF012	item												
79	canister, suction	SD009	item												
80	tubing, suction, non-latex (6ft uou)	SD132	item												
81	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item												
82	syringe 50-60ml	SC056	item												
83	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item												
84	gauze, non-sterile 4in x 4in	SG051	item												
85	cup, biopsy-specimen non-sterile 4oz	SL035	item												
86	paper, photo printing (8.5 x 11)	SK058	item												
87	lubricating jelly (K-Y) (5gm uou)	SJ032	item												
88	pack, cleaning and disinfecting, endoscope	SA042	pack												

	A	B	C	P	Q	R	S	T	U	V	W	X	Y	Z	AA
1				REFERENCE CODE				REFERENCE CODE				REFERENCE CODE			
2	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.			43237 RUC 2003		43237 FACILITY ONLY		43238 RUC 2003		43238 FACILITY ONLY		43240 PEAC 2003		43240 FACILITY ONLY	
3	Meeting Date: April 2013 Tab: 11 (EGD) Specialty: Gastroenterology	CMS Code	Staff Type	EGD; EUS exam limited to the esophagus		EGD; EUS exam limited to the esophagus		EGD; EUS exam limited to the esophagus with FNA		EGD; EUS exam limited to the esophagus with FNA		EGD; EUS exam with transmural drainage of pseudocyst		EGD; EUS exam with transmural drainage of pseudocyst	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	000	000	000	000	000	000	000	000
89	EQUIPMENT	CODE													
90	videoscope, gastroscopy	ES034													
91	stretcher	EF018													
92	IV infusion pump	EQ032													
93	table, power	EF031													
94	video system, endoscopy (processor, digital capture, monitor, printer, cart)	ES031													
95	suction machine (Gomco)	EQ235													
96	table, instrument, mobile	EF027													
97	electrosurgical generator, gastrocautery	EQ113													
98	endoscope disinfectant, rigid or fiberoptic, w-cart	ES005													
99	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011													



	A	B	C	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK
1				REFERENCE CODE				REFERENCE CODE					
2	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.			43242 PEAC 2002		43242 FACILITY ONLY		43259 PEAC 2002		43259 FACILITY ONLY		43253 FACILITY ONLY NEW CODE	
3	Meeting Date: April 2013 Tab: 11 (EGD) Specialty: Gastroenterology	CMS Code	Staff Type	EGD; EUS exam with FNA		EGD; EUS exam with FNA		EGD; EUS exam		EGD; EUS exam		EGD; EUS exam with celiac plexus	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	000	000	000	000	000	000
6	TOTAL CLINICAL LABOR TIME	L051A	RN	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
7	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	19.0	0.0	22.0	0.0	19.0	0.0	22.0	0.0	22.0
8	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	19.0	0.0	19.0	0.0	19.0	0.0	19.0	0.0	19.0
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
10	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
11	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	0.0	0.0	3.0	0.0	0.0	0.0	3.0	0.0	3.0
12	PRE-SERVICE												
13	Start: Following visit when decision for surgery or procedure made												
14	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		3		3		3		3		3
15	Coordinate pre-surgery services	L037D	RN/LPN/MTA		5		5		5		5		5
16	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3		3		3		3
17	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5		5		5		5
18	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		3		3		3		3		3
19	*Other Clinical Activity - specify:												
20	End: When patient enters office/facility for surgery/procedure												
21	SERVICE PERIOD												
22	Start: When patient enters office/facility for surgery/procedure:												
23	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA										
24	Obtain vital signs	L037D	RN/LPN/MTA										
25	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA										
26	Prepare room, equipment, supplies	L037D	RN/LPN/MTA										
27	Setup scope (non facility setting only)	L037D	RN/LPN/MTA										
28	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA										
29	Sedate/apply anesthesia	L051A	RN										
30	*Other Clinical Activity - specify:												
31	Intra-service												
32	Moderate sedation	L051A	RN										
33	Assist physician in performing procedure	L037D	RN/LPN/MTA										

	A	B	C	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK
1				REFERENCE CODE				REFERENCE CODE					
2	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.			43242 PEAC 2002		43242 FACILITY ONLY		43259 PEAC 2002		43259 FACILITY ONLY		43253 FACILITY ONLY NEW CODE	
3	Meeting Date: April 2013 Tab: 11 (EGD) Specialty: Gastroenterology	CMS Code	Staff Type	EGD; EUS exam with FNA		EGD; EUS exam with FNA		EGD; EUS exam		EGD; EUS exam		EGD; EUS exam with celiac plexus	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	000	000	000	000	000	000
34	Post-Service												
35	Monitor pt. following service/check tubes, monitors, drains	L051A	RN										
36	Clean room/equipment by physician staff	L037D	RN/LPN/MTA										
37	Clean Scope	L037D	RN/LPN/MTA										
38	Clean Surgical Instrument Package	L037D	RN/LPN/MTA										
39	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA										
40	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA										
41	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA										
42	*Other Clinical Activity - specify:			n/a		n/a		n/a		n/a		n/a	
43	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			n/a		n/a		n/a		n/a		n/a	
44	Dischrg mgmt (1.0 x 99238) (enter 12 min)			n/a		n/a		n/a		n/a		n/a	
45	Dischrg mgmt (1.0 x 99239) (enter 15 min)												
46	End: Patient leaves office												
47	POST-SERVICE Period												
48	Start: Patient leaves office/facility												
49	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA				3				3		3
50	Office visits: List Number and Level of Office Visits			# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits
51	99211 16 minutes		16										
52	99212 27 minutes		27										
53	99213 36 minutes		36										
54	99214 53 minutes		53										
55	99215 63 minutes		63										
56	Total Office Visit Time			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
57	*Other Clinical Activity - specify:												
58	End: with last office visit before end of global period												

	A	B	C	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK
1				REFERENCE CODE				REFERENCE CODE					
2	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.			43242 PEAC 2002	43242 FACILITY ONLY			43259 PEAC 2002	43259 FACILITY ONLY			43253 FACILITY ONLY NEW CODE	
3	Meeting Date: April 2013 Tab: 11 (EGD) Specialty: Gastroenterology	CMS Code	Staff Type	EGD; EUS exam with FNA	EGD; EUS exam with FNA			EGD; EUS exam	EGD; EUS exam			EGD; EUS exam with celiac plexus	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	000	000	000	000	000	000
59	MEDICAL SUPPLIES**	CODE UNIT											
60	SCRUB, DRESS, DRAPE												
61	pack, minimum multi-specialty visit	SA048	pack										
62	gown, staff, impervious	SB027	item										
63	cap, surgical	SB001	item										
64	mask, surgical, with face shield	SB034	item										
65	shoe covers, surgical	SB039	pair										
66	scrub brush (impregnated)	SM023	item										
67	drape, non-sterile, sheet 40in x 60in	SB006	item										
68	basin, emesis	SJ010	item										
69	denture cup	SJ016	item										
70	MODERATE SEDATION												
71	pack, moderate sedation	SA044	pack										
72	bite block	SD006	item										
73	PROCEDURE INSTRUMENTS / SUPPLIES												
74	endoscope anti-fog solution	SM014	ml										
75	endoscopic cytology brush	SD067	item										
76	endoscopic polypectomy snare	SD068	item										
77	cautery, patient ground pad with cord	SF021	item										
78	cautery, bipolar cord	SF012	item										
79	canister, suction	SD009	item										
80	tubing, suction, non-latex (6ft uou)	SD132	item										
81	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item										
82	syringe 50-60ml	SC056	item										
83	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item										
84	gauze, non-sterile 4in x 4in	SG051	item										
85	cup, biopsy-specimen non-sterile 4oz	SL035	item										
86	paper, photo printing (8.5 x 11)	SK058	item										
87	lubricating jelly (K-Y) (5gm uou)	SJ032	item										
88	pack, cleaning and disinfecting, endoscope	SA042	pack										

	A	B	C	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK
1				REFERENCE CODE				REFERENCE CODE					
2	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.			43242 PEAC 2002		43242 FACILITY ONLY		43259 PEAC 2002		43259 FACILITY ONLY		43253 FACILITY ONLY NEW CODE	
3	Meeting Date: April 2013 Tab: 11 (EGD) Specialty: Gastroenterology	CMS Code	Staff Type	EGD; EUS exam with FNA		EGD; EUS exam with FNA		EGD; EUS exam		EGD; EUS exam		EGD; EUS exam with celiac plexus	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	000	000	000	000	000	000
89	EQUIPMENT	CODE											
90	videoscope, gastroscopy	ES034											
91	stretcher	EF018											
92	IV infusion pump	EQ032											
93	table, power	EF031											
94	video system, endoscopy (processor, digital capture, monitor, printer, cart)	ES031											
95	suction machine (Gomco)	EQ235											
96	table, instrument, mobile	EF027											
97	electrosurgical generator, gastrocautery	EQ113											
98	endoscope disinfectant, rigid or fiberoptic, w-cart	ES005											
99	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011											

AMA/Specialty Society RVS Update Committee Summary of Recommendations  
*MPC List Screen*

April 2013

**Endoscopic Retrograde Cholangiopancreatography (ERCP)**

In September 2011, several ERCP codes were identified by CMS through the MPC List screen. In February 2013, the CPT Editorial Panel revised the entire ERCP section to include: 1) deletion of 5 codes; 2) establishment of 5 new codes; 3) new guidelines and coding instruction; and 4) revisions to ERCP, small intestine and stomal endoscopy codes. After survey of these procedures, the specialty societies noted that these ERCP procedures are not inherently performed with moderate sedation by the same physician. However, due to CMS' consistent position, at the April meeting and in multiple Medicare Physician Payment Rules, that the Agency is looking for larger bundling of services, not unbundling of services, the moderate sedation for these services will remain bundled. Therefore, the ERCP family of services will remain on Appendix G in the CPT codebook.

During the CPT 2014 cycle, the RUC reviewed all the esophagoscopy, EGD and ERCP families of codes. This provided a unique opportunity for the RUC and specialty societies to review relativity across the board for these endoscopy series of codes. As with any large review, the RUC placed the highest importance on relativity both within the immediate family and throughout the larger family of these endoscopic services. In January 2013, the RUC approved several new codes, which now bundle physician work components previously reported by separate codes into one code. These recommendations were valued using an incremental methodology. The RUC noted that this methodology was necessary for three reasons. First, given that an entire genre of services is being reviewed over two years, relativity amongst the family is critical. The potential for rank order anomalies is high considering the large amount of codes reviewed in succession. Second, CMS (then HCFA) used the incremental approach in their initial valuation of these services in 1992 and 1993. According to CMS commentary in the Federal Register for those years, the Agency established a hierarchy of work from the least to the most difficult endoscopic procedure. Following this, fixed increments were added to the base procedure. For example, "with biopsy" was valued at an increment of 0.32 RVUs and "removal of a foreign body" was valued at an increment of 1.07 RVUs. Therefore, the RUC determined that these new codes should be valued the same way endoscopic services were initially valued at the creation of the RBRVS. Finally, the RUC has established valuation of physician work through incremental intra-service work as an approved, viable alternate methodology. Apropos to this rationale, endoscopy is listed as an example of this methodology in the RUC's instructions for specialty societies developing work value recommendations.

***43260 Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with collection of specimen(s) by brushing or washing when performed***

The RUC reviewed the survey results from 66 gastroenterologists and recommends the following physician time components: pre-service time= 48 minutes, intra-service time= 48 minutes and post-service time= 25 minutes. The RUC agreed with the specialty societies that an additional 9 minutes of pre-service positioning is warranted. Patients will receive sedation next to the gantry because it is too narrow. Patients are then rolled over onto the fluoroscopic table and placed into the semi-prone position. Additionally, time is needed to strap the patient down and move equipment into place after the patient is properly positioned.

The RUC agreed with the specialty societies that the physician work has not changed since the last RUC valuation. Therefore, the RUC recommends the survey 25<sup>th</sup> percentile, the current value, of 5.95 work RVUs. To justify this value, the RUC compared the surveyed code to CPT codes 93458 *Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed* (work RVU= 5.85, intra time= 45 minutes) and 36223 *Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed* (work RVU= 6.00, intra time= 45 minutes) and noted that both reference codes have almost identical physician time components as the surveyed code. Therefore, the RUC agreed that the current work value of 5.95 for 43260 is accurately valued between these two reference codes. **The RUC recommends a work RVU of 5.95 for CPT code 43260.**

***43261 Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple***

The RUC reviewed the survey results from 57 gastroenterologists and recommends the following physician time components: pre-service time= 48 minutes, intra-service time= 55 minutes and post-service time= 23 minutes. The RUC agreed with the specialty societies that an additional 9 minutes of pre-service positioning is warranted. Patients will receive sedation next to the gantry because it is too narrow. Patients are then rolled over onto the fluoroscopic table and placed into the semi-prone position. Additionally, time is needed to strap the patient down and move equipment into place after the patient is properly positioned.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents slightly overestimated the value of this code at the median level. Consistent with the previously RUC approved esophagoscopy and EGD RUC recommendations for CPT 2014, the RUC noted that the identical increment between the esophagoscopy base code, 43200 (RUC recommended work RVU= 1.59), and the biopsy code, 43202 (RUC recommended work RVU= 1.89), should be maintained in this biopsy ERCP code. Therefore, the established increment for the physician work related to the biopsy, 0.30 work RVUs, was added to the base ERCP diagnostic code, 43260 (recommended work RVU= 5.95), for a recommended work RVU of 6.25 for 43261. The RUC noted that while this recommended value is almost identical to the current value of 6.26, the Committee agreed to accept the incremental value to ensure consistency is maintained with the other families of endoscopic codes reviewed in the CPT 2014 cycle. To validate this value across the RBRVS, the RUC compared the surveyed code to CPT codes 58563 *Hysteroscopy, surgical;*

with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation) (work RVU= 6.16, intra time= 60 minutes) and 36247 Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family (work RVU= 6.29, intra time= 60 minutes) and noted that both reference codes have almost identical physician time components as the surveyed code. Therefore, the RUC agreed that the recommended work value of 6.25 for 43261 is accurately valued between these two reference codes. **The RUC recommends a work RVU of 6.25 for CPT code 43261.**

**43262 Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy**

The RUC reviewed the survey results from 58 gastroenterologists and recommends the following physician time components: pre-service time= 48 minutes, intra-service time= 60 minutes and post-service time= 30 minutes. The RUC agreed with the specialty societies that an additional 9 minutes of pre-service positioning is warranted. Patients will receive sedation next to the gantry because it's too narrow. Patients are then rolled over onto the fluoroscopic table and placed into the semi-prone position. Additionally, time is needed to strap the patient down and move equipment into place after the patient is properly positioned.

The RUC agreed with the specialty societies that the current work value of 7.38 overstates the work involved in this procedure. To determine a more appropriate value, the RUC noted that there has previously not been an equivalent increment established for sphincterotomy in either the esophagoscopy or EGD family of services reviewed in the last two meetings. Therefore, the RUC accepted the specialty societies' recommendation of the survey 25<sup>th</sup> percentile work RVU of 6.60. To justify this value, the RUC compared 43262 to the key reference service 58560 Hysteroscopy, surgical; with division or resection of intrauterine septum (any method) (work RVU= 6.99) and agreed that with identical intra-service times, 60 minutes, and analogous total time, the two services should be valued similarly. Additionally, the RUC reviewed CPT code 52343 Cystourethroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision) (work RVU= 6.55) and noted that since both services have identical intra-service time and analogous physician work, the two should be valued similarly. **The RUC recommends a work RVU of 6.60 for CPT code 43262.**

**43263 Endoscopic retrograde cholangiopancreatography (ERCP); with pressure measurement of sphincter of Oddi**

The RUC reviewed the survey results from 43 gastroenterologists and recommends the following physician time components: pre-service time= 48 minutes, intra-service time= 60 minutes and post-service time= 30 minutes. The RUC agreed with the specialty societies that an additional 9 minutes of pre-service positioning is warranted. Patients will receive sedation next to the gantry because it's too narrow. Patients are then rolled over onto the fluoroscopic table and placed into the semi-prone position. Additionally, time is needed to strap the patient down and move equipment into place after the patient is properly positioned.

The RUC agreed with the specialty societies that the physician work involved in 43263 has not changed since the last RUC review in 2000 and should remain valued at 7.28 work RVUs. To justify this work value, the RUC compared the surveyed code to CPT codes 37212 Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day (work RVU= 7.06, intra time= 60 minutes) and 52240 Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of;

*LARGE bladder tumor(s)* (work RVU= 7.50, intra time= 60 minutes) and noted that both reference codes have almost identical physician time components as the surveyed code. Therefore, the RUC agreed that the recommended work value of 7.28 for 43263 is accurately valued between these two reference codes. Finally, the RUC noted that this service has almost identical physician time compared to 43262 and 43264, but higher work RVUs than both. The specialties noted that 43263 is a more intense procedure than these two referenced services. Since the sphincter cannot be paralyzed, it is being threaded with the cannula while moving back and forth. **The RUC recommends a work RVU of 7.28 for CPT code 43263.**

***43264 Endoscopic retrograde cholangiopancreatography (ERCP); with removal of calculi/debris from biliary/pancreatic duct(s)***

The RUC reviewed the survey results from 54 gastroenterologists and recommends the following physician time components: pre-service time= 48 minutes, intra-service time= 60 minutes and post-service time= 28 minutes. The RUC agreed with the specialty societies that an additional 9 minutes of pre-service positioning is warranted. Patients will receive sedation next to the gantry because it's too narrow. Patients are then rolled over onto the fluoroscopic table and placed into the semi-prone position. Additionally, time is needed to strap the patient down and move equipment into place after the patient is properly positioned.

The RUC agreed with the specialty societies that the current work value of 8.89 overstates the work involved in this procedure. To determine a more appropriate value, the RUC first noted that there is currently no equivalent established increment in either the esophagoscopy or EGD families of services for this procedure. Therefore, the RUC agreed that the 25<sup>th</sup> percentile work RVU of 6.73 accurately values the physician work involved in 43264. To justify this value, the RUC compared the surveyed code to CPT codes 37197 *Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), includes radiological supervision and interpretation, and imaging guidance (ultrasound or fluoroscopy), when performed* (work RVU= 6.29, intra time= 60 minutes) and 52343 *Cystourethroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU= 6.55, intra time= 60 minutes) and agreed that since both references codes have identical intra-service time and comparable total times to the surveyed, the recommended value of 6.73 for CPT code 43264 is relative to these similar services. **The RUC recommends a work RVU of 6.73 for CPT code 43264.**

***43265 Endoscopic retrograde cholangiopancreatography (ERCP); with destruction of calculi, any method (eg, mechanical, electrohydraulic, lithotripsy)***

The RUC reviewed the survey results from 52 gastroenterologists and recommends the following physician time components: pre-service time= 48 minutes, intra-service time= 78 minutes and post-service time= 28 minutes. The RUC agreed with the specialty societies that an additional 9 minutes of pre-service positioning is warranted. Patients will receive sedation next to the gantry because it's too narrow. Patients are then rolled over onto the fluoroscopic table and placed into the semi-prone position. Additionally, time is needed to strap the patient down and move equipment into place after the patient is properly positioned.



The RUC agreed with the specialty societies that the current work value of 10.00 overstates the work involved in this procedure. To determine a more appropriate value, the RUC first noted that there is currently no equivalent established increment in either the esophagoscopy or EGD families of services for this procedure. Therefore, the RUC agreed that the 25<sup>th</sup> percentile work RVU of 8.03 accurately values the physician work involved in 43265. To justify this value, the RUC compared the surveyed code to CPT code 37183 *Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanalization/dilatation, stent placement and all associated imaging guidance and documentation)* (work RVU= 7.99, intra time= 77.5 minutes) and agreed that while the two services nearly identical intra-service time, 43265 has greater total time compared to the reference code and is correctly valued higher. Additionally, CPT code 37224 *Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty* (work RVU= 9.00) was reviewed and the Committee noted that the reference code has two additional minutes of intra-service time and is slightly more intense than 43265 and should therefore be valued higher. **The RUC recommends a work RVU of 8.03 for CPT code 43265.**

***43274 Endoscopic retrograde cholangiopancreatography (ERCP); with placement of endoscopic stent into biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent***

The RUC reviewed the survey results from 50 gastroenterologists and recommends the following physician time components: pre-service time= 48 minutes, intra-service time= 68 minutes and post-service time= 23 minutes. The RUC agreed with the specialty societies that an additional 9 minutes of pre-service positioning is warranted. Patients will receive sedation next to the gantry because it's too narrow. Patients are then rolled over onto the fluoroscopic table and placed into the semi-prone position. Additionally, time is needed to strap the patient down and move equipment into place after the patient is properly positioned.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the median value of 10.00 work RVUs overestimates the physician work involved in this service. To determine an appropriate value, the RUC agreed to apply the incremental methodology to ensure this new, bundled service is correctly valued in comparison to the individual components codes previously valued in the equivalent endoscopic families.

The RUC noted that 43274 now bundles in the physician work to perform sphincterotomy and placement of an endoscopic stent. Therefore, the incremental methodology for this procedure consists of adding the following elements:

- The base ERCP code (43260, RUC recommended work RVU= 5.95)
- The established increment of a sphincterotomy = 0.65 (43262, RUC recommended work RVU= 6.60 – 43260, RUC recommended work RVU= 5.95) = 0.65
- The established increment of placement of an endoscopic stent = 2.14 (4320X4, RUC recommended work RVU= 3.73 – 43200, RUC recommended work RVU= 1.59) = 2.14

Taking the above work RVUs, as laid out, the RUC determined a work RVU of 8.74 ( $5.95 + 0.65 + 2.14$ ) accurately values the work of this bundled service relative to the individual component endoscopic codes, previously valued by the RUC. To validate this work RVU, the RUC compared the surveyed code to CPT codes 36254 *Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral* (work RVU= 8.15, intra time= 68 minutes) 58561 *Hysteroscopy, surgical; with removal of leiomyomata* (work RVU= 9.99, intra time= 75 minutes) and agreed that with similar intra-service time and comparable physician work, 43274 is accurately valued between these reference codes. **The RUC recommends a work RVU of 8.74 for CPT code 43274.**

**43275 Endoscopic retrograde cholangiopancreatography (ERCP); with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s)**

The RUC reviewed the survey results from 49 gastroenterologists and recommends the following physician time components: pre-service time= 48 minutes, intra-service time= 50 minutes and post-service time= 20 minutes. The RUC agreed with the specialty societies that an additional 9 minutes of pre-service positioning is warranted. Patients will receive sedation next to the gantry because it's too narrow. Patients are then rolled over onto the fluoroscopic table and placed into the semi-prone position. Additionally, time is needed to strap the patient down and move equipment into place after the patient is properly positioned.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents slightly overestimated the value of this code at the median level. Consistent with the esophagoscopy and EGD RUC recommendations for CPT 2014, the RUC noted that the identical increment between the esophagoscopy base code, 43200 (RUC recommended work RVU= 1.59), and the foreign body removal code, 43215 (RUC recommended work RVU= 2.60), should be maintained in this foreign body removal ERCP code. Therefore, the established increment for the physician work related to the biopsy, 1.01 work RVUs, was added to the base ERCP diagnostic code, 43260 (recommended work RVU= 5.95), for a recommended work RVU of 6.96 for 43275. To validate this work value across the RBRVS, the RUC compared the surveyed code to CPT codes 93457 *Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization* (work RVU= 6.89, intra time= 50 minutes) and 36252 *Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral* (work RVU= 6.99, intra time= 53 minutes) and agreed that with similar intra-service time and comparable physician work, 43275 is accurately valued in between these reference codes. **The RUC recommends a work RVU of 6.96 for CPT code 43275.**

***43276 Endoscopic retrograde cholangiopancreatography (ERCP); with removal and exchange of stent(s), biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent exchanged***

The RUC reviewed the survey results from 48 gastroenterologists and recommends the following physician time components: pre-service time= 48 minutes, intra-service time= 60 minutes and post-service time= 25 minutes. The RUC agreed with the specialty societies that an additional 9 minutes of pre-service positioning is warranted. Patients will receive sedation next to the gantry because it's too narrow. Patients are then rolled over onto the fluoroscopic table and placed into the semi-prone position. Additionally, time is needed to strap the patient down and move equipment into place after the patient is properly positioned.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the median value of 9.88 work RVUs overestimates the physician work involved in this service. To determine an appropriate value, the RUC agreed to apply the incremental methodology to ensure this new, bundled service is correctly valued in comparison to the individual components codes previously valued in the equivalent endoscopic families.

The RUC noted that 43276 now bundles in the physician work to perform removal of a foreign body and placement of a stent. Therefore, the incremental methodology for this procedure consists of adding the following elements:

- The base ERCP code (43260, RUC recommended work RVU= 5.95);
- The established increment of a removal of foreign body = 1.01 (43215, RUC recommended work RVU= 2.60 – 43200, RUC recommended work RVU= 1.59) = 1.01
- The established increment of placement of an endoscopic stent = 2.14 (4320X4, RUC recommended work RVU= 3.73 – 43200, RUC recommended work RVU= 1.59) = 2.14

Taking the above work RVUs, as laid out, the RUC determined a work RVU of 9.10 (5.95 + 1.01 + 2.14) accurately values the work of this bundled service relative to the individual component endoscopic codes, previously valued by the RUC. The specialty societies noted that the physician work of performing the sphincterotomy is not included because it is typically performed during the initial stent placement and during the subsequent removal or exchange. To validate this work RVU, the RUC compared the surveyed code to CPT codes 52346 *Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU= 8.58, intra time= 60 minutes) and 92920 *Percutaneous transluminal coronary angioplasty; single major coronary artery or branch* (work RVU= 10.10, intra time= 68 minutes) and agreed that with similar intra-service time and comparable physician work, 43276 is accurately valued in between these reference codes. Finally, the RUC discussed whether or not there is overlap in the work taking out and replacing the stent. The specialties explained that the work is truly sequential for both procedures and there is no overlap when done concomitantly. There is also no concern that the work of finding the ampulla is captured in both procedures, as the ampulla is found immediately. **The RUC recommends a work RVU of 9.10 for CPT code 43276.**

***43277 Endoscopic retrograde cholangiopancreatography (ERCP); with trans-endoscopic balloon dilation of biliary/pancreatic duct(s) or of ampulla (sphincteroplasty), including sphincterotomy, when performed, each duct***

The RUC reviewed the survey results from 47 gastroenterologists and recommends the following physician time components: pre-service time= 48 minutes, intra-service time= 70 minutes and post-service time= 25 minutes. The RUC agreed with the specialty societies that an additional 9 minutes of pre-service positioning is warranted. Patients will receive sedation next to the gantry because it's too narrow. Patients are then rolled over onto the fluoroscopic table and placed into the semi-prone position. Additionally, time is needed to strap the patient down and move equipment into place after the patient is properly positioned.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the median value of 10.00 work RVUs overestimates the physician work involved in this service. To determine an appropriate value, the RUC agreed to apply the incremental methodology to ensure this new, bundled service is correctly valued in comparison to the individual components codes previously valued in the equivalent endoscopic families.

The RUC noted that 43277 now bundles in the physician work to perform balloon dilation and a sphincterotomy. Therefore, the incremental methodology for this procedure consists of adding the following elements:

- The base ERCP code (43260, RUC recommended work RVU= 5.95);
- The established increment of balloon dilation = 0.51 (43220, RUC recommended work RVU= 2.10 – 43200, RUC recommended work RVU= 1.59) = 0.51
- The established increment of a sphincterotomy = 0.65 (43262, RUC recommended work RVU= 6.60 – 43260, RUC recommended work RVU= 5.95) = 0.65

Taking the above work RVUs, as laid out, the RUC determined a work RVU of 7.11 (5.95 + 0.51 + 0.65) accurately values the work of this bundled service relative to the individual component endoscopic codes, previously valued by the RUC. To validate this work RVU, the RUC compared the surveyed code to CPT codes 20555 *Placement of needles or catheters into muscle and/or soft tissue for subsequent interstitial radioelement application (at the time of or subsequent to the procedure)* (work RVU= 6.00, intra time= 70 minutes) and 31276 *Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus* (work RVU= 8.84, intra time= 75 minutes) and agreed that with similar intra-service time and comparable physician work, 43277 is accurately valued in between these reference codes. **The RUC recommends a work RVU of 7.11 for CPT code 43277.**

***43278 Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s), including pre- and post-dilation and guide wire passage, when performed***

The RUC reviewed the survey results from 40 gastroenterologists and recommends the following physician time components: pre-service time= 48 minutes, intra-service time= 75 minutes and post-service time= 30 minutes. The RUC agreed with the specialty societies that an additional 9 minutes of pre-service positioning is warranted. Patients will receive sedation next to the gantry because it's too narrow. Patients are then rolled over onto the fluoroscopic table and placed into the semi-prone position. Additionally, time is needed to strap the patient down and move equipment into place after the patient is properly positioned.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the 25<sup>th</sup> percentile value of 8.38 work RVUs overestimates the physician work involved in this service. To determine an appropriate value, the RUC agreed to apply the incremental methodology to ensure this new, bundled service is correctly valued in comparison to the individual components codes previously valued in the equivalent endoscopic families. Consistent with the esophagoscopy and EGD RUC recommendations for CPT 2014, the RUC noted that the identical increment between the esophagoscopy base code, 43200 (recommended work RVU= 1.59), and the ablation code, 4320X5 (recommended work RVU= 3.72), should be maintained in this foreign body removal ERCP code. Therefore, the established increment for the physician work related to the ablation, 2.13 work RVUs, was added to the base ERCP diagnostic code, 43260 (recommended work RVU= 5.95), for a recommended work RVU of 8.08 for 43278. To validate this work value across the RBRVS, the RUC compared the surveyed code to CPT codes 37183 *Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanalization/dilatation, stent placement and all associated imaging guidance and documentation)* (work RVU= 7.99, intra time= 77.5 minutes) and 31276 *Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus* (work RVU= 8.84, intra time= 75 minutes) and agreed that with similar intra-service time and comparable physician work, 43278 is accurately valued in between these reference codes. **The RUC recommends a work RVU of 8.08 for CPT code 43278.**

***43273 Endoscopic cannulation of papilla with direct visualization of pancreatic/common bile duct(s)***

The RUC reviewed the survey results from 47 gastroenterologists and recommends 30 minutes of intra-service time for this add-on code. The RUC agreed with the specialty societies that the physician work for this service has not changed. The RUC recommends the current work RVU of 2.24 for 43273, which is below the survey 25<sup>th</sup> percentile. To validate this work value, the RUC compared the surveyed code to add-on codes 43338 *Esophageal lengthening procedure* (eg, Collis gastroplasty or wedge gastroplasty) (work RVU= 2.21) and 49327 *Laparoscopy, surgical; with placement of interstitial device(s) for radiation therapy guidance* (eg, fiducial markers, dosimeter), intra-abdominal, intrapelvic, and/or retroperitoneum, including imaging guidance, if performed, single or multiple (work RVU= 2.38) and noted that all three codes have identical intra-service time, 30 minutes, and comparable physician work. Therefore, the RUC agreed that the recommended work value, in between these two services, is appropriate for CPT code 43273. Finally, the RUC noted that when this code was last reviewed as a new code in 2009, the median intra-service time was 45 minutes. However, review of the recommendation at that time reveals that the survey produced a much higher work RVU for this procedure. Since pre and post time were inadvertently collected in the ZZZ global survey, the RUC reduced the work value to

account for the removal of pre- and post-service minutes. The survey results were also complicated by the fact that 000-day global codes were included on the reference list and this was followed by the RUC using a 000-day reference code for a diagnostic esophagoscopy as comparison for the calculated value. Given the history of the previous valuation, the median intra-service time of 30 minutes is a more accurate depiction of this procedure compared to the previous survey. **The RUC recommends a work RVU of 2.24 for CPT code 43273.**

#### Practice Expense:

The RUC recommends the direct practice expense for these facility-based procedures as submitted by the specialty societies and approved by the Practice Expense Subcommittee.

#### Work Neutrality:

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

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<b>Category I</b> <b>Surgery</b> <b>Digestive System</b> <b>Esophagus</b> <b>Endoscopy</b>  For endoscopic procedures, code appropriate endoscopy of each anatomic site examined. Surgical endoscopy always includes diagnostic endoscopy.  ◎ ▲ 43235 <del>Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate</del> Esophagogastroduodenoscopy, flexible, transoral; diagnostic, with <del>or without</del> collection of specimen(s) by brushing or washing, when performed ( <del>separate procedure</del> )  ◎ ▲ 43259      with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum <del>/or jejunum as appropriate</del> or a surgically altered stomach where the jejunum is examined distal to the anastomosis				

Report the appropriate code(s) for each service performed. Therapeutic ERCP (43261, 43262, 43263, 43264, 43265, 43274, 43275, 43276, 43277, 43278) includes diagnostic ERCP (43260). ERCP includes guide wire passage when performed. An ERCP is considered complete if one or more of the ductal system(s), (pancreatic/biliary), is/are visualized. To report ERCP attempted but with unsuccessful cannulation of any ductal system, see 43235-43259.

Codes 43274, 43275, 43276, and 43277 describe ERCP with stent placement, removal or exchange (replacement) of stent(s), and balloon dilation within the pancreatico-biliary system. For reporting purposes, ducts that may be reported as stented or subject to stent replacement (exchange) or to balloon dilation include:

**Pancreas:** major and minor ducts

**Biliary tree:** common bile duct, right hepatic duct, left hepatic duct, cystic duct/gallbladder

ERCP with stent placement includes any balloon dilation performed in that duct. ERCP with more than one stent placement (eg, different ducts or side by side in the same duct) performed during the same day/session may be reported with 43274 more than once with modifier 59 appended to the subsequent procedure(s). For ERCP with more than one stent exchanged during the same day/session, 43276 may be reported for the initial stent exchange, and 43276 with modifier 59 for each additional stent exchange. ERCP with balloon dilation of more than one duct during the same day/session may be reported with modifier 59 appended to the subsequent procedure(s). Sphincteroplasty, which is balloon dilation of the ampulla (sphincter of Oddi), is reported with 43277, and includes sphincterotomy (43262) when performed.

To report ERCP via altered postoperative anatomy, see 43260, 43262, 43263, 43264, 43265, 43274, 43275, 43276, 43277, 43278, 43273 for Billroth II gastroenterostomy. See 47999 (Unlisted procedure, biliary tract), or 48999 (Unlisted procedure, pancreas) for ERCP via gastrostomy (laparoscopic or open) or via Roux-en-Y anatomy (eg, post-bariatric gastric bypass, post-total gastrectomy).

To report optical endomicroscopy of the biliary tract, use 47999. To report optical endomicroscopy of the pancreas, use 48999. Optical endomicroscopy may be reported not more than once per session.

Stone destruction includes any stone removal in the same ductal system (biliary/pancreatic). Code 43277 may be separately reported if sphincteroplasty or dilation of a ductal stricture is required before proceeding to remove stones/debris from the duct during the same session. Dilation that is incidental to the passage of an instrument to clear stones or debris is not separately reported.

(Do not report 43277 for use of a balloon catheter to clear stones/debris from a duct. Any dilation of the duct that may occur during this maneuver is considered inherent to the work of 43264 and 43265)

(For radiological supervision and interpretation, see 74328, 74329, 74330)

⊕▲ 43260	EE1	Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with <del>or without</del> collection of specimen(s) by brushing or washing ( <del>separate procedure</del> ) if <u>when performed</u>  ( <del>For radiological supervision and interpretation, see 74328, 74329, 74330</del> )	000	5.95  (No Change)
⊕ 43261	EE2	with biopsy, single or multiple  ( <del>For radiological supervision and interpretation, see 74328, 74329, 74330</del> )	000	6.25
⊕ 43262	EE3	with sphincterotomy/papillotomy  (43262 may be reported when sphincterotomy is performed in addition to 43261, 43263, 43264, 43265, 43275, 43278)  (Do not report 43262 in conjunction with 43274 for stent placement or exchange in the same duct)  ( <del>For radiological supervision and interpretation, see 74328, 74329, 74330</del> )	000	6.60
⊕▲ 43263	EE4	with pressure measurement of sphincter of Oddi ( <del>pancreatic duct or common bile duct</del> )  (Do not report 43263 more than once per session)  ( <del>For radiological supervision and interpretation, see 74328, 74329, 74330</del> )	000	7.28  (No Change)



⊙ ▲ 43264	EE5	<p>with <del>endoscopic retrograde</del> removal of calculi/debris from biliary/ <del>and/or</del> pancreatic duct(s)</p> <p><del>(When done with sphincterotomy, also use 43262)</del></p> <p><del>(For radiological supervision and interpretation, see 74328, 74329, 74330)</del></p> <p><u>(Do not report 43264 if no calculi or debris are found, even if balloon catheter is deployed)</u></p> <p><u>(Do not report 43264 in conjunction with 43265)</u></p>	000	6.73
⊙ ▲ 43265	EE6	<p>with <del>endoscopic retrograde</del> destruction, lithotripsy of calculus/calculi, any method (eg, <u>mechanical, electrohydraulic, lithotripsy</u>)</p> <p><u>(Do not report 43265 in conjunction with 43264)</u></p> <p><u>(Do not report 43265 if no calculi or debris are found, even if balloon catheter is deployed)</u></p> <p><del>(When done with sphincterotomy, also use 43262)</del></p> <p><del>(For radiological supervision and interpretation, see 74328, 74329, 74330)</del></p>	000	8.03
D ⊙ 43267		<p>with <del>endoscopic retrograde</del> insertion of nasobiliary or nasopancreatic drainage tube</p> <p><del>(When done with sphincterotomy, also use 43262)</del></p> <p><del>(For radiological supervision and interpretation, see 74328, 74329, 74330)</del></p> <p><u>(43267 has been deleted. To report, use 43274)</u></p>	000	N/A

D⊙43268		<p><del>with endoscopic retrograde insertion of tube or stent into bile or pancreatic duct</del></p> <p><del>(When done with sphincterotomy, also use 43262)</del></p> <p><del>(For radiological supervision and interpretation, see 74328, 74329, 74330)</del></p> <p><u>(43268 has been deleted. To report, use 43274)</u></p>	000	N/A
◻●43274	EE7	<p>with placement of endoscopic stent into biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent</p> <p><u>(For stent placement in both the pancreatic duct and the common bile duct during the same operative session, placement of separate stents in both the right and left hepatic ducts, or placement of two side-by-side stents in the same duct, 43274 may be reported for each additional stent placed, using modifier 59 with the subsequent procedure[s])</u></p> <p><u>(To report naso-biliary or naso-pancreatic drainage tube placement, use 43274)</u></p> <p><u>(Do not report 43274 in conjunction with 43262, 43275, 43276, 43277 for stent placement or replacement [exchange] in the same location)</u></p>	000	8.74
D⊙43269		<p><del>with endoscopic retrograde removal of foreign body and/or change of tube or stent</del></p> <p><del>(When done with sphincterotomy, also use 43262)</del></p> <p><del>(For radiological supervision and interpretation, see 74328, 74329, 74330)</del></p> <p><u>(43269 has been deleted. To report, see 43275, 43276)</u></p>	000	N/A

<div> <div> <div></div> <div>●</div> </div> <div>43275</div> </div>	EE8	<p>with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s)</p> <p><u>(Do not report 43275 in conjunction with 43274, 43276)</u></p> <p><u>(For removal of stent from biliary or pancreatic duct without ERCP, use 43247)</u></p> <p><u>(Report 43275 once for removal of one or more stents or foreign bodies from biliary/pancreatic duct[s] during the same session)</u></p>	000	6.96
<div> <div> <div></div> <div>●</div> </div> <div>43276</div> </div>	EE9	<p>with removal and exchange of stent(s), biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent exchanged</p> <p><u>(43276 includes removal and replacement [ie, exchange] of one stent. For replacement [exchange] of additional stent[s] during the same session, report 43276 with modifier 59 for each additional replacement [exchange])</u></p> <p><u>(Do not report 43276 in conjunction with 43275)</u></p> <p><u>(Do not report 43276 in conjunction with 43274 for stent placement or exchange in the same duct)</u></p>	000	9.10
<div> <div> <div></div> <div>●</div> </div> <div>43271</div> </div>		<p><del>with endoscopic retrograde balloon dilation of ampulla, biliary and/or pancreatic duct(s)</del></p> <p><del>(When done with sphincterotomy, also use 43262)</del></p> <p><del>(For radiological supervision and interpretation, see 74328, 74329, 74330)</del></p> <p><u>(43271 has been deleted. To report, use 43277)</u></p>	000	N/A

●43277	EE10	<p>with trans-endoscopic balloon dilation of biliary/pancreatic duct(s) or of ampulla (sphincteroplasty), including sphincterotomy, when performed, each duct</p> <p><u>(Do not report 43277 for incidental dilation using balloon for stone/debris removal reported with 43264, 43265)</u></p> <p><u>(If sphincterotomy without sphincteroplasty is performed on a separate pancreatic duct orifice during the same session [ie, pancreas divisum], report 43262 with modifier 59)</u></p> <p><u>(Do not report 43277 in conjunction with 43274, 43276 for dilation and stent placement/exchange in the same duct)</u></p> <p><u>(For bilateral balloon dilation [both right and left hepatic ducts], 43277 may be reported twice with modifier 59 appended to the second procedure)</u></p>	000	7.11
D●43272		<p><del>with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique</del></p> <p><del>(For radiological supervision and interpretation, see 74328, 74329, 74330)</del></p> <p><del>(43272 has been deleted. To report, use 43278)</del></p>	000	N/A
●43278	EE11	<p>with ablation of tumor(s), polyp(s), or other lesion(s), including pre- and post-dilation and guide wire passage, when performed</p> <p><u>(For ampullectomy, use 43254)</u></p>	000	8.08

Ⓢ+▲43273	EE12	<p>Endoscopic cannulation of papilla with direct visualization of <u>pancreatic/common bile duct(s) and/or pancreatic duct(s)</u> (List separately in addition to code(s) for primary procedure)</p> <p><u>(Report 43273 once per procedure)</u></p> <p>Use 43273 in conjunction with <del>43260-43265</del>with 43260, 43261, 43262, 43263, <del>43267-43272</del><u>43264, 43265, 43274, 43275, 43276, 43277, 43278</u></p>	ZZZ	2.24 (No Change)
<p><u>43274</u> Code is out of numerical sequence. See 43260-43273</p> <p><u>43275</u> Code is out of numerical sequence. See 43260-43273</p> <p><u>43276</u> Code is out of numerical sequence. See 43260-43273</p> <p><u>43277</u> Code is out of numerical sequence. See 43260-43273</p> <p><u>43278</u> Code is out of numerical sequence. See 43260-43273</p>				
<p><b>Biliary Tract Endoscopy</b></p> <p>▲47552 Biliary endoscopy, percutaneous via T-tube or other tract; diagnostic, with <del>or without</del> collection of specimen(s) by brushing and/or washing <u>(separate procedure), when performed</u></p> <p>47556 with dilation of biliary duct stricture(s) with stent (For ERCP, see 43260-<del>43278</del><u>43272</u>, <u>74328, 74329, 74330, 74363, 75982</u>) (If imaging guidance is performed, see 74363, 75982)</p>				
<p><b>Pancreas</b></p> <p>(For peroral pancreatic endoscopic procedures, see 43260-<del>43278</del><u>43272</u>)</p>				

**Radiology**  
**Diagnostic Radiology**  
**(Diagnostic Imaging)**  
**Gastrointestinal Tract**

74328	Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation (For procedure, see 43260-43278 as appropriate)
74329	Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation (For procedure, see 43260- <del>43278</del> 43272 as appropriate)
74330	Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation (For procedure, see 43260- <del>43278</del> 43272 as appropriate)

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43260      Tracking Number   EE1

Original Specialty Recommended RVU: **5.95**Presented Recommended RVU: **5.95**

Global Period: 000

RUC Recommended RVU: **5.95**

CPT Descriptor: Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with collection of specimen(s) by brushing or washing when performed

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 70-year-old patient with a history of abdominal pain and unexplained pancreatitis is referred for evaluation. Imaging studies with MRCP are equivocal. Diagnostic ERCP is performed to evaluate the pancreatic and biliary ducts.

Percentage of Survey Respondents who found Vignette to be Typical: 74%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 52%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 30%

Description of Pre-Service Work: Review with the patient any symptoms including dysphagia and sleep apnea. The patient's history is reviewed to assess past problems with sedation and the need for and timing of pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's imaging studies and other diagnostic tests are reviewed. The pre-service review is documented. The risks and benefits of the procedure and sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained. The physician verifies all endoscopic and imaging equipment is available, operational and appropriate imaging settings and computer entries are made. A time out is performed. The patient is positioned on the procedure table in the supine position. A patient support pad is positioned on the fluoroscopy table and the patient's positioning is adjusted. The endoscopic, imaging and moderate sedation monitoring equipment is positioned to provide access for the procedure. Appropriate protective attire and shielding are applied and verification that all others in the suite are properly protected including the patient.. The patient is rolled to the left side and sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide when indicated, and sequential non-invasive blood pressure measurements. A bite block is placed in the mouth. The patient is repositioned in the prone position.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible side viewing upper endoscope is inserted into the mouth into the oropharynx and blindly advanced through the esophagus into the stomach. The stomach is insufflated with air after suctioning liquid contents. Examination of the entire stomach in the forward and retroflexed positions is performed. The endoscope is advanced through the pylorus into the duodenal bulb.

Circumferential inspection of the duodenum is performed after air insufflation. Next the instrument is advanced into the second portion of the duodenum. The ampulla of Vater is identified and examined. The endoscope is positioned for cannulation of the ampulla. If required, antiperistaltic medications are administered intravenously. The ampulla is cannulated, and the catheter is directed into the duct(s) of clinical interest (common bile duct and/or pancreatic duct). Contrast material is injected into the cannula. A cholangiogram and/or pancreatogram is obtained under fluoroscopic guidance and reviewed for abnormalities. If indicated, washing or brushings of suspicious abnormalities in the common bile duct and/or pancreatic duct are obtained. The endoscope is withdrawn into the stomach to allow examination of the gastric fundus and the remainder of the gastric mucosa. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. At the conclusion of the procedure, the endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. The patient is assessed for physical signs and symptoms suggestive of complications, including abdominal pain, nausea/vomiting, respiratory distress, and bleeding. Radiographic images are reviewed with the technologist for entry into the image storing system. Post procedure orders are completed and discussed with staff. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to the referral source and other appropriate parties. Data are entered into the procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others including a discussion regarding potential procedure complications. Restrictions, prescriptions, follow-up tests, instructions and appointments are provided to the patient and pertinent others.



**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2012			
<b>Presenter(s):</b>	Dr. Nicholas Nickl (ASGE), Dr. Edward Bentley (ASGE), Dr. Joel Brill (AGA), Dr. Shivan Mehta, MD (AGA), Dr. Bruce Cameron (ACG)				
<b>Specialty(s):</b>	Gastroenterology				
<b>CPT Code:</b>	43260				
<b>Sample Size:</b>	947	<b>Resp N:</b>	66	<b>Response:</b> 6.9 %	
<b>Description of Sample:</b>	The ACG, AGA and ASGE conducted an enhanced random sample as approved by the Research Subcommittee. The sampling methodology was a random sample of member gastroenterologists with the addition of physicians identified by industry as performers of ERCP procedures and survey volunteers who responded to educational articles and identified themselves as ERCP performers.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	30.00	<b>75.00</b>	150.00	600.00
<b>Survey RVW:</b>	3.80	5.95	<b>6.97</b>	9.75	16.68
<b>Pre-Service Evaluation Time:</b>			<b>45.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>10.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>10.00</b>		
<b>Intra-Service Time:</b>	20.00	45.00	<b>48.00</b>	60.00	120.00
<b>Immediate Post Service-Time:</b>	<b>25.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	43260	<b>Recommended Physician Work RVU: 5.95</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>33.00</b>	<b>33.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>10.00</b>	<b>1.00</b>	<b>9.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>5.00</b>	<b>5.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>48.00</b>		
<b>Immediate Post Service-Time:</b>	<b>25.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		

Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
52342	000	5.85	RUC Time

CPT Descriptor Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 16      % of respondents: 24.2 %

**TIME ESTIMATES (Median)**

	CPT Code: 43260	Key Reference CPT Code: 52342	Source of Time RUC Time
Median Pre-Service Time	48.00	60.00	
Median Intra-Service Time	48.00	60.00	
Median Immediate Post-service Time	25.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>121.00</b>	<b>140.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.56
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.25	3.69
--	------	------

Urgency of medical decision making	3.88	3.44
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.56	3.88
--------------------------	------	------

Physical effort required	4.25	3.63
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.81	3.81
---	------	------

Outcome depends on the skill and judgment of physician	4.75	4.06
--	------	------

Estimated risk of malpractice suit with poor outcome	4.63	3.75
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.75	3.31
----------------------------------	------	------

Intra-Service intensity/complexity	4.25	3.56
------------------------------------	------	------

Post-Service intensity/complexity	3.63	3.19
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

## Background

Code 43262 was identified for the Fourth Five-Year Review through CMS and RUC screens as potentially misvalued through the Harvard valued utilization over 30,000 frequency screen. The code was presented to the RUC at the October 2010 meeting. The RUC reviewed the service and believed that the GI specialties did not provide compelling evidence to change the current value of the service. Therefore, the RUC recommended maintaining the current work RVU of 7.38 for CPT code 43262. CMS maintained the current work RVU of 7.38 and the current physician time for CPT code 43262 for CY 2012. However, CMS requested that the RUC undertake a comprehensive review of the entire family of ERCP codes, including the base CPT code 43260, and provide CMS with work RVU recommendations.

The specialties agreed to survey the entire family of codes (43260-43273). In review of this family of codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In January 2013, the CPT Editorial Panel approved revised guidelines along with revision, addition, and deletion of codes within the ERCP code set.

## Overview of ERCP Family RVW Recommendations

The specialty consensus panel spent a significant amount of time reviewing the survey data for the current set of ERCP codes, comparing the data and values with the esophagoscopy codes (43200-43228) and EGD codes (43235-43259) that were approved by the RUC at the October 2012 and January 2013 RUC meetings. After reviewing the survey data, the consensus panel determined that for the ERCP code set, the incremental value above the base code for ERCP (43260) should be similar where possible to the analogous incremental value above the base codes for esophagoscopy and EGD previously approved.

## Discussion and Recommendation

**43260** Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with collection of specimen(s) by brushing or washing when performed

**We recommend the current RVW of 5.95.** The work performing this procedure has not changed. The survey data support the current value.

**Pre-time Package 2b** is appropriate, with an additional 9 minutes for positioning the patient, endoscopy equipment/monitor, and anesthesia lines/equipment prior to and after induction MAC. The procedure is performed in the prone position on a fluoroscopy table. In addition, the recommended scrub, dress, wait time matches the survey median.

### Comparison to Key Ref 52342

Both 43260 and key reference code 52342 *Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)* are performed under anesthesia (general, MAC, spinal). Although 52342 survey data from 2000 indicates more intra-time, the intensity of 43260 is higher as the patient has unexplained pancreatitis, compared with the 52342 patient that has a diagnosed stricture that will be dilated.

### Comparison To Other RUC-Reviewed Codes with 40-55 Minutes Intra-Service Time

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2012	<b>35475</b>	Repair arterial blockage	5.75	0.110	92	17	4	5	43	23
2012	<b>52351</b>	Cystouretero & or	5.75	0.096	118	33	5	15	45	20

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
		pyeloscope								
2010	<b>93458</b>	L hrt artery/ventricle angio	5.85	0.093	123	40	3	5	45	30
	<b>43260</b>	<b>ERCP</b>	<b>5.95</b>	<b>0.091</b>	<b>119</b>	<b>33</b>	<b>10</b>	<b>10</b>	<b>48</b>	<b>25</b>
2012	<b>36223</b>	Place cath carotid/inom art	6.00	0.096	123	40	3	5	45	30
2012	<b>36225</b>	Place cath subclavian art	6.00	0.096	123	40	3	5	45	30
2010	<b>93456</b>	R hrt coronary artery angio	6.15	0.112	118	40	3	5	40	30
1995	<b>52277</b>	Cystoscopy and treatment	6.16	0.095	130	45			45	40
2010	<b>93453</b>	R&I hrt cath w/ventriclgrphy	6.24	0.101	123	40	3	5	45	30
1997	<b>52282</b>	Cystoscopy implant stent	6.39	0.096	120	40			50	30
2012	<b>36226</b>	Place cath vertebral art	6.50	0.096	128	40	3	5	50	30

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43260

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 34035

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare data base 11,345 in 2011. (11,345\*3 = 34,035)

Specialty Gastroenterology Frequency 31000 Percentage 91.08 %

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?  
 11,300 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.  
 Please explain the rationale for this estimate. Medicare data base 11,345 in 2011

Specialty Gastroenterology	Frequency 10300	Percentage 91.15 %
----------------------------	-----------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? No

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43260

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43261      Tracking Number   EE2

Original Specialty Recommended RVU: **6.25**Presented Recommended RVU: **6.25**

Global Period: 000

RUC Recommended RVU: **6.25**

CPT Descriptor: Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 72-year-old patient with weight loss, abdominal pain, and elevated laboratory tests (AST, ALT, amylase, alkaline phosphatase) is referred for evaluation. Biliary dilation is identified on imaging studies. A diagnostic ERCP is performed where a mass at the ampulla of Vater is identified; biopsies are obtained.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 55%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 22%

Description of Pre-Service Work: Review with the patient any symptoms including dysphagia and sleep apnea. The patient's history is reviewed to assess past problems with sedation and the need for and timing of pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's imaging studies and other diagnostic tests are reviewed. The pre-service review is documented. The risks and benefits of the procedure and sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained. The physician verifies all endoscopic and imaging equipment is available, operational and appropriate imaging settings and computer entries are made. A time out is performed. The patient is positioned on the procedure table in the supine position. A patient support pad is positioned on the fluoroscopy table and the patient's positioning is adjusted. The endoscopic, imaging and moderate sedation monitoring equipment is positioned to provide access for the procedure. Appropriate protective attire and shielding are applied and verification that all others in the suite are properly protected including the patient. The patient is rolled to the left side and sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide when indicated, and sequential non-invasive blood pressure measurements. A bite block is placed in the mouth. The patient is repositioned in the prone position.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible side viewing upper endoscope is inserted into the mouth into the oropharynx and blindly advanced through the esophagus into the stomach. The stomach is insufflated with air after suctioning liquid contents. Examination of the entire stomach in the forward and retroflexed positions is performed. The endoscope is advanced through the pylorus into the duodenal bulb. Circumferential inspection of the duodenum is performed after air insufflation. Next the instrument is advanced into the

second portion of the duodenum. The ampulla of Vater is identified and examined. The endoscope is positioned for cannulation of the ampulla. If required, antiperistaltic medications are administered intravenously. The ampulla is cannulated, and the catheter is directed into the duct(s) of clinical interest (common bile duct and/or pancreatic duct). Contrast material is injected into the cannula. A cholangiogram and/or pancreatogram is obtained under fluoroscopic guidance and reviewed for abnormalities. If indicated, washing or brushings of suspicious abnormalities in the common bile duct and/or pancreatic duct are obtained. Endoscopically directed biopsies are taken of tissue in the ducts, GI lumen or papilla. The endoscope is withdrawn into the stomach to allow examination of the gastric fundus and the remainder of the gastric mucosa. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. At the conclusion of the procedure, the endoscope is withdrawn.

**Description of Post-Service Work:** The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. The patient is assessed for physical signs and symptoms suggestive of complications, including abdominal pain, nausea/vomiting, respiratory distress, and bleeding. Radiographic images are reviewed with the technologist for entry into the image storing system. Post procedure orders are completed and discussed with staff. Cytology and pathology forms are completed; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to the referral source and other appropriate parties. Data are entered into the procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others including a discussion regarding potential procedure complications. Restrictions, prescriptions, follow-up tests, instructions and appointments are provided to the patient and pertinent others.



**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2012				
<b>Presenter(s):</b>	Dr. Nicholas Nickl (ASGE), Dr. Edward Bentley (ASGE), Dr. Joel Brill (AGA), Dr. Shivan Mehta, MD (AGA), Dr. Bruce Cameron (ACG)				
<b>Specialty(s):</b>	ASGE, AGA, ACG				
<b>CPT Code:</b>	43261				
<b>Sample Size:</b>	951	<b>Resp N:</b>	57	<b>Response:</b> 5.9 %	
<b>Description of Sample:</b>	The ACG, AGA and ASGE conducted an enhanced random sample as approved by the Research Subcommittee. The sampling methodology was a random sample of member gastroenterologists with the addition of physicians identified by industry as performers of ERCP procedures and survey volunteers who responded to educational articles and identified themselves as ERCP performers.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	15.00	<b>50.00</b>	100.00	500.00
<b>Survey RVW:</b>	3.50	6.00	<b>6.99</b>	9.99	20.16
<b>Pre-Service Evaluation Time:</b>			<b>50.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>10.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>10.00</b>		
<b>Intra-Service Time:</b>	20.00	45.00	<b>55.00</b>	60.00	135.00
<b>Immediate Post Service-Time:</b>	<b>23.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	43261	<b>Recommended Physician Work RVU: 6.25</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>33.00</b>	<b>33.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>10.00</b>	<b>1.00</b>	<b>9.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>5.00</b>	<b>5.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>55.00</b>		
<b>Immediate Post Service-Time:</b>	<b>23.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		

Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
52342	000	5.85	RUC Time

CPT Descriptor Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 12      % of respondents: 21.0 %

**TIME ESTIMATES (Median)**

	CPT Code: 43261	Key Reference CPT Code: 52342	Source of Time RUC Time
Median Pre-Service Time	48.00	60.00	
Median Intra-Service Time	55.00	60.00	
Median Immediate Post-service Time	23.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>126.00</b>	<b>140.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.92	3.42
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.42	3.58
--	------	------

Urgency of medical decision making	3.83	3.42
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.50	3.75
--------------------------	------	------

Physical effort required	4.25	3.58
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.58	3.67
---	------	------

Outcome depends on the skill and judgment of physician	4.75	3.83
--	------	------

Estimated risk of malpractice suit with poor outcome	4.50	3.67
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.75	3.33
----------------------------------	------	------

Intra-Service intensity/complexity	4.17	3.58
------------------------------------	------	------

Post-Service intensity/complexity	3.92	3.25
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

## Background

Code 43262 was identified for the Fourth Five-Year Review through CMS and RUC screens as potentially misvalued through the Harvard valued utilization over 30,000 frequency screen. The code was presented to the RUC at the October 2010 meeting. The RUC reviewed the service and believed that the GI specialties did not provide compelling evidence to change the current value of the service. Therefore, the RUC recommended maintaining the current work RVU of 7.38 for CPT code 43262. CMS maintained the current work RVU of 7.38 and the current physician time for CPT code 43262 for CY 2012. However, CMS requested that the RUC undertake a comprehensive review of the entire family of ERCP codes, including the base CPT code 43260, and provide CMS with work RVU recommendations.

The specialties agreed to survey the entire family of codes (43260-43273). In review of this family of codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In January 2013, the CPT Editorial Panel approved revised guidelines along with revision, addition, and deletion of codes within the ERCP code set.

## Overview of ERCP Family RVW Recommendations

The specialty consensus panel spent a significant amount of time reviewing the survey data for the current set of ERCP codes, comparing the data and values with the esophagoscopy codes (43200-43228) and EGD codes (43235-43259) that were approved by the RUC at the October 2012 and January 2013 RUC meetings. After reviewing the survey data, the consensus panel determined that for the ERCP code set, the incremental value above the base code for ERCP (43260) should be similar where possible to the analogous incremental value above the base codes for esophagoscopy and EGD previously approved.

## Discussion and Recommendation

**43261** Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple

**We recommend an RVW of 6.25.** This value is less than the current RVW and is equal to the recommendation for the ERCP base 43260 plus an increment of 0.30 (43201-43200) (ie, valuing the increment) approved by the RUC in October 2012 for endoscopic biopsies.

**Pre-time Package 2b** is appropriate, with an additional 9 minutes for positioning the patient, endoscopy equipment/monitor, and anesthesia lines/equipment prior to and after induction MAC. The procedure is performed in the prone position on a fluoroscopy table. In addition, the recommended scrub, dress, wait time matches the survey median.

### Comparison to Key Ref 52342

Both 43261 and key reference code 52342 *Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)* are performed under anesthesia (general, MAC, spinal). The survey data for 52342 from 2000 is comparable to current survey data for 43261, however we believe the intensity and complexity of 43261 is higher to evaluate the biliary tree and identify and biopsy the mass.

### Comparison To Other RUC-Reviewed Codes with 40-60 Minutes Intra-Service Time

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2012	<b>52351</b>	Cystouretero / pyeloscope	5.75	0.096	118	33	5	15	45	20
2008	<b>52342</b>	Cysto w/up stricture tx	5.85	0.070	140	40	10	10	60	20
2010	<b>93458</b>	L hrt artery/ventricle angio	5.85	0.093	123	40	3	5	45	30
2012	<b>36223</b>	Place cath carotid/inom art	6.00	0.096	123	40	3	5	45	30

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2012	<b>36225</b>	Place cath subclavian art	6.00	0.096	123	40	3	5	45	30
1995	<b>52277</b>	Cystoscopy and treatment	6.16	0.095	130	45			45	40
1997	<b>58559</b>	Hysteroscopy lysis	6.16	0.078	125	40			60	25
1997	<b>58563</b>	Hysteroscopy ablation	6.16	0.077	130	40			60	30
	<b>43261</b>	<b>ERCP, biopsy</b>	<b>6.25</b>	<b>0.085</b>	<b>124</b>	<b>33</b>	<b>10</b>	<b>10</b>	<b>55</b>	<b>23</b>
2011	<b>36247</b>	Ins cath abd/l-ext art 3rd	6.29	0.080	131	33	3	5	60	30
2012	<b>37197</b>	Remove intrvas foreign body	6.29	0.083	121	33	3	5	60	20
1997	<b>52282</b>	Cystoscopy implant stent	6.39	0.096	120	40			50	30
2012	<b>36224</b>	Place cath carotd art	6.50	0.096	128	40	3	5	50	30
2012	<b>36226</b>	Place cath vertebral art	6.50	0.096	128	40	3	5	50	30
2008	<b>52343</b>	Cysto w/renal stricture tx	6.55	0.078	150	45	10	10	60	25
2010	<b>93459</b>	L hrt art/grft angio	6.60	0.096	133	45	3	5	50	30
2002	<b>34812</b>	Xpose for endoprosth femorl	6.74	0.098	150	75			45	30

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43261

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 4000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare data base 1329 in 2011 (1,329\*3 ~ 4000)

Specialty Gastroenterology	Frequency 3500	Percentage 87.50 %
----------------------------	----------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,350

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare data base 1329 in 2011

Specialty Gastroenterology	Frequency 1200	Percentage 88.88 %
----------------------------	----------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? No

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43261

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43262      Tracking Number   EE3

Original Specialty Recommended RVU: **6.60**Presented Recommended RVU: **6.60**

Global Period: 000

RUC Recommended RVU: **6.60**

CPT Descriptor: Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 72-year-old patient presents with abdominal pain and abnormal laboratory tests (AST, ALT, alkaline phosphatase, total bilirubin, amylase). Imaging tests show a dilated common bile duct with ductal stone. Therapeutic ERCP with sphincterotomy is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 49%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 20%

Description of Pre-Service Work: Review with the patient any symptoms including dysphagia and sleep apnea. The patient's history is reviewed to assess past problems with sedation and the need for and timing of pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's imaging studies and other diagnostic tests are reviewed. The pre-service review is documented. The risks and benefits of the procedure and sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained. The physician verifies all endoscopic and imaging equipment is available, operational and appropriate imaging settings and computer entries are made. A time out is performed. The patient is positioned on the procedure table in the supine position. A patient support pad is positioned on the fluoroscopy table and the patient's positioning is adjusted. The endoscopic, imaging and moderate sedation monitoring equipment is positioned to provide access for the procedure. Appropriate protective attire and shielding are applied and verification that all others in the suite are properly protected including the patient. The patient is rolled to the left side and sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide when indicated, and sequential non-invasive blood pressure measurements. A bite block is placed in the mouth. The patient is repositioned in the prone position.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible side viewing upper endoscope is inserted into the mouth into the oropharynx and blindly advanced through the esophagus into the stomach. The stomach is insufflated with air after suctioning liquid contents. Examination of the entire stomach in the forward and retroflexed positions is performed. The endoscope is advanced through the pylorus into the duodenal bulb. Circumferential inspection of the duodenum is performed after air insufflation. Next the instrument is advanced into the

second portion of the duodenum. The ampulla of Vater is identified and examined. The endoscope is positioned for cannulation of the ampulla. If required, antiperistaltic medications are administered intravenously. The ampulla is cannulated, and the catheter is directed into the duct(s) of clinical interest (common bile duct and/or pancreatic duct). Contrast material is injected into the cannula. A cholangiogram and/or pancreatogram is obtained under fluoroscopic guidance and reviewed for abnormalities. If indicated, washing or brushings of suspicious abnormalities in the common bile duct and/or pancreatic duct are obtained. A guidewire is introduced into the cannulating catheter through the endoscope and into the duct. Under direct visualization, the sphincterotome is properly positioned across the sphincter. The sphincter is incised using electrocautery current in the appropriate orientation until the sphincter muscle fibers are divided and the opening is appropriately sized. Contrast material is injected into the sphincterotome. Another cholangiogram and/or pancreatogram is obtained under fluoroscopic guidance and reviewed for abnormalities such as leak from sphincterotomy. The sphincterotome is withdrawn through the endoscope. The endoscope is withdrawn into the stomach to allow examination of the gastric fundus and the remainder of the gastric mucosa. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. At the conclusion of the procedure, the endoscope is withdrawn

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. The patient is assessed for physical signs and symptoms suggestive of complications, including abdominal pain, nausea/vomiting, respiratory distress, and bleeding. Radiographic images are reviewed with the technologist for entry into the image storing system. Post procedure orders are completed and discussed with staff. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to the referral source and other appropriate parties. Data is entered into the procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others including a discussion regarding potential procedure complications. Restrictions, prescriptions, follow-up tests, instructions and appointments are provided to the patient and pertinent others.



**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2012			
<b>Presenter(s):</b>	Dr. Nicholas Nickl (ASGE), Dr. Edward Bentley (ASGE), Dr. Joel Brill (AGA), Dr. Shivan Mehta (AGA), Dr. Bruce Cameron (ACG)				
<b>Specialty(s):</b>	ACG, AGA, ASGE				
<b>CPT Code:</b>	43262				
<b>Sample Size:</b>	952	<b>Resp N:</b>	58	<b>Response:</b> 6.0 %	
<b>Description of Sample:</b>	The ACG, AGA and ASGE conducted an enhanced random sample as approved by the Research Subcommittee. The sampling methodology was a random sample of member gastroenterologists with the addition of physicians identified by industry as performers of ERCP procedures and survey volunteers who responded to educational articles and identified themselves as ERCP performers.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	46.00	<b>90.00</b>	180.00	500.00
<b>Survey RVW:</b>	4.40	6.60	<b>8.00</b>	10.00	23.52
<b>Pre-Service Evaluation Time:</b>			<b>45.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>10.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>10.00</b>		
<b>Intra-Service Time:</b>	10.00	45.00	<b>60.00</b>	74.00	150.00
<b>Immediate Post Service-Time:</b>	<b>30.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

**Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:** 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	43262	<b>Recommended Physician Work RVU: 6.60</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>33.00</b>	<b>33.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>10.00</b>	<b>1.00</b>	<b>9.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>5.00</b>	<b>5.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>60.00</b>		
<b>Immediate Post Service-Time:</b>	<b>30.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		

Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
58560	000	6.99	RUC Time

CPT Descriptor Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11      % of respondents: 18.9 %

**TIME ESTIMATES (Median)**

	CPT Code: 43262	Key Reference CPT Code: 58560	Source of Time RUC Time
Median Pre-Service Time	48.00	40.00	
Median Intra-Service Time	60.00	60.00	
Median Immediate Post-service Time	30.00	25.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>138.00</b>	<b>125.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.09	3.55
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.27	3.64
Urgency of medical decision making	4.45	3.45

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.82	4.09
Physical effort required	4.36	3.82

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	5.00	3.91
Outcome depends on the skill and judgment of physician	4.82	3.91
Estimated risk of malpractice suit with poor outcome	4.91	4.18

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.00	3.64
Intra-Service intensity/complexity	4.64	4.00
Post-Service intensity/complexity	3.82	3.64

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**

Code 43262 was identified for the Fourth Five-Year Review through CMS and RUC screens as potentially misvalued through the Harvard valued utilization over 30,000 frequency screen. The code was presented to the RUC at the October 2010 meeting. The RUC reviewed the service and believed that the GI specialties did not provide compelling evidence to change the current value of the service. Therefore, the RUC recommended maintaining the current work RVU of 7.38 for CPT code 43262. CMS maintained the current work RVU of 7.38 and the current physician time for CPT code 43262 for CY 2012. However, CMS requested that the RUC undertake a comprehensive review of the entire family of ERCP codes, including the base CPT code 43260, and provide CMS with work RVU recommendations.

The specialties agreed to survey the entire family of codes (43260-43273). In review of this family of codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In January 2013, the CPT Editorial Panel approved revised guidelines along with revision, addition, and deletion of codes within the ERCP code set.

### Overview of ERCP Family RVW Recommendations

The specialty consensus panel spent a significant amount of time reviewing the survey data for the current set of ERCP codes, comparing the data and values with the esophagoscopy codes (43200-43228) and EGD codes (43235-43259) that were approved by the RUC at the October 2012 and January 2013 RUC meetings. After reviewing the survey data, the consensus panel determined that for the ERCP code set, the incremental value above the base code for ERCP (43260) should be similar where possible to the analogous incremental value above the base codes for esophagoscopy and EGD previously approved.

### Discussion and Recommendation

**43262** Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy

**We recommend an RVW of 6.60.** The value is the 25% of the current survey and less than the current value. The incremental difference of 0.65 RVUs over the base code is less than the incremental difference in work between 47610 (open chole) and 47620 (open chole, w-sphincterotomy) (RVW diff = 2.15).

**Pre-time Package 2b** is appropriate, with an additional 9 minutes for positioning the patient, endoscopy equipment/monitor, and anesthesia lines/equipment prior to and after induction MAC. The procedure is performed in the prone position on a fluoroscopy table. In addition, the recommended scrub, dress, wait time matches the survey median.

#### Comparison to Key Ref 58560

Anesthesia is similar for both 43262 and 58560 *Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)*. The survey data for 58560 from 1997 is comparable to current survey data for 43262.

#### Comparison To Other RUC-Reviewed Codes with 50-60 Minutes Intra-Service Time

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2008	<b>52342</b>	Cysto w/up stricture tx	5.85	0.070	140	40	10	10	60	20
1997	<b>58559</b>	Hysteroscopy lysis	6.16	0.078	125	40			60	25
1997	<b>58563</b>	Hysteroscopy ablation	6.16	0.077	130	40			60	30
2012	<b>37197</b>	Remove intrvas foreign body	6.29	0.083	121	33	3	5	60	20

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
1997	<b>52282</b>	Cystoscopy implant stent	6.39	0.096	120	40			50	30
2012	<b>36226</b>	Place cath vertebral art	6.50	0.096	128	40	3	5	50	30
2008	<b>52343</b>	Cysto w/renal stricture tx	6.55	0.078	150	45	10	10	60	25
	<b>43262</b>	ERCP; sphincterotomy	6.60	0.079	150	40	10	10	60	30
2010	<b>93457</b>	R hrt art/grft angio	6.89	0.102	133	45	3	5	50	30
2011	<b>36252</b>	Ins cath ren art 1st bilat	6.99	0.103	124	33	3	5	53	30
1997	<b>58560</b>	Hysteroscopy resect septum	6.99	0.092	125	40			60	25
2012	<b>37212</b>	Thrombolytic venous ther	7.06	0.090	138	40	3	5	60	30
2010	<b>93460</b>	R&I hrt art/ventricle angio	7.35	0.113	128	40	3	5	50	30
2012	<b>52240</b>	Cystoscopy and treatment	7.50	0.101	133	33	5	15	60	20
2011	<b>36253</b>	Ins cath ren art 2nd+ unilat	7.55	0.101	131	33	3	5	60	30
2012	<b>37211</b>	Thrombolytic art therapy	8.00	0.105	138	40	3	5	60	30
2012	<b>52354</b>	Cystouretero w/biopsy	8.00	0.110	133	33	5	15	60	20
2010	<b>37220</b>	Iliac revasc	8.15	0.108	138	40	3	5	60	30

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.  
☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.  
☐ Multiple codes allow flexibility to describe exactly what components the procedure included.  
☐ Multiple codes are used to maintain consistency with similar codes.  
☐ Historical precedents.  
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43262

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology

How often? Sometimes

Specialty

How often?

Specialty

How often?

Estimate the number of times this service might be provided nationally in a one-year period? 175000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare data base 57,878 in 2011 (57,878\*3 ~ 175,000)

Specialty Gastroenterology	Frequency 160000	Percentage 91.42 %
----------------------------	------------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?  
22,525 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.  
Please explain the rationale for this estimate. Medicare data base 57,878 in 2011 - utilization going to 4327X7 and savings from (43268 & 43269)

Specialty Gastroenterology	Frequency 53000	Percentage 91.37 %
----------------------------	-----------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? No

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43262

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor:

52356X Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double J type)

Global Period: 000

Meeting Date: April 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The AUA expert panel consists of ten urologists who represent urological practices, both academic and private settings, from across the United States. They represent the states of Washington, Illinois, New York, Kentucky, and Florida. The panel reviews current RUC practice expense information, requests input for supplies and equipment from several urology practices, reviews the information, makes recommendations and submits them to the AMA.

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

This new code 52356 is a combination of two existing CPT codes 52353 and 52332 as required by RUC and CMS through the two codes reported during the same encounter over 75% of the time.

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time: N/A

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence: N/A

5. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Complete pre-service diagnostic and referral forms

Coordinate pre-service surgery services

Schedule space and equipment in facility

Provide pre-service education/obtain consent

Intra-Service Clinical Labor Activities:

None

Post-Service Clinical Labor Activities:

Follow-up phone calls and prescriptions



**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43264      Tracking Number   EE5

Original Specialty Recommended RVU: **6.73**Presented Recommended RVU: **6.73**

Global Period: 000

RUC Recommended RVU: **6.73**

CPT Descriptor: Endoscopic retrograde cholangiopancreatography (ERCP); with removal of calculi/debris from biliary/pancreatic duct(s)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 68 year old patient presents with abdominal pain and abnormal laboratory tests (AST, ALT, alkaline phosphatase, total bilirubin, amylase). Imaging studies show an apparent retained common bile duct stone. Therapeutic ERCP with stone removal is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 52%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 29%

Description of Pre-Service Work: Review with the patient any symptoms including dysphagia and sleep apnea. The patient's history is reviewed to assess past problems with sedation and the need for and timing of pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's imaging studies and other diagnostic tests are reviewed. The pre-service review is documented. The risks and benefits of the procedure and sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained. The physician verifies all endoscopic and imaging equipment is available, operational and appropriate imaging settings and computer entries are made. A time out is performed. The patient is positioned on the procedure table in the supine position. A patient support pad is positioned on the fluoroscopy table and the patient's positioning is adjusted. The endoscopic, imaging and sedation monitoring equipment is positioned to provide access for the procedure. Appropriate protective attire and shielding are applied and verification that all others in the suite are properly protected including the patient. The patient is rolled to the left side and sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide when indicated, and sequential non-invasive blood pressure measurements. . A bite block is placed in the mouth. The patient is repositioned in the prone position.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible side viewing upper endoscope is inserted into the mouth into the oropharynx and blindly advanced through the esophagus into the stomach. The stomach is insufflated with air after suctioning liquid contents. Examination of the entire stomach in the forward and retroflexed positions is performed. The endoscope is advanced through the pylorus into the duodenal bulb.

Circumferential inspection of the duodenum is performed after air insufflation. Next the instrument is advanced into the second portion of the duodenum. The ampulla of Vater is identified and examined. The endoscope is positioned for cannulation of the ampulla. If required, antiperistaltic medications are administered intravenously. The ampulla is cannulated, and the catheter is directed into the duct(s) of clinical interest (common bile duct and/or pancreatic duct). Contrast material is injected into the cannula. A cholangiogram and/or pancreatogram is obtained under fluoroscopic guidance and reviewed for abnormalities. If indicated, washing or brushings of suspicious abnormalities in the common bile duct and/or pancreatic duct are obtained. A guidewire is introduced into the cannulating catheter through the endoscope and into the duct. The cannulating catheter is withdrawn through the endoscope while maintaining counter-pressure on the guidewire to ensure stable positioning. A therapeutic retrieval balloon is passed over the guidewire and through the endoscope. Under direct visualization, the retrieval balloon is passed into the duct. The retrieval balloon is advanced into the proximal duct, inflated, and then pulled distally to sweep the duct of calculi or debris. The balloon is deflated. Balloon advancement, inflation, and sweep of the duct are repeated as necessary until no further material is delivered into the duodenum. Alternatively a stone retrieval basket may be used to capture the stone and remove it from the duct. Contrast material is injected into the balloon catheter. Another cholangiogram and/or pancreatogram is obtained under fluoroscopic guidance and reviewed for abnormalities. The balloon and guidewire are withdrawn through the endoscope. The endoscope is withdrawn into the stomach to allow examination of the gastric fundus and the remainder of the gastric mucosa. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. At the conclusion of the procedure, the endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. The patient is assessed for physical signs and symptoms suggestive of complications, including abdominal pain, nausea/vomiting, respiratory distress, and bleeding. Radiographic images are reviewed with the technologist for entry into the image storing system. Post procedure orders are completed and discussed with staff. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to the referral source and other appropriate parties. Data are entered into the procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others including a discussion regarding potential procedure complications. Restrictions, prescriptions, follow-up tests, instructions and appointments are provided to the patient and pertinent others.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2012				
<b>Presenter(s):</b>	Dr. Nicholas Nickl (ASGE), Dr. Edward Bentley (ASGE), Dr. Joel Brill (AGA), Dr. Shivan Mehtah (AGA), Dr. Bruce Cameron (ACG)				
<b>Specialty(s):</b>	ACG, AGA, ASGE				
<b>CPT Code:</b>	43264				
<b>Sample Size:</b>	952	<b>Resp N:</b>	54	<b>Response:</b> 5.6 %	
<b>Description of Sample:</b>	The ACG, AGA and ASGE conducted an enhanced random sample as approved by the Research Subcommittee. The sampling methodology was a random sample of member gastroenterologists with the addition of physicians identified by industry as performers of ERCP procedures and survey volunteers who responded to educational articles and identified themselves as ERCP performers.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	31.00	<b>50.00</b>	150.00	400.00
<b>Survey RVW:</b>	4.50	6.73	<b>9.00</b>	10.38	26.88
<b>Pre-Service Evaluation Time:</b>			<b>45.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>10.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>10.00</b>		
<b>Intra-Service Time:</b>	25.00	60.00	<b>60.00</b>	75.00	160.00
<b>Immediate Post Service-Time:</b>	<b>28.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	43264	<b>Recommended Physician Work RVU: 6.73</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>33.00</b>	<b>33.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>10.00</b>	<b>1.00</b>	<b>9.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>5.00</b>	<b>5.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>60.00</b>		
<b>Immediate Post Service-Time:</b>	<b>28.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		

Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
58561	000	9.99	RUC Time

CPT Descriptor Hysteroscopy, surgical; with removal of leiomyomata**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 9 % of respondents: 16.6 %

**TIME ESTIMATES (Median)**

	CPT Code: 43264	Key Reference CPT Code: 58561	Source of Time RUC Time
Median Pre-Service Time	48.00	40.00	
Median Intra-Service Time	60.00	75.00	
Median Immediate Post-service Time	28.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>136.00</b>	<b>145.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.22	4.22
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.67	3.89
--	------	------

Urgency of medical decision making	4.44	3.78
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.78	4.22
--------------------------	------	------

Physical effort required	4.44	4.22
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.67	4.22
---	------	------

Outcome depends on the skill and judgment of physician	4.67	4.22
--	------	------

Estimated risk of malpractice suit with poor outcome	4.78	4.44
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.89	3.89
----------------------------------	------	------

Intra-Service intensity/complexity	4.56	4.00
------------------------------------	------	------

Post-Service intensity/complexity	3.78	3.56
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

## Background

Code 43262 was identified for the Fourth Five-Year Review through CMS and RUC screens as potentially misvalued through the Harvard valued utilization over 30,000 frequency screen. The code was presented to the RUC at the October 2010 meeting. The RUC reviewed the service and believed that the GI specialties did not provide compelling evidence to change the current value of the service. Therefore, the RUC recommended maintaining the current work RVU of 7.38 for CPT code 43262. CMS maintained the current work RVU of 7.38 and the current physician time for CPT code 43262 for CY 2012. However, CMS requested that the RUC undertake a comprehensive review of the entire family of ERCP codes, including the base CPT code 43260, and provide CMS with work RVU recommendations.

The specialties agreed to survey the entire family of codes (43260-43273). In review of this family of codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In January 2013, the CPT Editorial Panel approved revised guidelines along with revision, addition, and deletion of codes within the ERCP code set.

## Overview of ERCP Family RVW Recommendations

The specialty consensus panel spent a significant amount of time reviewing the survey data for the current set of ERCP codes, comparing the data and values with the esophagoscopy codes (43200-43228) and EGD codes (43235-43259) that were approved by the RUC at the October 2012 and January 2013 RUC meetings. After reviewing the survey data, the consensus panel determined that for the ERCP code set, the incremental value above the base code for ERCP (43260) should be similar where possible to the analogous incremental value above the base codes for esophagoscopy and EGD previously approved.

## Discussion and Recommendation

**43264** Endoscopic retrograde cholangiopancreatography (ERCP); with removal of calculi/debris from biliary/pancreatic duct(s)

**We recommend an RVW of 6.73.** The value is the 25% of the current survey and less than the current value.

**Pre-time Package 2b** is appropriate, with an additional 9 minutes for positioning the patient, endoscopy equipment/monitor, and anesthesia lines/equipment prior to and after induction MAC. The procedure is performed in the prone position on a fluoroscopy table. In addition, the recommended scrub, dress, wait time matches the survey median.

### Comparison to Key Ref 58561

Anesthesia is similar for both 43264 and 58561 *Hysteroscopy, surgical; with removal of leiomyomata*). The intra-service time for 58561 from 1997 is slightly greater and accounted for by a higher RVW.

### Comparison To Other RUC-Reviewed Codes with ~60 Minutes Intra-Service Time

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2008	<b>52342</b>	Cysto w/up stricture tx	5.85	0.070	140	40	10	10	60	20
1997	<b>58559</b>	Hysteroscopy lysis	6.16	0.078	125	40			60	25
1997	<b>58563</b>	Hysteroscopy ablation	6.16	0.077	130	40			60	30

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2012	<b>37197</b>	Remove intrvas foreign body	6.29	0.083	121	33	3	5	60	20
1997	<b>52282</b>	Cystoscopy implant stent	6.39	0.096	120	40			50	30
2012	<b>36226</b>	Place cath vertebral art	6.50	0.096	128	40	3	5	50	30
2008	<b>52343</b>	Cysto w/renal stricture tx	6.55	0.078	150	45	10	10	60	25
	<b>43264</b>	ERCP; removal of calculi biliary duct	6.73	0.082	148	40	10	10	60	28
2010	<b>93457</b>	R hrt art/grft angio	6.89	0.102	133	45	3	5	50	30
2011	<b>36252</b>	Ins cath ren art 1st bilat	6.99	0.103	124	33	3	5	53	30
1997	<b>58560</b>	Hysteroscopy resect septum	6.99	0.092	125	40			60	25
2012	<b>37212</b>	Thrombolytic venous ther	7.06	0.090	138	40	3	5	60	30
2010	<b>93460</b>	R&I hrt art/ventricle angio	7.35	0.113	128	40	3	5	50	30
2012	<b>52240</b>	Cystoscopy and treatment	7.50	0.101	133	33	5	15	60	20
2011	<b>36253</b>	Ins cath ren art 2nd+ unilat	7.55	0.101	131	33	3	5	60	30
2012	<b>37211</b>	Thrombolytic art therapy	8.00	0.105	138	40	3	5	60	30
2012	<b>52354</b>	Cystouretero w/biopsy	8.00	0.110	133	33	5	15	60	20
2010	<b>37220</b>	Iliac revasc	8.15	0.108	138	40	3	5	60	30

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43264

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 138000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare data base 45,885 in 2011 (45,885\*3 ~ 138,000)

Specialty Gastroenterology	Frequency 125000	Percentage 90.57 %
----------------------------	------------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?  
46,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.  
Please explain the rationale for this estimate. Medicare data base 45,885 in 2011

Specialty Gastroenterology	Frequency 42000	Percentage 91.30 %
----------------------------	-----------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? No

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43264

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.



**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43265      Tracking Number   EE6

Original Specialty Recommended RVU: **8.03**Presented Recommended RVU: **8.03**

Global Period: 000

RUC Recommended RVU: **8.03**

CPT Descriptor: Endoscopic retrograde cholangiopancreatography (ERCP); with destruction of calculi, any method (eg, mechanical, electrohydraulic, lithotripsy)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 75 year old patient with recurrent right upper quadrant pain, abnormal laboratory tests (AST, ALT, alkaline phosphatase, total bilirubin, amylase), and jaundice is referred for evaluation. Imaging studies including MRCP reveal a dilated common bile duct with several common bile duct stones  $\geq$  2cm in diameter. Therapeutic ERCP with mechanical lithotripsy and clearing of stones from the common bile duct is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 48%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 11%

Description of Pre-Service Work: Review with the patient any symptoms including dysphagia and sleep apnea. The patient's history is reviewed to assess past problems with sedation and the need for and timing of pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's imaging studies and other diagnostic tests are reviewed. The pre-service review is documented. The risks and benefits of the procedure and sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained. The physician verifies all endoscopic and imaging equipment is available, operational and appropriate imaging settings and computer entries are made. A time out is performed. The patient is positioned on the procedure table in the supine position. A patient support pad is positioned on the fluoroscopy table and the patient's positioning is adjusted. The endoscopic, imaging and sedation monitoring equipment is positioned to provide access for the procedure. Appropriate protective attire and shielding are applied and verification that all others in the suite are properly protected including the patient. The patient is rolled to the left side and sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide when indicated, and sequential non-invasive blood pressure measurements. A bite block is placed in the mouth. The patient is repositioned in the prone position.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible side viewing upper endoscope is inserted into the mouth into the oropharynx and blindly advanced through the esophagus into the stomach. The stomach is insufflated with air after suctioning liquid contents. Examination of the entire stomach in

the forward and retroflexed positions is performed. The endoscope is advanced through the pylorus into the duodenal bulb. Circumferential inspection of the duodenum is performed after air insufflation. Next the instrument is advanced into the second portion of the duodenum. The ampulla of Vater is identified and examined. The endoscope is positioned for cannulation of the ampulla. If required, antiperistaltic medications are administered intravenously. The ampulla is cannulated, and the catheter is directed into the duct(s) of clinical interest (common bile duct and/or pancreatic duct). Contrast material is injected into the cannula. A cholangiogram and/or pancreatogram is obtained under fluoroscopic guidance and reviewed for abnormalities. If indicated, washing or brushings of suspicious abnormalities in the common bile duct and/or pancreatic duct are obtained. A guidewire is introduced into the cannulating catheter through the endoscope and into the duct. The cannulating catheter is withdrawn through the endoscope while maintaining counter-pressure on the guidewire to ensure stable positioning. A lithotripter device is passed over the guidewire through the endoscope. Under direct visualization, the lithotripter device is positioned into the duct. A cholangiogram and/or pancreatogram is obtained under fluoroscopic guidance and the lithotripter is positioned over the calculi. The stone(s) is crushed with the device until sufficiently small enough fragments are formed for clearance. The lithotripter device is withdrawn through the endoscope while maintaining counter-pressure on the guidewire to ensure stable positioning. A therapeutic retrieval balloon is passed over the guidewire and through the endoscope. Under direct visualization, the retrieval balloon is passed into the duct. The retrieval balloon is advanced into the duct, inflated, and then pulled distally to sweep the duct of calculi or debris. The balloon is deflated. Balloon advancement, inflation, and sweep of the duct is repeated as necessary until no further stone material is delivered into the duodenum. A cholangiogram and/or pancreatogram is obtained under fluoroscopic guidance to confirm that the calculi have been crushed and removed. Radiographic images are reviewed. The endoscope is withdrawn into the stomach to allow examination of the gastric fundus and the remainder of the gastric mucosa. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. At the conclusion of the procedure, the endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. The patient is assessed for physical signs and symptoms suggestive of complications, including abdominal pain, nausea/vomiting, respiratory distress, and bleeding. Radiographic images are reviewed with the technologist for entry into the image storing system. Post procedure orders are completed and discussed with staff. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to the referral source and other appropriate parties. Data are entered into the procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others including a discussion regarding potential procedure complications. Restrictions, prescriptions, follow-up tests, instructions and appointments are provided to the patient and pertinent others.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2012				
<b>Presenter(s):</b>	Dr. Nicholas Nickl (ASGE), Dr. Edward Bentley (ASGE), Dr. Joel Brill (AGA), Dr. Shivan Meht (AGA), Dr. Bruce Cameron (ACG)				
<b>Specialty(s):</b>	ACG, AGA, ASGE				
<b>CPT Code:</b>	43265				
<b>Sample Size:</b>	952	<b>Resp N:</b>	52	<b>Response:</b> 5.4 %	
<b>Description of Sample:</b>	The ACG, AGA and ASGE conducted an enhanced random sample as approved by the Research Subcommittee. The sampling methodology was a random sample of member gastroenterologists with the addition of physicians identified by industry as performers of ERCP procedures and survey volunteers who responded to educational articles and identified themselves as ERCP performers.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	10.00	<b>18.00</b>	40.00	200.00
<b>Survey RVW:</b>	5.00	8.03	<b>10.50</b>	12.00	28.56
<b>Pre-Service Evaluation Time:</b>			<b>50.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>10.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>10.00</b>		
<b>Intra-Service Time:</b>	35.00	64.00	<b>78.00</b>	90.00	160.00
<b>Immediate Post Service-Time:</b>	<b>28.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

**Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:** 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	43265	<b>Recommended Physician Work RVU: 8.03</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>33.00</b>	<b>33.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>10.00</b>	<b>1.00</b>	<b>9.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>5.00</b>	<b>5.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>78.00</b>		
<b>Immediate Post Service-Time:</b>	<b>28.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		

Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
52342	000	5.85	RUC Time

CPT Descriptor Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 9      % of respondents: 17.3 %

**TIME ESTIMATES (Median)**

	CPT Code: 43265	Key Reference CPT Code: 52342	Source of Time RUC Time
Median Pre-Service Time	48.00	60.00	
Median Intra-Service Time	78.00	60.00	
Median Immediate Post-service Time	28.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>154.00</b>	<b>140.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.89	4.00
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.33	4.00
--	------	------

Urgency of medical decision making	4.56	3.78
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.89	4.33
--------------------------	------	------

Physical effort required	4.78	4.11
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.89	4.11
---	------	------

Outcome depends on the skill and judgment of physician	4.78	4.11
--	------	------

Estimated risk of malpractice suit with poor outcome	4.67	4.00
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.33	3.78
----------------------------------	------	------

Intra-Service intensity/complexity	4.89	4.11
------------------------------------	------	------

Post-Service intensity/complexity	4.00	3.67
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

## Background

Code 43262 was identified for the Fourth Five-Year Review through CMS and RUC screens as potentially misvalued through the Harvard valued utilization over 30,000 frequency screen. The code was presented to the RUC at the October 2010 meeting. The RUC reviewed the service and believed that the GI specialties did not provide compelling evidence to change the current value of the service. Therefore, the RUC recommended maintaining the current work RVU of 7.38 for CPT code 43262. CMS maintained the current work RVU of 7.38 and the current physician time for CPT code 43262 for CY 2012. However, CMS requested that the RUC undertake a comprehensive review of the entire family of ERCP codes, including the base CPT code 43260, and provide CMS with work RVU recommendations.

The specialties agreed to survey the entire family of codes (43260-43273). In review of this family of codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In January 2013, the CPT Editorial Panel approved revised guidelines along with revision, addition, and deletion of codes within the ERCP code set.

## Overview of ERCP Family RVW Recommendations

The specialty consensus panel spent a significant amount of time reviewing the survey data for the current set of ERCP codes, comparing the data and values with the esophagoscopy codes (43200-43228) and EGD codes (43235-43259) that were approved by the RUC at the October 2012 and January 2013 RUC meetings. After reviewing the survey data, the consensus panel determined that for the ERCP code set, the incremental value above the base code for ERCP (43260) should be similar where possible to the analogous incremental value above the base codes for esophagoscopy and EGD previously approved.

## Discussion and Recommendation

**43265** Endoscopic retrograde cholangiopancreatography (ERCP); with destruction of calculi, any method (eg, mechanical, electrohydraulic, lithotripsy)

**We recommend an RVW of 8.03.** The value is the 25% of the current survey and less than the current value.

**Pre-time Package 2b** is appropriate, with an additional 9 minutes for positioning the patient, endoscopy equipment/monitor, and anesthesia lines/equipment prior to and after induction MAC. The procedure is performed in the prone position on a fluoroscopy table. In addition, the recommended scrub, dress, wait time matches the survey median.

### Comparison to Key Ref 52342

Both 43265 and key reference code 52342 *Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)* are performed under anesthesia (general, MAC, spinal). The intensity of 43265 is higher because of the large size of the stones and the additional risk of pancreatitis and bile duct perforation associated with 43265.

### Comparison To Other RUC-Reviewed Codes with ~78 Minutes Intra-Service Time

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
1997	<b>58560</b>	Hysteroscopy resect septum	6.99	0.092	125	40			60	25
2012	<b>37212</b>	Thrombolytic venous	7.06	0.090	138	40	3	5	60	30

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
		therapy								
2003	<b>20982</b>	Ablate bone tumor(s) perq	7.27	0.071	158	23	15	10	80	30
2012	<b>52240</b>	Cystoscopy and treatment	7.50	0.101	133	33	5	15	60	20
2008	<b>37183</b>	Remove hepatic shunt (tips)	7.99	0.086	135	28			78	30
2012	<b>37211</b>	Thrombolytic art therapy	8.00	0.105	138	40	3	5	60	30
2012	<b>52354</b>	Cystouretero w/biopsy	8.00	0.110	133	33	5	15	60	20
	<b>43265</b>	ERCP; destruction of calculi	8.03	0.080	166	40	10	10	78	28
2010	<b>93461</b>	R&I hrt art/ventricle angio	8.10	0.095	153	45	3	5	65	35
2011	<b>36254</b>	Ins cath ren art 2nd+ bilat	8.15	0.098	139	33	3	5	68	30
2007	<b>55920</b>	Place needles pelvic for rt	8.31	0.074	175	30	10	15	90	30
2005	<b>37184</b>	Prim art mech thrombectomy	8.66	0.080	160	20	10	10	90	30
2007	<b>41019</b>	Place needles h&n for rt	8.84	0.079	175	30	10	15	90	30
2012	<b>52355</b>	Cystouretero w/excise tumor	9.00	0.084	163	33	5	15	90	20

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43265

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology

How often? Rarely

Specialty

How often?

Specialty

How often?

Estimate the number of times this service might be provided nationally in a one-year period? 8500

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare data base 2786 in 2011 (2,786\*3 ~ 8,500)

Specialty Gastroenterology	Frequency 7800	Percentage 91.76 %
----------------------------	----------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,800

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare data base 2786 in 2011

Specialty Gastroenterology	Frequency 2600	Percentage 92.85 %
----------------------------	----------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? No

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43265

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.



**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43274      Tracking Number   EE7

Original Specialty Recommended RVU: **8.74**Presented Recommended RVU: **8.74**

Global Period: 000

RUC Recommended RVU: **8.74**

CPT Descriptor: Endoscopic retrograde cholangiopancreatography (ERCP); with placement of endoscopic stent into biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 72-year-old patient presents with abdominal and back pain, weight loss, abnormal laboratory tests (AST, ALT, alkaline phosphatase, total bilirubin, amylase) and jaundice. Imaging studies show dilation of the common bile duct with a lesion suspicious for pancreatic cancer. Therapeutic ERCP with sphincterotomy is performed, followed by placement of stent across the biliary obstruction, is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 50%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 29%

Description of Pre-Service Work: Review with the patient any symptoms including dysphagia and sleep apnea. The patient's history is reviewed to assess past problems with sedation and the need for and timing of pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's imaging studies and other diagnostic tests are reviewed. The pre-service review is documented. The risks and benefits of the procedure and sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained. The physician verifies all endoscopic and imaging equipment is available, operational and appropriate imaging settings and computer entries are made. A time out is performed. The patient is positioned on the procedure table in the supine position. A patient support pad is positioned on the fluoroscopy table and the patient's positioning is adjusted. The endoscopic, imaging and sedation monitoring equipment is positioned to provide access for the procedure. Appropriate protective attire and shielding are applied and verification that all others in the suite are properly protected including the patient. The patient is rolled to the left side and sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide when indicated, and sequential non-invasive blood pressure measurements. A bite block is placed in the mouth. The patient is repositioned in the prone position.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible side viewing upper endoscope is inserted into the mouth into the oropharynx and blindly advanced through the esophagus into the stomach. The stomach is insufflated with air after suctioning liquid contents. Examination of the entire stomach in the forward and retroflexed positions is performed. The endoscope is advanced through the pylorus into the duodenal bulb. Circumferential inspection of the duodenum is performed after air insufflation. Next the instrument is advanced into the second portion of the duodenum. The ampulla of Vater is identified and examined. The endoscope is positioned for cannulation of the ampulla. If required, antiperistaltic medications are administered intravenously. Additional sedation is administered as required to maintain adequate sedation throughout the procedure. The ampulla is cannulated, and the catheter is directed into the duct(s) of clinical interest (common bile duct and/or pancreatic duct). Contrast material is injected into the cannula. A cholangiogram and/or pancreatogram is obtained under fluoroscopic guidance and reviewed for abnormalities. If indicated, washing or brushings of suspicious abnormalities in the common bile duct and/or pancreatic duct are obtained. A guidewire is introduced into the cannulating catheter through the endoscope and into the duct. If needed, a sphincterotome is properly positioned across the sphincter. The sphincter is incised using electrocautery current in the appropriate orientation until the sphincter muscle fibers are divided and the opening is appropriately sized. The sphincterotome is withdrawn and the guiding catheter is then exchanged over the guidewire to bypass the obstruction. Bile samples can be aspirated for culture and cytology. The length of the stricture is determined on cholangiography with the help of radiopaque ring markers. A suitable length stent is chosen so that the proximal flap of the stent lies about 1 cm above the obstruction; if necessary the guidewire is retracted between the two points and the distance traveled on the outside of the catheter is measured. The stricture may be dilated prior to stent insertion with graded dilators or pneumatic balloon dilators inserted over the guidewire. The stent is directed over the guidewire and then positioned through the obstruction. The stent is deployed using endoscopic and fluoroscopic guidance. Bile is seen draining through the stent into the duodenum. The guidewire and introducer are removed. The endoscope is withdrawn into the stomach to allow examination of the gastric fundus and the remainder of the gastric mucosa. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. At the conclusion of the procedure, the endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. The patient is assessed for physical signs and symptoms suggestive of complications, including abdominal pain, nausea/vomiting, respiratory distress, bleeding and fever. Radiographic images are reviewed with the technologist for entry into the image storing system. Post procedure orders are completed and discussed with staff. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to the referral source and other appropriate parties. Data are entered into the procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others including a discussion regarding potential procedure complications including recognizing and managing stent occlusion. Restrictions, prescriptions, follow-up tests, instructions and appointments are provided to the patient and pertinent others.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2012			
<b>Presenter(s):</b>	Dr. Nicholas Nickl (ASGE), Dr. Edward Bentley (ASGE), Dr. Joel Brill (AGA), Dr. Shivan Mehta (AGA), Dr. Bruce Cameron (ACG)				
<b>Specialty(s):</b>	ASGE, AGA, ACG				
<b>CPT Code:</b>	43274				
<b>Sample Size:</b>	952	<b>Resp N:</b>	50	<b>Response:</b> 5.2 %	
<b>Description of Sample:</b>	The ACG, AGA and ASGE conducted an enhanced random sample as approved by the Research Subcommittee. The sampling methodology was a random sample of member gastroenterologists with the addition of physicians identified by industry as performers of ERCP procedures and survey volunteers who responded to educational articles and identified themselves as ERCP performers.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	15.00	<b>45.00</b>	100.00	300.00
<b>Survey RVW:</b>	3.05	7.73	<b>10.00</b>	12.45	30.52
<b>Pre-Service Evaluation Time:</b>			<b>50.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>10.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>10.00</b>		
<b>Intra-Service Time:</b>	15.00	60.00	<b>68.00</b>	90.00	180.00
<b>Immediate Post Service-Time:</b>	<b>23.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	43274	<b>Recommended Physician Work RVU: 8.74</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>33.00</b>	<b>33.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>10.00</b>	<b>1.00</b>	<b>9.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>5.00</b>	<b>5.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>68.00</b>		
<b>Immediate Post Service-Time:</b>	<b>23.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		

Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
37221	000	10.00	RUC Time

CPT Descriptor Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 9      % of respondents: 16.9 %

**TIME ESTIMATES (Median)**

	CPT Code: 43274	Key Reference CPT Code: 37221	Source of Time RUC Time
Median Pre-Service Time	48.00	48.00	
Median Intra-Service Time	68.00	90.00	
Median Immediate Post-service Time	23.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>139.00</b>	<b>168.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.44	4.00
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.89	4.44
--	------	------

Urgency of medical decision making	4.44	4.11
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	5.00	4.56
--------------------------	------	------

Physical effort required	4.78	4.44
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.89	4.56
---	------	------

Outcome depends on the skill and judgment of physician	5.00	4.44
--	------	------

Estimated risk of malpractice suit with poor outcome	4.44	4.56
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.67	4.33
----------------------------------	------	------

Intra-Service intensity/complexity	4.89	4.67
------------------------------------	------	------

Post-Service intensity/complexity	4.44	4.22
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

## Background

Code 43262 was identified for the Fourth Five-Year Review through CMS and RUC screens as potentially misvalued through the Harvard valued utilization over 30,000 frequency screen. The code was presented to the RUC at the October 2010 meeting. The RUC reviewed the service and believed that the GI specialties did not provide compelling evidence to change the current value of the service. Therefore, the RUC recommended maintaining the current work RVU of 7.38 for CPT code 43262. CMS maintained the current work RVU of 7.38 and the current physician time for CPT code 43262 for CY 2012. However, CMS requested that the RUC undertake a comprehensive review of the entire family of ERCP codes, including the base CPT code 43260, and provide CMS with work RVU recommendations.

The specialties agreed to survey the entire family of codes (43260-43273). In review of this family of codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In January 2013, the CPT Editorial Panel approved revised guidelines along with revision, addition, and deletion of codes within the ERCP code set.

## Overview of ERCP Family RVW Recommendations

The specialty consensus panel spent a significant amount of time reviewing the survey data for the current set of ERCP codes, comparing the data and values with the esophagoscopy codes (43200-43228) and EGD codes (43235-43259) that were approved by the RUC at the October 2012 and January 2013 RUC meetings. After reviewing the survey data, the consensus panel determined that for the ERCP code set, the incremental value above the base code for ERCP (43260) should be similar where possible to the analogous incremental value above the base codes for esophagoscopy and EGD previously approved.

## Discussion and Recommendation

**43274** Endoscopic retrograde cholangiopancreatography (ERCP); with placement of endoscopic stent into biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent

**We recommend an RVW of 8.74** for new code 43274.

**Pre-time Package 2b** is appropriate, with an additional 9 minutes for positioning the patient, endoscopy equipment/monitor, and anesthesia lines/equipment prior to and after induction MAC. The procedure is performed in the prone position on a fluoroscopy table. In addition, the recommended scrub, dress, wait time matches the survey median.

### Comparison to Key Ref 37221

Key reference code 37221 Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed although performed under moderate sedation, includes stent placement and balloon angioplasty and is therefore very similar to code 43274. Code 37221 may take more time intraoperatively because the work includes lower intensity imaging.

### Comparison To Other RUC-Reviewed Codes with ~68 Minutes Intra-Service Time

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2012	<b>52354</b>	Cystouretero w/biopsy	8.00	0.110	133	33	5	15	60	20

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2010	93461	R&I hrt art/ventricle angio	8.10	0.095	153	45	3	5	65	35
2011	36254	Ins cath ren art 2nd+ bilat	8.15	0.098	139	33	3	5	68	30
2010	37220	Iliac revasc	8.15	0.108	138	40	3	5	60	30
2008	52346	Cystouretero w/renal strict	8.58	0.116	140	40	10	10	60	20
	43274	ERCP; stent + pre-post dilation + spincterotomy	8.74	0.103	151	40	10	10	68	23
2003	59076	Fetal shunt placement w/us	8.99	0.114	165	60	30	15	60	
2000	34820	Xpose for endoprosth iliac	9.74	0.097	185	80			75	30
1997	58561	Hysteros remove myoma	9.99	0.112	145	40			75	30
2012	92920	Prq cardiac angioplast 1 art	10.10	0.127	137	33	1	5	68	30
2012	92937	Prq revasc byp graft 1 vsl	11.20	0.145	136	33	1	5	67	30
2012	92928	Prq card stent w/angio 1 vsl	11.21	0.128	145	33	1	5	76	30

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.  
☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.  
☐ Multiple codes allow flexibility to describe exactly what components the procedure included.  
☐ Multiple codes are used to maintain consistency with similar codes.  
☐ Historical precedents.  
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43274 = stent (43268) + sphincterotomy (43262) + 43271

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology

How often? Sometimes

Specialty

How often?

Specialty

How often?

Estimate the number of times this service might be provided nationally in a one-year period? 180000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare database 2011 stent (43268) = 36,493 + sphincterotomy (43262) = 40% \* 57,878 = 23,151 - TOTAL ~ 60,000 \* 3 = 180,000

Specialty Gastroenterology

Frequency 165000

Percentage 91.66 %

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?  
 36,493 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.  
 Please explain the rationale for this estimate. Medicare database 2011 stent (43268) = 36,493 additional reporting for other  
 services goes to savings

Specialty Gastroenterology	Frequency 33000	Percentage 90.42 %
----------------------------	-----------------	--------------------

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States?

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43268

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.



**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 64616	Tracking Number S2	Original Specialty Recommended RVU: <b>1.85</b>
		Presented Recommended RVU: <b>1.79</b>
Global Period: 000		RUC Recommended RVU: <b>1.79</b>

CPT Descriptor: Chemodenervation of muscle(s); neck muscle(s), excluding muscles of the larynx, unilateral (eg, for cervical dystonia, spasmodic torticollis)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 60-year-old female presents with a history of progressive involuntary head turn to the right associated with right tilt. The symptom is worse with certain activities and better if she touches her chin. She has significant neck and shoulder pain that interfere with her functioning and sleep. The exam is consistent with torticollis. Chemodenervation is recommended.

Percentage of Survey Respondents who found Vignette to be Typical: 99%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 6%

Description of Pre-Service Work: The medication is brought to room temperature and reconstituted with sterile saline by slowly injecting the diluents into the vial. The physician then gently mixes the toxin by rotating the vial. The drug is drawn into a syringe. The injection sites are cleaned using alcohol swabs and the neck is positioned for optimal medication delivery to the first injection site. The physician reviews the patient history, takes an interval history, reviews the patient's medications and allergies. The effect (e.g., benefit, duration of effect, any side effects) of any prior treatment is reviewed. To determine the muscles involved, a focused physical examination is performed. The patient is observed both at rest and walking to determine the pattern of torticollis (presence of anterocollis, tilt, turn and retrocollis along with any associated shoulder movements). Active and passive movements while palpating affected muscles are also used to determine injection sites. Optimal injection sites are determined and marked. Patient questions are answered and informed consent is obtained. The duration of expected treatment effect is discussed. A "time-out" is performed. The physician cleans the injection sites using alcohol swabs and puts on gloves

Description of Intra-Service Work: The toxin is injected. Injections are performed. Following the injection, pressure is held briefly to control any bleeding. The patients is then repositioned for each subsequent injection.

Description of Post-Service Work: Bandages are placed over injection sites. The expected results and follow-up plans are discussed with the patient. Drug accounting is completed. The procedure report is generated, reviewed, and signed

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)		01/2013				
Presenter(s):	Kevin Kerber, MD; Wayne Cornblath, MD; Janice Massey, MD					
Specialty(s):	American Academy of Neurology, American Association of Neuromuscular & Electrodiagnostic Medicine					
CPT Code:	64616					
Sample Size:	1093	Resp N:	80	Response: 7.3 %		
Description of Sample:	The societies used a combined a sample of members and physicians who indicated they perform the service.					
		Low	25 <sup>th</sup> pctl	Median*	75th pctl	High
Service Performance Rate		0.00	10.00	25.00	84.00	400.00
Survey RVW:		0.88	1.79	2.25	3.00	10.00
Pre-Service Evaluation Time:				10.00		
Pre-Service Positioning Time:				5.00		
Pre-Service Scrub, Dress, Wait Time:				5.00		
Intra-Service Time:		5.00	10.00	15.00	30.00	55.00
Immediate Post Service-Time:	5.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00		
Discharge Day Mgmt:	0.00	99238x 0.00	99239x 0.00	99217x 0.00		
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00	15x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00	
Sub Obs Care:	0.00	99224x 0.00	99225x 0.00	99226x 0.00		

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

5 - NF Procedure without sedation/anesthesia care

CPT Code:	64616	Recommended Physician Work RVU: 1.79					
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package		Adjustments/Recommended Pre-Service Time		
Pre-Service Evaluation Time:		10.00	7.00		3.00		
Pre-Service Positioning Time:		5.00	0.00		5.00		
Pre-Service Scrub, Dress, Wait Time:		0.00	0.00		0.00		
Intra-Service Time:		15.00					
Immediate Post Service-Time:	5.00						
Post Operative Visits	Total Min**	CPT Code and Number of Visits					
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00				
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.0	99239x 0.0	99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00	15x 0.00	
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00		
Sub Obs Care:	0.00	99224x 0.00	99225x 0.00	99226x 0.00			

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99244	XXX	3.02	RUC Time

CPT Descriptor Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
92004	XXX	1.82	RUC Time	2,151,572

CPT Descriptor 1 Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
64483	000	1.90	RUC Time	853,509

CPT Descriptor 2 Injection, anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code:** 20      **% of respondents:** 25.0 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 64616</b>	<b>Key Reference CPT Code: 99244</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	15.00	10.00	
Median Intra-Service Time	15.00	40.00	
Median Immediate Post-service Time	5.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>35.00</b>	<b>65.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.00	4.20
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.90	4.30
--	------	------

Urgency of medical decision making	3.60	3.90
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.85	4.15
--------------------------	------	------

Physical effort required	4.30	3.70
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.65	3.85
---	------	------

Outcome depends on the skill and judgment of physician	4.75	4.60
--	------	------

Estimated risk of malpractice suit with poor outcome	4.35	4.05
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.25	2.95
----------------------------------	------	------

Intra-Service intensity/complexity	4.55	4.30
------------------------------------	------	------

Post-Service intensity/complexity	2.75	3.10
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The existing code 64613 describes multiple uses of the procedure (for treatment of spasmodic dysphonia and spasmodic torticollis). We believe these two uses are separate and distinct and involve different levels of work and intensity when injecting the neck muscle versus injecting the larynx.

The new code that will primarily be reported by neurology is 64616: Chemodenervation of muscle(s); neck muscle(s), excluding muscles of the larynx, unilateral (eg, for cervical dystonia, spasmodic torticollis). Otolaryngology will primarily report code 64617. Previously one unit of 64613 was reported regardless of the number of sites that were injected. The new code will be reported the same way.

This was a strong survey with 80 responses and 99% agreement with the vignette. The median work RVU of 2.25 is higher than the existing RVU and the societies felt a slightly lower value would be appropriate. The societies recommend pre-service evaluation time of 10 minutes and 5 minutes of positioning time. The time required to mix the toxin and position the patient support the time beyond the standard 7 minutes in the selected pre-service package. Respondents rated 64616 as requiring more technical skill, physical effort and psychological stress than the key reference service 99244.

The societies recommend a work RVU of 1.85 for new CPT code 64616 which falls between the existing RVU of 2.01 and above the survey's 25<sup>th</sup> percentile for a physician work value of 1.79. Our recommended times are 15/15/5. We believe this recommendation is supported by the crosswalk code, 64615 which has a work RVU of 1.85 and the same times. 64615 is part of the same chemodenervation family and was valued in April of 2012.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64613

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology                      How often? Sometimes

Specialty PMR                              How often? Sometimes

Specialty                                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 174519

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This number is three times the 2011 medicare claims reporting data for 64613, which we feel accurately represents the national reporting of this code for one year.

Specialty Neurology	Frequency 139615	Percentage 79.99 %
---------------------	------------------	--------------------

Specialty PMR	Frequency 20942	Percentage 11.99 %
---------------	-----------------	--------------------

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 58,173 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We used 2011 Medicare claims data for 64613 to develop the following estimates; taking into consideration Otolaryngology will not report the new code, rather use 64613XX.

Specialty Neurology	Frequency 46538	Percentage 79.99 %
---------------------	-----------------	--------------------

Specialty Physical Medicine and Rehabilitation	Frequency 6900	Percentage 11.86 %
--	----------------	--------------------

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 64613

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43276      Tracking Number   EE9

Original Specialty Recommended RVU: **9.10**Presented Recommended RVU: **9.10**

Global Period: 000

RUC Recommended RVU: **9.10**

CPT Descriptor: Endoscopic retrograde cholangiopancreatography (ERCP); with removal and exchange of stent(s), biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent exchanged

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 70 year old patient with a history of biliary obstruction due to pancreatic carcinoma had undergone ERCP with placement of a 10Fr biliary stent 4 months prior. The patient now presents with pain, fever, abnormal laboratory tests (AST, ALT, alkaline phosphatase, total bilirubin, amylase) and jaundice. Imaging studies reveal dilation of the biliary duct. Therapeutic ERCP with removal of the previous stent and insertion of an expandable metallic stent is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 53%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 29%

Description of Pre-Service Work: Review with the patient any symptoms including dysphagia and sleep apnea. The patient's history is reviewed to assess past problems with sedation and the need for and timing of pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's imaging studies and other diagnostic tests are reviewed. The pre-service review is documented. The risks and benefits of the procedure and sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained. The physician verifies all endoscopic and imaging equipment is available, operational and appropriate imaging settings and computer entries are made. A time out is performed. The patient is positioned on the procedure table in the supine position. A patient support pad is positioned on the fluoroscopy table and the patient's positioning is adjusted. The endoscopic, imaging and sedation monitoring equipment is positioned to provide access for the procedure. Appropriate protective attire and shielding are applied and verification that all others in the suite are properly protected including the patient. The patient is rolled to the left side and sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide when indicated, and sequential non-invasive blood pressure measurements. A bite block is placed in the mouth. The patient is repositioned in the prone position.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible side viewing upper endoscope is inserted into the mouth into the oropharynx and blindly advanced through the esophagus into the stomach. The stomach is insufflated with air after suctioning liquid contents. Examination of the entire stomach in the forward and retroflexed positions is performed. The endoscope is advanced through the pylorus into the duodenal bulb. Circumferential inspection of the duodenum is performed after air insufflation. Next the instrument is advanced into the second portion of the duodenum. The ampulla of Vater with the stent is identified and examined. The endoscope is positioned for stent retrieval. If required, antiperistaltic medications are administered intravenously. A stent retrieval device is placed through the endoscope and under direct vision is used to grasp the stent. The stent is brought out through the endoscope channel or with the endoscope which is withdrawn through the mouth, extracting the stent from the patient requiring the side viewing endoscope be inserted. The endoscope is positioned for cannulation of the ampulla. The ampulla is cannulated, and the catheter is directed into the duct(s) of clinical interest (common bile duct and/or pancreatic duct). Contrast material is injected into the cannula. A cholangiogram and/or pancreatogram is obtained under fluoroscopic guidance. A guidewire is introduced into the cannulating catheter through the endoscope and into the duct. If indicated, a sphincterotome is properly positioned across the sphincter. The sphincter is incised using electrocautery current in the appropriate orientation until the sphincter muscle fibers are divided and the opening is appropriately sized. Contrast material is injected into the sphincterotome. Another cholangiogram and/or pancreatogram is obtained under fluoroscopic guidance and reviewed for abnormalities. The sphincterotome is withdrawn through the endoscope. The stricture may be dilated prior to stent insertion with graded dilators or pneumatic balloon dilators inserted over the guidewire. A suitable length stent is chosen so that the proximal flap of the stent lies about 1 cm above the obstruction; if necessary the guidewire is retracted between the two points and the distance traveled on the outside of the catheter is measured. The stent is directed over the guidewire and then positioned through the obstruction. The stent is deployed using endoscopic and fluoroscopic guidance. Bile is seen draining through the stent into the duodenum. The guidewire and introducer are removed. Contrast material is injected. A cholangiogram and/or pancreatogram is obtained under fluoroscopic guidance to confirm positioning. Radiographic images are reviewed. The endoscope is withdrawn into the stomach to allow examination of the gastric fundus and the remainder of the gastric mucosa. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. At the conclusion of the procedure, the endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. The patient is assessed for physical signs and symptoms suggestive of complications, including abdominal pain, nausea/vomiting, respiratory distress, and fever. Radiographic images are reviewed with the technologist for entry into the image storing system. Post procedure orders are completed and discussed with staff. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to the referral source and other appropriate parties. Data is entered into the procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others including a discussion regarding potential procedure complications including recognizing and managing stent occlusion. Restrictions, prescriptions, follow-up tests, instructions and appointments are provided to the patient and pertinent others.



**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2012				
<b>Presenter(s):</b>	Dr. Nicholas Nickl (ASGE), Dr. Edward Bentley (ASGE), Dr. Joel Brill (AGA), Dr. Shivan Mehta (AGA), Dr. Bruce Cameron (ACG)				
<b>Specialty(s):</b>	ASGE, AGA, ACG				
<b>CPT Code:</b>	43276				
<b>Sample Size:</b>	952	<b>Resp N:</b>	48	<b>Response:</b> 5.0 %	
<b>Description of Sample:</b>	The ACG, AGA and ASGE conducted an enhanced random sample as approved by the Research Subcommittee. The sampling methodology was a random sample of member gastroenterologists with the addition of physicians identified by industry as performers of ERCP procedures and survey volunteers who responded to educational articles and identified themselves as ERCP performers.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	10.00	<b>25.00</b>	56.00	200.00
<b>Survey RVW:</b>	3.50	6.95	<b>9.88</b>	11.25	30.52
<b>Pre-Service Evaluation Time:</b>			<b>48.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>10.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>10.00</b>		
<b>Intra-Service Time:</b>	15.00	60.00	<b>60.00</b>	76.00	180.00
<b>Immediate Post Service-Time:</b>	<b>25.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	43276	<b>Recommended Physician Work RVU: 9.10</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>33.00</b>	<b>33.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>10.00</b>	<b>1.00</b>	<b>9.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>5.00</b>	<b>5.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>60.00</b>		
<b>Immediate Post Service-Time:</b>	<b>25.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		

Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31638	000	4.88	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 10      % of respondents: 20.8 %

**TIME ESTIMATES (Median)**

	CPT Code: 43276	Key Reference CPT Code: 31638	Source of Time RUC Time
Median Pre-Service Time	48.00	50.00	
Median Intra-Service Time	60.00	60.00	
Median Immediate Post-service Time	25.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>133.00</b>	<b>140.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.20	4.00
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	4.00
--	------	------

Urgency of medical decision making	4.30	3.90
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.80	4.30
--------------------------	------	------

Physical effort required	4.50	4.30
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.70	4.20
---	------	------

Outcome depends on the skill and judgment of physician	4.60	4.20
--	------	------

Estimated risk of malpractice suit with poor outcome	4.60	4.20
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.00	4.00
----------------------------------	------	------

Intra-Service intensity/complexity	4.40	4.30
------------------------------------	------	------

Post-Service intensity/complexity	3.90	3.90
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

## Background

Code 43262 was identified for the Fourth Five-Year Review through CMS and RUC screens as potentially misvalued through the Harvard valued utilization over 30,000 frequency screen. The code was presented to the RUC at the October 2010 meeting. The RUC reviewed the service and believed that the GI specialties did not provide compelling evidence to change the current value of the service. Therefore, the RUC recommended maintaining the current work RVU of 7.38 for CPT code 43262. CMS maintained the current work RVU of 7.38 and the current physician time for CPT code 43262 for CY 2012. However, CMS requested that the RUC undertake a comprehensive review of the entire family of ERCP codes, including the base CPT code 43260, and provide CMS with work RVU recommendations.

The specialties agreed to survey the entire family of codes (43260-43273). In review of this family of codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In January 2013, the CPT Editorial Panel approved revised guidelines along with revision, addition, and deletion of codes within the ERCP code set.

## Overview of ERCP Family RVW Recommendations

The specialty consensus panel spent a significant amount of time reviewing the survey data for the current set of ERCP codes, comparing the data and values with the esophagoscopy codes (43200-43228) and EGD codes (43235-43259) that were approved by the RUC at the October 2012 and January 2013 RUC meetings. After reviewing the survey data, the consensus panel determined that for the ERCP code set, the incremental value above the base code for ERCP (43260) should be similar where possible to the analogous incremental value above the base codes for esophagoscopy and EGD previously approved.

## Discussion and Recommendation

**43276** Endoscopic retrograde cholangiopancreatography (ERCP); with removal and exchange of stent(s), biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent exchanged

**We recommend an RVW of 9.10.** This value is equal to the increment of 2.14 approved by the RUC for endoscopic stent with pre- and post-dilation for esophagoscopy code pair 43200/43204 and EGD code pair 43235/43268 plus the recommendation for ERCP stent removal (43275) ( $6.96+2.14=9.10$ ) (ie, valuing the increment).

**Pre-time Package 2b** is appropriate, with an additional 9 minutes for positioning the patient, endoscopy equipment/monitor, and anesthesia lines/equipment prior to and after induction MAC. The procedure is performed in the prone position on a fluoroscopy table. In addition, the recommended scrub, dress, wait time matches the survey median.

### Comparison to Key Ref 31638

Key Reference code 31638 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required)* includes lower intensity fluoroscopic guidance which increases the intra-service time, but at lower intensity.

### Comparison To Other RUC-Reviewed Codes with ~60 Minutes Intra-Service Time

	CPT	DESC	RVW	IWP/UT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2008	<b>52345</b>	Cysto/uretero w/up stricture	7.55	0.128	135	45	10	15	45	20
2012	<b>52354</b>	Cystouretero w/biopsy	8.00	0.110	133	33	5	15	60	20

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2010	37220	Iliac revasc	8.15	0.108	138	40	3	5	60	30
2008	52346	Cystouretero w/renal strict	8.58	0.116	140	40	10	10	60	20
2003	59072	Umbilical cord occlud w/us	8.99	0.110	175	40	30	15	60	30
2003	59076	Fetal shunt placement w/us	8.99	0.114	165	60	30	15	60	
	43276	ERCP; stent removal & exchange, biliary/pancreatic duct	9.10	0.122	145	40	10	10	60	25
2000	34820	Xpose for endoprosth iliac	9.74	0.097	185	80			75	30
1997	58561	Hysteros remove myoma	9.99	0.112	145	40			75	30
2012	92920	Prq cardiac angioplast 1 art	10.10	0.127	137	33	1	5	68	30
2012	92937	Prq revasc byp graft 1 vsl	11.20	0.145	136	33	1	5	67	30

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.  
☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.  
☐ Multiple codes allow flexibility to describe exactly what components the procedure included.  
☐ Multiple codes are used to maintain consistency with similar codes.  
☐ Historical precedents.  
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43269 + 43262 + 43271

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology

How often? Sometimes

Specialty

How often?

Specialty

How often?

Estimate the number of times this service might be provided nationally in a one-year period? 75000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare database 2011 stent (43269) 20,375 \*65% + sphincterotomy (43262) = 20% \* 57,878 = 11,576 - TOTAL ~ 25,000 \* 3 = 75,000

Specialty Gastroenterology

Frequency 69000

Percentage 92.00 %

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 8,150  
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare database 2011 stent (43269) 20,375 \*40% other components go to savings

Specialty Gastroenterology	Frequency 23000	Percentage 92.00 %
----------------------------	-----------------	--------------------

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States?

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43269

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:43277      Tracking Number   EE10

Original Specialty Recommended RVU: **7.11**Presented Recommended RVU: **7.11**

Global Period: 000

RUC Recommended RVU: **7.11**

CPT Descriptor: Endoscopic retrograde cholangiopancreatography (ERCP); with trans-endoscopic balloon dilation of biliary/pancreatic duct(s) or of ampulla (sphincteroplasty), including sphincterotomy, when performed, each duct

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 70-year-old presents with abdominal pain, abnormal laboratory tests (AST, ALT, alkaline phosphatase, total bilirubin, amylase) and jaundice. Imaging studies reveal dilation of the biliary duct and a large common bile duct stone. Therapeutic ERCP with sphincterotomy and sphincteroplasty and removal of the stone (reported separately with 43264) is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 50%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Review with the patient any symptoms including dysphagia and sleep apnea. The patient's history is reviewed to assess past problems with sedation and the need for and timing of pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's imaging studies and other diagnostic tests are reviewed. The pre-service review is documented. The risks and benefits of the procedure and sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained. The physician verifies all endoscopic and imaging equipment is available, operational and appropriate imaging settings and computer entries are made. A time out is performed. The patient is positioned on the procedure table in the supine position. A patient support pad is positioned on the fluoroscopy table and the patient's positioning is adjusted. The endoscopic, imaging and sedation monitoring equipment is positioned to provide access for the procedure. Appropriate protective attire and shielding are applied and verification that all others in the suite are properly protected including the patient. The patient is rolled to the left side and sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide when indicated, and sequential non-invasive blood pressure measurements. A bite block is placed in the mouth. The patient is repositioned in the prone position.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible side viewing upper endoscope is inserted into the mouth into the oropharynx and blindly advanced through the esophagus

into the stomach. The stomach is insufflated with air after suctioning liquid contents. Examination of the entire stomach in the forward and retroflexed positions is performed. The endoscope is advanced through the pylorus into the duodenal bulb. Circumferential inspection of the duodenum is performed after air insufflation. Next the instrument is advanced into the second portion of the duodenum. The ampulla of Vater is identified and examined. The endoscope is positioned for cannulation of the ampulla. If required, antiperistaltic medications are administered intravenously. Additional sedation is administered as required to maintain adequate sedation throughout the procedure. The ampulla is cannulated, and the catheter is directed into the duct(s) of clinical interest (common bile duct and/or pancreatic duct). Contrast material is injected into the cannula. A cholangiogram and/or pancreatogram is obtained under fluoroscopic guidance and reviewed for abnormalities. If indicated, washing or brushings of suspicious abnormalities in the common bile duct and/or pancreatic duct are obtained. A guidewire is introduced into the cannulating catheter through the endoscope and into the duct. Under direct visualization, a sphincterotome is properly positioned across the sphincter. The sphincter is incised using electrocautery current in the appropriate orientation until the sphincter muscle fibers are divided and the opening is appropriately sized. Contrast material is injected into the sphincterotome. Another cholangiogram and/or pancreatogram is obtained under fluoroscopic guidance and reviewed for abnormalities. The sphincterotome is withdrawn through the endoscope. A dilating balloon is passed over the guidewire and through the endoscope. Under direct visualization, the balloon is passed into the duct. The dilating balloon is positioned so that the stricture lies at the midpoint of the balloon; radiopaque markers are viewed under fluoroscopy to position the balloon. The balloon is then inflated with dilute (10%) contrast and the pressure adjusted according to the type of balloon and manufacturer's recommendation. The dilation is performed under fluoroscopy and a waist is seen at the midpoint of the balloon upon inflating the balloon. Effective dilation is achieved when the waist disappears. The balloon is kept inflated for 30–60 sec and then deflated. The balloon is then re-inflated, noting the opening pressure when the waist disappears on the balloon. With successful dilation the opening pressure should be lower with repeat dilation. The balloon is then completely deflated, the guidewire removed and contrast injected while the balloon catheter is pulled back to assess the effect of dilation. A cholangiogram and/or pancreatogram is obtained under fluoroscopic guidance to confirm dilation of the stricture. Radiographic images are reviewed. The endoscope is withdrawn into the stomach to allow examination of the gastric fundus and the remainder of the gastric mucosa. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. At the conclusion of the procedure, the endoscope is withdrawn.

**Description of Post-Service Work:** The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. The patient is assessed for physical signs and symptoms suggestive of complications, including abdominal pain, nausea/vomiting, respiratory distress, and bleeding. Radiographic images are reviewed with the technologist for entry into the image storing system. Post procedure orders are completed and discussed with staff. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to the referral source and other appropriate parties. Data are entered into the procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others including a discussion regarding potential procedure complications. Restrictions, prescriptions, follow-up tests, instructions and appointments are provided to the patient and pertinent others.



**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2012				
<b>Presenter(s):</b>	Dr. Nicholas Nickl (ASGE), Dr. Edward Bentley (ASGE), Dr. Joel Brill (AGA), Dr. Shivan Mehta (AGA), Dr. Bruce Cameron (ACG)				
<b>Specialty(s):</b>	ASGE, AGA, ACG				
<b>CPT Code:</b>	43277				
<b>Sample Size:</b>	952	<b>Resp N:</b>	47	<b>Response:</b> 4.9 %	
<b>Description of Sample:</b>	The ACG, AGA and ASGE conducted an enhanced random sample as approved by the Research Subcommittee. The sampling methodology was a random sample of member gastroenterologists with the addition of physicians identified by industry as performers of ERCP procedures and survey volunteers who responded to educational articles and identified themselves as ERCP performers.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	7.00	20.00	35.00	175.00
<b>Survey RVW:</b>	3.60	7.00	10.00	11.50	28.34
<b>Pre-Service Evaluation Time:</b>			50.00		
<b>Pre-Service Positioning Time:</b>			10.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10.00		
<b>Intra-Service Time:</b>	15.00	60.00	70.00	75.00	150.00
<b>Immediate Post Service-Time:</b>	<b>25.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

**Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:** 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	43277	<b>Recommended Physician Work RVU: 7.11</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		33.00	33.00	0.00
<b>Pre-Service Positioning Time:</b>		10.00	1.00	9.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00
<b>Intra-Service Time:</b>		70.00		
<b>Immediate Post Service-Time:</b>	<b>25.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		

Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31638	000	4.88	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 6      % of respondents: 12.7 %

**TIME ESTIMATES (Median)**

	CPT Code: 43277	Key Reference CPT Code: 31638	Source of Time RUC Time
Median Pre-Service Time	48.00	50.00	
Median Intra-Service Time	70.00	60.00	
Median Immediate Post-service Time	25.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>143.00</b>	<b>140.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.50	4.17
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.50	4.17
--	------	------

Urgency of medical decision making	4.33	4.00
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	5.00	4.33
--------------------------	------	------

Physical effort required	4.50	4.33
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	5.00	4.17
---	------	------

Outcome depends on the skill and judgment of physician	4.67	4.17
--	------	------

Estimated risk of malpractice suit with poor outcome	4.83	4.33
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.33	3.83
----------------------------------	------	------

Intra-Service intensity/complexity	4.67	4.00
------------------------------------	------	------

Post-Service intensity/complexity	4.00	3.67
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

## Background

Code 43262 was identified for the Fourth Five-Year Review through CMS and RUC screens as potentially misvalued through the Harvard valued utilization over 30,000 frequency screen. The code was presented to the RUC at the October 2010 meeting. The RUC reviewed the service and believed that the GI specialties did not provide compelling evidence to change the current value of the service. Therefore, the RUC recommended maintaining the current work RVU of 7.38 for CPT code 43262. CMS maintained the current work RVU of 7.38 and the current physician time for CPT code 43262 for CY 2012. However, CMS requested that the RUC undertake a comprehensive review of the entire family of ERCP codes, including the base CPT code 43260, and provide CMS with work RVU recommendations.

The specialties agreed to survey the entire family of codes (43260-43273). In review of this family of codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In January 2013, the CPT Editorial Panel approved revised guidelines along with revision, addition, and deletion of codes within the ERCP code set.

## Overview of ERCP Family RVW Recommendations

The specialty consensus panel spent a significant amount of time reviewing the survey data for the current set of ERCP codes, comparing the data and values with the esophagoscopy codes (43200-43228) and EGD codes (43235-43259) that were approved by the RUC at the October 2012 and January 2013 RUC meetings. After reviewing the survey data, the consensus panel determined that for the ERCP code set, the incremental value above the base code for ERCP (43260) should be similar where possible to the analogous incremental value above the base codes for esophagoscopy and EGD previously approved.

## Discussion and Recommendation

**43277** Endoscopic retrograde cholangiopancreatography (ERCP); with trans-endoscopic balloon dilation of biliary/pancreatic duct(s) or of ampulla (sphincteroplasty), including sphincterotomy, when performed, each duct

**We recommend an RVW of 7.11.** This value is equal to the increment of 0.51 approved by the RUC for balloon dilation for esophagoscopy code pair 43200/43220 and EGD code pair 43235/43249 plus the recommendation for ERCP with sphincterotomy 43262 ( $6.60 + 0.51 = 7.11$ ).

**Pre-time Package 2b** is appropriate, with an additional 9 minutes for positioning the patient, endoscopy equipment/monitor, and anesthesia lines/equipment prior to and after induction MAC. The procedure is performed in the prone position on a fluoroscopy table. In addition, the recommended scrub, dress, wait time matches the survey median.

### Comparison to Key Ref 31638

Key Reference code 31638 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required)* includes lower intensity fluoroscopic guidance which increases the intra-service time, but at lower intensity.

### Comparison To Other RUC-Reviewed Codes with 50-60 Minutes Intra-Service Time

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2012	<b>52240</b>	Cystoscopy and treatment	7.50	0.101	133	33	5	15	60	20
2011	<b>36253</b>	Ins cath ren art 2nd+ unilat	7.55	0.101	131	33	3	5	60	30
2008	<b>52345</b>	Cysto/uretero w/up stricture	7.55	0.128	135	45	10	15	45	20

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2012	<b>37211</b>	Thrombolytic art therapy	8.00	0.105	138	40	3	5	60	30
2012	<b>52354</b>	Cystouretero w/biopsy	8.00	0.110	133	33	5	15	60	20
2010	<b>93461</b>	R&I hrt art/ventricle angio	8.10	0.095	153	45	3	5	65	35
2011	<b>36254</b>	Ins cath ren art 2nd+ bilat	8.15	0.098	139	33	3	5	68	30
2010	<b>37220</b>	Iliac revasc	8.15	0.108	138	40	3	5	60	30
2008	<b>52346</b>	Cystouretero w/renal strict	8.58	0.116	140	40	10	10	60	20
	<b>43277</b>	ERCP, balloon dilation sprincteroplasty/-otomy	7.11	0.076	155	40	10	10	70	25
1994	<b>31276</b>	Sinus endoscopy surgical	8.84	0.100	135	30			75	30
2003	<b>59072</b>	Umbilical cord occlud w/us	8.99	0.110	175	40	30	15	60	30
2003	<b>59076</b>	Fetal shunt placement w/us	8.99	0.114	165	60	30	15	60	
2000	<b>34820</b>	Xpose for endoprosth iliac	9.74	0.097	185	80			75	30
1997	<b>58561</b>	Hysteros remove myoma	9.99	0.112	145	40			75	30
2012	<b>92920</b>	Prq cardiac angioplast 1 art	10.10	0.127	137	33	1	5	68	30
2012	<b>92937</b>	Prq revasc byp graft 1 vsl	11.20	0.145	136	33	1	5	67	30
2012	<b>92928</b>	Prq card stent w/angio 1 vsl	11.21	0.128	145	33	1	5	76	30

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43262 + 43271

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 54000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare data base 2011, 43271 = 12,486 + sphincterotomy (43262) = 10% \* 57,878 = 5,788 - TOTAL ~ 18,000 \* 3 = 54,000

Specialty Gastroenterology	Frequency 51000	Percentage 94.44 %
----------------------------	-----------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 5,788

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare data base 2011, 43262 = 57,878 \*10%

Specialty Gastroenterology	Frequency 5500	Percentage 95.02 %
----------------------------	----------------	--------------------

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States?

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 43271

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43278      Tracking Number   EE11

Original Specialty Recommended RVU: **8.08**Presented Recommended RVU: **8.08**

Global Period: 000

RUC Recommended RVU: **8.08**

CPT Descriptor: Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s), including pre- and post-dilation and guide wire passage, when performed

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 70-year-old patient presents with a history of recurrent pancreatitis and abnormal laboratory tests (AST, ALT, alkaline phosphatase, amylase). Imaging studies are suggestive of a lesion at the ampulla of Vater. Therapeutic ERCP with ablation of the ampullary mass is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 50%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Review with the patient any symptoms including dysphagia and sleep apnea. The patient's history is reviewed to assess past problems with sedation and the need for and timing of pre-procedure antibiotics or contrast allergy prophylaxis. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment, Mallampati score, and cardiopulmonary and abdominal evaluation is performed; an ASA physical status classification is assigned. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's imaging studies and other diagnostic tests are reviewed. The pre-service review is documented. The risks and benefits of the procedure and sedation are reviewed with the patient; informed consent for both the procedure and sedation is obtained. The physician verifies all endoscopic, ablation and imaging equipment is available, operational and appropriate imaging settings and computer entries are made. A time out is performed. The patient is positioned on the procedure table in the supine position. A patient support pad is positioned on the fluoroscopy table and the patient's positioning is adjusted. The endoscopic, ablation, imaging and sedation monitoring equipment is positioned to provide access for the procedure. Appropriate protective attire and shielding are applied and verification that all others in the suite are properly protected including the patient. The patient is rolled to the left side and sedation is administered to the patient while continuously monitoring pulse oximetry, carbon dioxide when indicated, and sequential non-invasive blood pressure measurements. A bite block is placed in the mouth. The patient is repositioned in the prone position.

Description of Intra-Service Work: The level of sedation is assessed prior to inserting the endoscope. A standard flexible side viewing upper endoscope is inserted into the mouth into the oropharynx and blindly advanced through the esophagus

into the stomach. The stomach is insufflated with air after suctioning liquid contents. Examination of the entire stomach in the forward and retroflexed positions is performed. The endoscope is advanced through the pylorus into the duodenal bulb. Circumferential inspection of the duodenum is performed after air insufflation. Next the instrument is advanced into the second portion of the duodenum. The ampulla of Vater is identified and examined. The endoscope is positioned for cannulation of the ampulla. If required, antiperistaltic medications are administered intravenously. The ampulla is cannulated, and the catheter is directed into the duct(s) of clinical interest (common bile duct and/or pancreatic duct). Contrast material is injected into the cannula. A cholangiogram and/or pancreatogram is obtained under fluoroscopic guidance and reviewed for abnormalities. If indicated, washing or brushings of suspicious abnormalities in the common bile duct and/or pancreatic duct are obtained. A guidewire is introduced into the cannulating catheter through the endoscope and into the duct. If necessary, the appropriate area may be dilated with graded dilators or pneumatic balloon dilators inserted over the guidewire. A therapeutic ablation catheter is passed into the endoscope to the abnormal area. Ablation of the lesion proceeds under direct visualization. The process is repeated until the lesion has been ablated. A cholangiogram and/or pancreatogram is obtained under fluoroscopic guidance. Radiographic images are reviewed. The endoscope is withdrawn into the stomach to allow examination of the gastric fundus and the remainder of the gastric mucosa. Photodocumentation of appropriate normal landmarks and abnormalities is obtained. At the conclusion of the procedure, the endoscope is withdrawn.

Description of Post-Service Work: The patient's condition including post-procedure vital signs is assessed. When the patient has reached a suitable level of consciousness, the patient is transferred to the observation area. The patient is assessed for physical signs and symptoms suggestive of complications, including abdominal pain, nausea/vomiting, respiratory distress, and bleeding. Radiographic images are reviewed with the technologist for entry into the image storing system. Post procedure orders are completed and discussed with staff. Cytology forms are completed if pertinent; post procedure specimen verification and documentation and reporting for quality purposes are completed. Photographs are reviewed and labeled. A procedure report is generated and forwarded to the referral source and other appropriate parties. Data are entered into the procedure registry. The patient is assessed for suitability to discharge from the recovery suite relative to established discharge criteria. When stable for discharge, the findings and recommendations are reviewed with the patient and pertinent others including a discussion regarding potential procedure complications. Restrictions, prescriptions, follow-up tests, instructions and appointments are provided to the patient and pertinent others.



**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2012				
<b>Presenter(s):</b>	Dr. Nicholas Nickl (ASGE), Dr. Edward Bentley (ASGE), Dr. Joel Brill (AGA), Dr. Shivan Mehta (AGA), Dr. Bruce Cameron (ACG)				
<b>Specialty(s):</b>	ASGE, AGA, ACG				
<b>CPT Code:</b>	43278				
<b>Sample Size:</b>	945	<b>Resp N:</b>	40	<b>Response:</b> 4.2 %	
<b>Description of Sample:</b>	The ACG, AGA and ASGE conducted an enhanced random sample as approved by the Research Subcommittee. The sampling methodology was a random sample of member gastroenterologists with the addition of physicians identified by industry as performers of ERCP procedures and survey volunteers who responded to educational articles and identified themselves as ERCP performers.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	1.00	5.00	16.00	225.00
<b>Survey RVW:</b>	5.00	8.38	11.00	12.20	30.52
<b>Pre-Service Evaluation Time:</b>			50.00		
<b>Pre-Service Positioning Time:</b>			10.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10.00		
<b>Intra-Service Time:</b>	30.00	64.00	75.00	90.00	180.00
<b>Immediate Post Service-Time:</b>	<b>30.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	43278	<b>Recommended Physician Work RVU: 8.08</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		33.00	33.00	0.00
<b>Pre-Service Positioning Time:</b>		10.00	1.00	9.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00
<b>Intra-Service Time:</b>		75.00		
<b>Immediate Post Service-Time:</b>	<b>30.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		

Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
37225	000	12.00	RUC Time

CPT Descriptor Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 8      % of respondents: 20.0 %

**TIME ESTIMATES (Median)**

	CPT Code: 43278	Key Reference CPT Code: 37225	Source of Time RUC Time
Median Pre-Service Time	48.00	48.00	
Median Intra-Service Time	75.00	118.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>153.00</b>	<b>196.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.57	4.14
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.86	4.14
--	------	------

Urgency of medical decision making	4.43	4.57
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	5.00	4.86
--------------------------	------	------

Physical effort required	5.00	4.86
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	5.00	4.86
---	------	------

Outcome depends on the skill and judgment of physician	5.00	4.57
--	------	------

Estimated risk of malpractice suit with poor outcome	4.86	4.71
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.57	4.14
----------------------------------	------	------

Intra-Service intensity/complexity	5.00	4.71
------------------------------------	------	------

Post-Service intensity/complexity	4.43	4.14
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

## Background

Code 43262 was identified for the Fourth Five-Year Review through CMS and RUC screens as potentially misvalued through the Harvard valued utilization over 30,000 frequency screen. The code was presented to the RUC at the October 2010 meeting. The RUC reviewed the service and believed that the GI specialties did not provide compelling evidence to change the current value of the service. Therefore, the RUC recommended maintaining the current work RVU of 7.38 for CPT code 43262. CMS maintained the current work RVU of 7.38 and the current physician time for CPT code 43262 for CY 2012. However, CMS requested that the RUC undertake a comprehensive review of the entire family of ERCP codes, including the base CPT code 43260, and provide CMS with work RVU recommendations.

The specialties agreed to survey the entire family of codes (43260-43273). In review of this family of codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In January 2013, the CPT Editorial Panel approved revised guidelines along with revision, addition, and deletion of codes within the ERCP code set.

## Overview of ERCP Family RVW Recommendations

The specialty consensus panel spent a significant amount of time reviewing the survey data for the current set of ERCP codes, comparing the data and values with the esophagoscopy codes (43200-43228) and EGD codes (43235-43259) that were approved by the RUC at the October 2012 and January 2013 RUC meetings. After reviewing the survey data, the consensus panel determined that for the ERCP code set, the incremental value above the base code for ERCP (43260) should be similar where possible to the analogous incremental value above the base codes for esophagoscopy and EGD previously approved.

## Discussion and Recommendation

**43278** Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s), including pre- and post-dilation and guide wire passage, when performed

**We recommend an RVW of 8.08.** This value is equal to the increment of 2.13 approved by the RUC for ablation for the esophagoscopy code pair 43200/432X5 plus the recommendation for ERCP 43260 (5.95 + 2.13= 8.08).

**Pre-time Package 2b** is appropriate, with an additional 9 minutes for positioning the patient, endoscopy equipment/monitor, and anesthesia lines/equipment prior to and after induction MAC. The procedure is performed in the prone position on a fluoroscopy table. In addition, the recommended scrub, dress, wait time matches the survey median.

### Comparison to Key Ref 37225

Key Reference code 37225 *Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed* was chosen most often, but only 8 times, and does not compare well with 4327X8. Several other reference codes were also chosen often and this is reflected in the wide variation of work estimate.

### Comparison To Other RUC-Reviewed Codes with ~70 Minutes Intra-Service Time

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2012	<b>52240</b>	Cystoscopy and treatment	7.50	0.101	133	33	5	15	60	20
2011	<b>36253</b>	Ins cath ren art 2nd+ unilat	7.55	0.101	131	33	3	5	60	30
2008	<b>52345</b>	Cysto/uretero w/up stricture	7.55	0.128	135	45	10	15	45	20

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2012	37211	Thrombolytic art therapy	8.00	0.105	138	40	3	5	60	30
2012	52354	Cystouretero w/biopsy	8.00	0.110	133	33	5	15	60	20
	43278	ERCP; ablation (pre&post dilation)	8.08	0.083	165	40	10	10	75	30
2010	93461	R&I hrt art/ventricle angio	8.10	0.095	153	45	3	5	65	35
2011	36254	Ins cath ren art 2nd+ bilat	8.15	0.098	139	33	3	5	68	30
2010	37220	Iliac revasc	8.15	0.108	138	40	3	5	60	30
1994	31276	Sinus endoscopy surgical	8.84	0.100	135	30			75	30
2003	59072	Umbilical cord occlud w/us	8.99	0.110	175	40	30	15	60	30
2000	34820	Xpose for endoprosth iliac	9.74	0.097	185	80			75	30

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.  
☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.  
☐ Multiple codes allow flexibility to describe exactly what components the procedure included.  
☐ Multiple codes are used to maintain consistency with similar codes.  
☐ Historical precedents.  
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43271+ 43272

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 900

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare data base 302 in 2011

Specialty Gastroenterology Frequency 880 Percentage 97.77 %

Specialty Frequency 0 Percentage 0.00 %

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 300  
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare data base for 2011 for CPT code 43271 = 12,486 \* 25%, 43272 goes to savings

Specialty Gastroenterology	Frequency 290	Percentage 96.66 %
----------------------------	---------------	--------------------

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States?

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43272

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 43273      Tracking Number   EE12

Original Specialty Recommended RVU: **2.24**Presented Recommended RVU: **2.24**

Global Period: ZZZ

RUC Recommended RVU: **2.24**

CPT Descriptor: Endoscopic cannulation of papilla with direct visualization of pancreatic/common bile duct(s) (List separately in addition to code(s) for primary procedure)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 72-year-old patient presents with abdominal pain, jaundice and abnormal laboratory tests (AST, ALT, alkaline phosphatase, total bilirubin, amylase). Imaging studies reveal the presence of a stricture in the common hepatic duct with proximal dilation, suggestive of a cholangiocarcinoma. After diagnostic ERCP is performed, direct pancreato-choledochoscopy is performed to visualize and evaluate the lesion.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 47%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 2%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: The cholangioscope is passed through the duodenoscope and into the biliary tree. Direct visualization is performed with careful inspection of the biliary and pancreatic epithelium. Multiple biopsies are taken of any suspicious lesions. The right and left intrahepatic biliary tree, common hepatic duct and common bile duct are all viewed. The cholangioscope is then withdrawn and passed into the pancreatic duct. The pancreatic duct is viewed. When clinically indicated, biopsy(ies) and/or cytology samples are taken from appropriate areas.

At conclusion of the procedure, the cholangioscope is withdrawn. The physician proceeds with the remainder of the ERCP procedure.

Description of Post-Service Work: N/A

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2012				
<b>Presenter(s):</b>	Dr. Nicholas Nickl (ASGE), Dr. Edward Bentley (ASGE), Dr. Joel Brill (AGA), Dr. Shivan Metha (AGA), Dr. Bruce Cameron (ACG)				
<b>Specialty(s):</b>	ASGE, AGA, ACG				
<b>CPT Code:</b>	43273				
<b>Sample Size:</b>	951	<b>Resp N:</b>	47	<b>Response:</b> 4.9 %	
<b>Description of Sample:</b>	The ACG, AGA and ASGE conducted an enhanced random sample as approved by the Research Subcommittee. The sampling methodology was a random sample of member gastroenterologists with the addition of physicians identified by industry as performers of ERCP procedures and survey volunteers who responded to educational articles and identified themselves as ERCP performers.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	1.00	5.00	20.00	100.00
<b>Survey RVW:</b>	2.00	2.70	4.00	6.60	15.00
<b>Pre-Service Evaluation Time:</b>			0.00		
<b>Pre-Service Positioning Time:</b>			0.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.00		
<b>Intra-Service Time:</b>	15.00	30.00	30.00	63.00	150.00
<b>Immediate Post Service-Time:</b>	<u>0.00</u>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

ZZZ Global Code

<b>CPT Code:</b>	43273	<b>Recommended Physician Work RVU: 2.24</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		0.00	0.00	0.00
<b>Pre-Service Positioning Time:</b>		0.00	0.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	0.00	0.00
<b>Intra-Service Time:</b>		30.00		
<b>Immediate Post Service-Time:</b>	<u>0.00</u>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.0 99239x 0.0 99217x 0.00		



Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31627	000	2.00	RUC Time

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with computer-assisted, image-guided navigation (List separately in addition to code for primary procedure[s])

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 19      % of respondents: 40.4 %

**TIME ESTIMATES (Median)**

	CPT Code: 43273	Key Reference CPT Code: 31627	Source of Time RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	30.00	60.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	

Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>30.00</b>	<b>60.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.53	3.79
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.63	4.00
--	------	------

Urgency of medical decision making	4.37	3.79
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.95	3.89
--------------------------	------	------

Physical effort required	4.84	3.74
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.63	3.68
---	------	------

Outcome depends on the skill and judgment of physician	4.53	3.84
--	------	------

Estimated risk of malpractice suit with poor outcome	4.42	3.68
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.89	3.26
----------------------------------	------	------

Intra-Service intensity/complexity	4.63	3.68
------------------------------------	------	------

Post-Service intensity/complexity	3.79	3.37
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

## Background

Code 43262 was identified for the Fourth Five-Year Review through CMS and RUC screens as potentially misvalued through the Harvard valued utilization over 30,000 frequency screen. The code was presented to the RUC at the October 2010 meeting. The RUC reviewed the service and believed that the GI specialties did not provide compelling evidence to change the current value of the service. Therefore, the RUC recommended maintaining the current work RVU of 7.38 for CPT code 43262. CMS maintained the current work RVU of 7.38 and the current physician time for CPT code 43262 for CY 2012. However, CMS requested that the RUC undertake a comprehensive review of the entire family of ERCP codes, including the base CPT code 43260, and provide CMS with work RVU recommendations.

The specialties agreed to survey the entire family of codes (43260-43273). In review of this family of codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In January 2013, the CPT Editorial Panel approved revised guidelines along with revision, addition, and deletion of codes within the ERCP code set.

## Overview of ERCP Family RVW Recommendations

The specialty consensus panel spent a significant amount of time reviewing the survey data for the current set of ERCP codes, comparing the data and values with the esophagoscopy codes (43200-43228) and EGD codes (43235-43259) that were approved by the RUC at the October 2012 and January 2013 RUC meetings. After reviewing the survey data, the consensus panel determined that for the ERCP code set, the incremental value above the base code for ERCP (43260) should be similar where possible to the analogous incremental value above the base codes for esophagoscopy and EGD previously approved.

## Discussion and Recommendation

**43273** Endoscopic cannulation of papilla with direct visualization of pancreatic/common bile duct(s) (List separately in addition to code(s) for primary procedure)

**We recommend maintaining the current RVW of 2.24.** When code 43273 was reviewed in 2008, the RUC subtracted RVUs from the median RVW to account for pre- and post-time that was collected on the ZZZ survey. There was no evidence that the survey respondents included this time in their work estimation. The survey results were also complicated by the fact that 0-day global codes were included on the reference list and this was followed by the RUC using a 0-day reference code for a diagnostic esophagoscopy as comparison for the calculated value. The current survey did not include global codes on the reference list.

### Comparison to Key Ref 31627

Key Reference code 31627 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with computer-assisted, image-guided navigation (List separately in addition to code for primary procedure[s])* is basically an add-on code for using the computer to assist with a procedure. This work would be more time consuming, but not more intense than 43273 add-on to ERCP procedures.

### Comparison To ZZZ Add-on Codes Reviewed by the RUC since 2010

As shown in the table below, the current RVW of 2.24 compares well with other services that are performed under MAC or general anesthesia.

### Comparison To ZZZ Add-on Codes Reviewed by the RUC since 2010

As shown in the table below, the current RVW of 2.24 compares well with other services that are performed under MAC or general anesthesia.

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2010	<b>11047</b>	Deb bone add-on	1.80	0.059	31				30	1

	CPT	DESC	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	POST
2010	<b>93464</b>	Exercise w/hemodynamic meas	1.80	0.060	30				30	
2010	<b>93463</b>	Drug admin & hemodynmic meas	2.00	0.067	30				30	
2011	<b>15121</b>	Skn spl t a-grft f/n/hf/g add	2.00	0.067	30				30	
2012	<b>36227</b>	Place cath xtrnl carotid	2.09	0.139	15				15	
2012	<b>13133</b>	Cmplx rpr f/c/c/m/n/ax/g/h/f	2.19	0.063	35				35	
2010	<b>43338</b>	Esoph lengthening	2.21	0.074	30				30	
	<b>43273</b>	Endoscopic pancreatoscopy	2.24	0.075	30				30	
2010	<b>49327</b>	Lap ins device for rt	2.38	0.079	30				30	
2012	<b>13153</b>	Cmplx rpr e/n/e/l addl 5cm/<	2.38	0.053	45				45	
2010	<b>38900</b>	lo map of sent lymph node	2.50	0.055	47	2			45	
2012	<b>20985</b>	Cptr-asst dir ms px	2.50	0.114	30	10			20	
2010	<b>43283</b>	Lap esoph lengthening	2.95	0.074	40				40	
2011	<b>29826</b>	Shoulder arthroscopy/surgery	3.00	0.075	40				40	
2011	<b>32506</b>	Wedge resect of lung add-on	3.00	0.120	25				25	
2011	<b>32507</b>	Wedge resect of lung diag	3.00	0.100	30				30	
2011	<b>32667</b>	Thoracoscopy w/w resect addl	3.00	0.120	25				25	
2011	<b>32668</b>	Thoracoscopy w/w resect diag	3.00	0.100	30				30	

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43273

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology

How often? Rarely

Specialty

How often?

Specialty

How often?

Estimate the number of times this service might be provided nationally in a one-year period? 12000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare data base 4,025 in 2011 (4,25\*3 ~ 12,000)

Specialty Gastroenterology	Frequency 10800	Percentage 90.00 %
----------------------------	-----------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 4,000

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare data base 4,025 in 2011

Specialty Gastroenterology	Frequency 3600	Percentage 90.00 %
----------------------------	----------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? No

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 43273

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

Track #	Code	Description	Current RVW	RUC Rec	Survey RVW Median	Survey RVW 25%	Pre-Svc Pkg	Pre	Intra	Post	Total	IWPUT
ERCP												
EE1	43260	Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with collection of specimen(s) by brushing or washing when performed	5.95	5.95	6.97	5.95	2b	48	48	25	121	0.091
EE2	43261	Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple	6.26	6.25	6.99	6.00	2b	48	55	23	126	0.086
EE3	43262	Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy	7.38	6.60	8.00	6.60	2b	48	60	30	138	0.082
EE5	43264	Endoscopic retrograde cholangiopancreatography (ERCP); with removal of calculi/debris from biliary/pancreatic duct(s)	8.89	6.73	9.00	6.73	2b	48	60	28	136	0.085
EE10	43277	Endoscopic retrograde cholangiopancreatography (ERCP); with trans-endoscopic balloon dilation of biliary/pancreatic duct(s) or of ampulla (sphincteroplasty), including sphincterotomy, when performed, each duct	NEW	7.11	10.00	7.00	2b	48	70	25	143	0.079
EE4	43263	Endoscopic retrograde cholangiopancreatography (ERCP); with pressure measurement of sphincter of Oddi	7.28	7.28	8.60	7.50	2b	48	60	30	138	0.093
EE6	43265	Endoscopic retrograde cholangiopancreatography (ERCP); with destruction of calculi, any method (eg, mechanical, electrohydraulic, lithotripsy)	10.00	8.03	10.50	8.03	2b	48	78	28	154	0.082
EE11	43278	Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s), including pre- and post-dilation and guide wire passage, when performed	NEW	8.08	11.00	8.38	2b	48	75	30	153	0.085
EE7	43274	Endoscopic retrograde cholangiopancreatography (ERCP); with placement of endoscopic stent into biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent	NEW	8.74	10.00	7.73	2b	48	68	23	139	0.106
EE8	43275	Endoscopic retrograde cholangiopancreatography (ERCP); with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s)	NEW	6.96	7.65	5.85	2b	48	50	20	118	0.110
EE9	43276	Endoscopic retrograde cholangiopancreatography (ERCP); with removal and exchange of stent(s), biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent exchanged	NEW	9.10	9.88	6.95	2b	48	60	25	133	0.126
EE12	43273	Endoscopic cannulation of papilla with direct visualization of pancreatic/common bile duct(s) (List separately in addition to code(s) for primary procedure)	2.24	2.24	4.00	2.70	NA		30		30	0.075

EGD Approved Increments				
EGD Code	Description	RUC RVU	Increment above base EGD Code (43235)	EGD Code Rationale
43239	biopsy	2.56	0.30	43235 (2.26) + increment of 43202-43200 (0.30)
43236	submucosal injection	2.57	0.31	43235 (2.26) + increment of 43201-43200 (0.31)
43249	balloon dilation > 30mm	2.77	0.51	43235 (2.26) + increment of 43220-43200 (0.51)
43242	FNA w EUS	5.39	0.65	43259 (4.74) + increment of 43238-43237 (0.65)
43248	guide wire insertion	3.01	0.75	43235 (2.26) + increment of 43226-43200 (0.75)
43252	optical endomicroscopy	3.06	0.80	43235 (2.26) + increment of 43206-43200 (0.80)
43250	hot biopsy	3.07	0.81	43235 (2.26) + increment of 43216-43200 (0.81)
43247	foreign body removal	3.27	1.01	43235 (2.26) + increment of 43215-43200 (1.01)
Esophagoscopy Approved Increments				
Esoph Code	Description	RUC RVU	Increment above base Esoph Code (43200)	Esophagoscopy Code Rationale
43202	biopsy	1.89	0.30	Current value
43201	submucosal injection	1.90	0.31	Direct crosswalk to MPC code 64483
43215	foreign body removal	2.60	1.01	Current value
43216	hot biopsy	2.40	0.81	Current value
43220	balloon dilation > 30mm	2.10	0.51	Current value
43226	guide wire insertion	2.34	0.75	Current value
43206	optical endomicroscopy	2.39	0.80	Direct crosswalk to code 12006
43217	removal of lesion by snare	2.90	1.31	Current value
Esoph Code	Description	RUC RVU	Increment above base Esoph Code (43200)	Esophagoscopy Code Rationale
43229	ablation (includes pre- and post-dilation)	3.72	2.13	43270 25th percentile (4.39)- 0.67 (diff 43235-43200) = 3.72
43212	endoscopic stent (includes pre- and post-dilation)	3.73	2.14	43266 25th percentile (4.40)- 0.67 (diff 43235-43200) = 3.73
43214	balloon dilation < 30mm	3.78	2.19	43233 25th percentile (4.45) - 0.67 (diff 43235-43200) = 3.78
43211	endoscopic mucosal resection	4.58	2.99	43254 25th percentile (5.25) - 0.78 = 4.58
ERCP Approved Increments				
ERCP Code	Description	RUC RVU	Increment above base ERCP Code (43260)	ERCP Code Rationale
43274	sphincterotomy	8.74	0.65	43260 (5.95) increment of 43262-43260 (0.65)

ISSUE: ERCP  
TAB: 12

Source	CPT	DESC	Resp	IWPUT	RVW					Total Time	PRE PKG	PRE-TIME			INTRA-TIME					IMMD POST	SURVEY EXPERIENCE				
					MIN	25th	MED	75th	MAX			EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX		MIN	25th	MED	75th	MAX
REF	52342	Cystourethroscopy; with treatment of ure	16	0.070			5.85			140		40	10	10			60		20						
RUC-93	43260	Endoscopic retrograde cholangiopancreatogra		0.110			5.95			86		20					46		20						
SVY	43260	Endoscopic retrograde cholangiopancrea	66	0.106	3.80	5.95	6.97	9.75	16.68	138		45	10	10	20	45	48	60	120	25	0	30	75	150	600
REC	43260	ERCP		0.091			5.95			121	2b	33	10	5			48		25						

Rationale

Current

REF	52342	Cystourethroscopy; with treatment of ure	12	0.070			5.85			140		40	10	10			60		20						
RUC-93	43261	Endoscopic retrograde cholangiopancreatogra		0.098			6.26			95		20					55		20						
SVY	43261	Endoscopic retrograde cholangiopancrea	57	0.092	3.50	6.00	6.99	9.99	20.16	148		50	10	10	20	45	55	60	135	23	0	15	50	100	500
REC	43261	ERCP; biopsy		0.086			6.25			126	2b	33	10	5			55		23						

Rationale

Building block: 43260 (5.95) + established incr. esoph/EGD (0.30) = 6.25

REF	58560	Hysteroscopy, surgical; with division of	11	0.092			6.99			125		40					60		25						
HARVARD	43262	Endoscopic retrograde cholangiopancreatogra		0.080			7.38			153		25	25				75		28						
SVY	43262	Endoscopic retrograde cholangiopancrea	58	0.100	4.40	6.60	8.00	10.00	23.52	155		50	10	10	10	45	60	74	150	30	0	46	90	180	500
REC	43262	ERCP; sphincterotomy		0.082			6.60			138	2b	33	10	5			60		30						

Rationale

25th percentile

REF	31600	Tracheostomy, planned (separate proced	6	0.114			7.17			156		50					40		66						
RUC-00	43263	Endoscopic retrograde cholangiopancreatogra		0.070			7.28			164		47.5					76		40						
SVY	43263	Endoscopic retrograde cholangiopancrea	43	0.108	4.20	7.50	8.60	11.00	24.36	160		50	10	10	25	60	60	70	150	30	0	0	2	11	100
REC	43263	ERCP; sphincter of Oddi		0.093			7.28			138	2b	33	10	5			60		30						

Rationale

Current

REF	58561	Hysteroscopy, surgical; with removal of	9	0.112			9.99			145		40					75		30						
HARVARD	43264	Endoscopic retrograde cholangiopancreatogra		0.109			8.89			147		25	25				69		28						
SVY	43264	Endoscopic retrograde cholangiopancrea	54	0.118	4.50	6.73	9.00	10.38	26.88	153		45	10	10	25	60	60	75	160	28	0	31	50	150	400
REC	43264	ERCP; removal of calculi biliary duct		0.085			6.73			136	2b	33	10	5			60		28						

Rationale

25th percentile

REF	52342	Cystourethroscopy; with treatment of ure	9	0.070			5.85			140		40	10	10			60		20						
RUC-00	43265	Endoscopic retrograde cholangiopancreatogra		0.100			10.00			159		40					83.5		35						
SVY	43265	Endoscopic retrograde cholangiopancrea	52	0.109	5.00	8.03	10.50	12.00	28.56	176		50	10	10	35	64	78	90	160	28	0	10	18	40	200
REC	43265	ERCP; destruction of calculi		0.082			8.03			154	2b	33	10	5			78		28						

Rationale

25th percentile

REF	31627	Bronchoscopy, rigid or flexible, including	19	0.033			2.00			60							60								
RUC-09	43273	Endoscopic cannulation of papilla with direct v		0.050			2.24			45							45								
SVY	43273	Endoscopic cannulation of papilla with d	47	0.133	2.00	2.70	4.00	6.60	15.00	30					15	30	30	63	150		0	1	5	20	100
REC	43273	Endoscopic pancreatoscopy		0.075			2.24			30							30								

Rationale

Current

REF	37221	Revascularization, endovascular, open o	9	0.092			10.00			168		40	3	5			90		30						
HARVARD	43268	Endoscopic retrograde cholangiopancreatogra		0.076			7.38			158		26	25				78		29						
HARVARD	43262	Endoscopic retrograde cholangiopancreatography (ERCP); with sp		7.38			153			25	25	25					75		28						
SVY	43274	Endoscopic retrograde cholangiopancrea	50	0.119	3.05	7.73	10.00	12.45	30.52	161		50	10	10	15	60	68	90	180	23	0	15	45	100	300
REC	43274	ERCP; stent placement (pre-post dilation)		0.106			8.74			139	2b	33	10	5			68		23						

Rationale

Building block: ERCP base 43260 (5.95) + (incr of sphincterotomy 43262 (6.60-5.95) = 0.65) + (incr of endoscopic stent placment 4320X4 [3.73] - base code 43200 [1.59]= 2.14) = 8.74. TI

REF	31638	Bronchoscopy, rigid or flexible, including	9	0.055			4.88			140		20	15	15			60		30						
CURRENT	43269	Endoscopic retrograde cholangiopancreatogra		0.093			8.20			141		40					71		30						
SVY	43275	Endoscopic retrograde cholangiopancrea	49	0.118	1.85	5.85	7.65	8.60	20.16	135		45	10	10	10	30	50	60	120	20	0	10	30	50	200
REC	43275	ERCP; removal of stent		0.110			6.96			118	2b	33	10	5			50		20						

Rationale

building block: 43260 (5.95) + established incr. esoph/EGD foreign body removal (1.01) = 6.96

REF	31638	Bronchoscopy, rigid or flexible, including	10	0.055			4.88			140		20	15	15			60		30						
CURRENT	43269	Endoscopic retrograde cholangiopancreatogra		0.093			8.20			141		40					71		30						
SVY	43276	Endoscopic retrograde cholangiopancrea	48	0.132	3.50	6.95	9.88	11.25	30.52	153		48	10	10	15	60	60	76	180	25	0	10	25	56	200
REC	43276	ERCP; stent removal & exchange, biliary/pancreati		0.126			9.10			133	2b	33	10	5			60		25						

Rationale

Building block: ERCP base 43260 (5.95) + established increment removal of foreign body (1.01) + established increment of esoph/EGD stent placement (2.14) = 9.10

REF	31638	Bronchoscopy, rigid or flexible, including	6	0.055			4.88			140		20	15	15			60		30						
HARVARD	43271	Endoscopic retrograde cholangiopancreatogra		0.100			7.38			134		22	25				61		26						
HARVARD	43262	Endoscopic retrograde cholangiopancreatogra		0.080			7.38			153		25	25				75		28						
SVY	43277	Endoscopic retrograde cholangiopancrea	47	0.115	3.60	7.00	10.00	11.50	28.34	165		50	10	10	15	60	70	75	150	25	0	7	20	35	175
REC	43277	ERCP; balloon dilation		0.079			7.11			143	2b	33	10	5			70		25						

Rationale

Building block: ERCP base 43260 (5.95) + increment of dilation 43220 (2.10 ) - esophagoscopy 43200 (1.59) 0.51 + increment of sphincterotomy 43262 (6.60 - 5.95 = 0.65) = 7.11.

REF	37225	Revascularization, endovascular, open o	8	0.087			12.00			196		40	3	5			118		30						
CURRENT	43272	Endoscopic retrograde cholangiopancreatogra		0.106			7.38			105		25					60		20						
HARVARD	43271	Endoscopic retrograde cholangiopancreatogra		0.100			7.38			134		22	25				61		26						
SVY	43278	Endoscopic retrograde cholangiopancrea	40	0.119	5.00	8.38	11.00	12.20	30.52	175		50	10	10	30	64	75	90	180	30	0	1	5	16	225
REC	43278	ERCP; ablation (pre&post dilation)		0.085			8.08			153	2b	33	10	5			75		30						

Rationale

Building block: ERCP base 43260 (5.95) + established increment of ablation (4320X5 [3.72] - base code 43200 [1.59] = 2.13) = 8.08



**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor:

43260	Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with collection of specimen(s) by brushing or washing when performed
43261	Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple
43262	Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy
43263	Endoscopic retrograde cholangiopancreatography (ERCP); with pressure measurement of sphincter of Oddi
43264	Endoscopic retrograde cholangiopancreatography (ERCP); with removal of calculi/debris from biliary/pancreatic duct(s)
43265	Endoscopic retrograde cholangiopancreatography (ERCP); with destruction of calculi, any method (eg, mechanical, electrohydraulic, lithotripsy)
43274	Endoscopic retrograde cholangiopancreatography (ERCP); with placement of endoscopic stent into biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent
43275	Endoscopic retrograde cholangiopancreatography (ERCP); with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s)
43276	Endoscopic retrograde cholangiopancreatography (ERCP); with removal and exchange of stent(s), biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent exchanged
43277	Endoscopic retrograde cholangiopancreatography (ERCP); with trans-endoscopic balloon dilation of biliary/pancreatic duct(s) or of ampulla (sphincteroplasty), including sphincterotomy, when performed, each duct
43278	Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s), including pre- and post-dilation and guide wire passage, when performed
43273	Endoscopic cannulation of papilla with direct visualization of pancreatic/common bile duct(s) (List separately in addition to code(s) for primary procedure)

Global Period: 000

Meeting Date: April 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The ACG, AGA and ASGE convened a group from a broad range of geographic locations with differing practice circumstances and settings - community, academic, teaching, and public; urban, suburban and rural; single and multi-specialty group; independent and employed - who typically perform these services. The committee served as the consensus panel to develop PE recommendations.

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

**CPT Code: Tab 12 (ERCP)**  
**Specialty Society('s) ACG, AGA, ASGE**

Current Time data					Survey Code Recommendation			
CPT	Source	Pre	Intra	Post	CPT	Pre	Intra	Post
43260	PEAC-03	19	0	3	43260	19	0	3
43261	PEAC-03	19	0	3	43261	19	0	3
43262	RUC-10	19	0	3	43262	19	0	3
43263	PEAC-03	19	0	3	43263	19	0	3
43264	PEAC-03	19	0	3	43264	19	0	3
43265	PEAC-03	19	0	3	43265	19	0	3
43274	NEW	NA	NA	NA	43274	19	0	3
43275	NEW	NA	NA	NA	43275	19	0	3
43276	NEW	NA	NA	NA	43276	19	0	3
43277	NEW	NA	NA	NA	43277	19	0	3
43278	NEW	NA	NA	NA	43278	19	0	3
43273	NEW	NA	NA	NA	43273	0	0	0

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time: NA

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence: NA

5. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

For all codes shown above, EXCEPT 43273:

- Three minutes to complete pre-service diagnostic and referral forms.
- Five minutes to coordinate pre-surgery services with other qualified healthcare providers
- Three minutes for scheduling space and equipment in facility
- Five minutes to perform pre-service education/ obtain consent
- Three minutes for pre-op prescriptions

Intra-Service Clinical Labor Activities:

NA

Post-Service Clinical Labor Activities:

For all codes shown above, EXCEPT 43273:

- Three minutes for a follow-up phone call to patient

	A	B	C	D	E	F	G	H	I	J	K
1				REFERENCE CODE				REFERENCE CODE			
	Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.					43260		43260 FACILITY ONLY		43261 FACILITY ONLY	
2											
3	Meeting Date: April 2013 Tab: 12 (ERCP) Specialty: Gastroenterology	CMS Code	Staff Type	ERCP, diagnostic		ERCP, diagnostic		ERCP, biopsy		ERCP, biopsy	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	000	000	000	000
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	22.0	0.0	22.0	0.0	22.0	0.0	22.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	19.0	0.0	19.0	0.0	19.0	0.0	19.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	3.0	0.0	3.0	0.0	3.0	0.0	3.0
10	PRE-SERVICE										
11	Start: Following visit when decision for surgery or procedure made										
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		3		3		3		3
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA		5		5		5		5
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3		3		3
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5		5		5
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		3		3		3		3
17	*Other Clinical Activity - specify:										
18	End: When patient enters office/facility for surgery/procedure										
19	SERVICE PERIOD										
20	Start: When patient enters office/facility for surgery/procedure:										
21	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA								
22	Obtain vital signs	L037D	RN/LPN/MTA								
23	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA								
24	Prepare room, equipment, supplies	L037D	RN/LPN/MTA								
25	Setup scope (non facility setting only)	L037D	RN/LPN/MTA								
26	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA								
27	Sedate/apply anesthesia	L051A	RN								
28	*Other Clinical Activity - specify:										
29	Intra-service										
30	Assist physician in performing procedure	L037D	RN/LPN/MTA								
31	Post-Service										
32	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MTA								
33	Clean room/equipment by physician staff	L037D	RN/LPN/MTA								
34	Clean Scope	L037D	RN/LPN/MTA								
35	Clean Surgical Instrument Package	L037D	RN/LPN/MTA								
36	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA								
37	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA								
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA								
39	*Other Clinical Activity - specify:										
40	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			n/a		n/a		n/a		n/a	
41	Dischrg mgmt (1.0 x 99238) (enter 12 min)			n/a		n/a		n/a		n/a	
42	Dischrg mgmt (1.0 x 99239) (enter 15 min)			n/a		n/a		n/a		n/a	
43	End: Patient leaves office										
44	POST-SERVICE Period										
45	Start: Patient leaves office/facility										
46	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA		3		3		3		3
47	Office visits: List Number and Level of Office Visits										
48	99211 16 minutes		16	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits
49	99212 27 minutes		27								
50	99213 36 minutes		36								
51	99214 53 minutes		53								
52	99215 63 minutes		63								
53	Total Office Visit Time			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
54	*Other Clinical Activity - specify:										
55	End: with last office visit before end of global period										
56	MEDICAL SUPPLIES**										
57	NONE - FACILITY ONLY	CODE	UNIT								
58	EQUIPMENT										
59	NONE - FACILITY ONLY	CODE									

	A	B	C	L	M	N	O	P	Q	R	S
1				REFERENCE CODE				REFERENCE CODE			
2	<p>Please note: The supply has a purchase price of \$100 or more please bold the item name and CMS code.</p> <p>**Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.</p>			43262		43262 FACILITY ONLY		43263		43263 FACILITY ONLY	
3	<b>Meeting Date: April 2013</b> <b>Tab: 12 (ERCP)</b> <b>Specialty: Gastroenterology</b>	CMS Code	Staff Type	ERCP, with sphincterotomy / papillotomy		ERCP, with sphincterotomy / papillotomy		ERCP, pressure measurement		ERCP, pressure measurement	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	000	000	000	000
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	22.0	0.0	22.0	0.0	22.0	0.0	22.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	19.0	0.0	19.0	0.0	19.0	0.0	19.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	3.0	0.0	3.0	0.0	3.0	0.0	3.0
10	PRE-SERVICE										
11	Start: Following visit when decision for surgery or procedure made										
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		3		3		3		3
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA		5		5		5		5
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3		3		3
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5		5		5
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		3		3		3		3
17	*Other Clinical Activity - specify:										
18	End: When patient enters office/facility for surgery/procedure										
19	SERVICE PERIOD										
20	Start: When patient enters office/facility for surgery/procedure:										
21	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA								
22	Obtain vital signs	L037D	RN/LPN/MTA								
23	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA								
24	Prepare room, equipment, supplies	L037D	RN/LPN/MTA								
25	Setup scope (non facility setting only)	L037D	RN/LPN/MTA								
26	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA								
27	Sedate/apply anesthesia	L051A	RN								
28	*Other Clinical Activity - specify:										
29	Intra-service										
30	Assist physician in performing procedure	L037D	RN/LPN/MTA								
31	Post-Service										
32	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MTA								
33	Clean room/equipment by physician staff	L037D	RN/LPN/MTA								
34	Clean Scope	L037D	RN/LPN/MTA								
35	Clean Surgical Instrument Package	L037D	RN/LPN/MTA								
36	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA								
37	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA								
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA								
39	*Other Clinical Activity - specify:										
40	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			n/a		n/a		n/a		n/a	
41	Dischrg mgmt (1.0 x 99238) (enter 12 min)			n/a		n/a		n/a		n/a	
42	Dischrg mgmt (1.0 x 99239) (enter 15 min)			n/a		n/a		n/a		n/a	
43	End: Patient leaves office										
44	POST-SERVICE Period										
45	Start: Patient leaves office/facility										
46	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA		3		3		3		3
47	Office visits: List Number and Level of Office Visits			# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits
48	99211 16 minutes		16								
49	99212 27 minutes		27								
50	99213 36 minutes		36								
51	99214 53 minutes		53								
52	99215 63 minutes		63								
53	Total Office Visit Time			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
54	*Other Clinical Activity - specify:										
55	End: with last office visit before end of global period										
56	MEDICAL SUPPLIES**			CODE	UNIT						
57	NONE - FACILITY ONLY										
58	EQUIPMENT			CODE							
59	NONE - FACILITY ONLY										



	A	B	C	T	U	V	W	X	Y	Z	AA
1				REFERENCE CODE		REFERENCE CODE					
2	<p>Please note: The supply has a purchase price of \$100 or more please bold the item name and CMS code.</p> <p>**Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.</p>			43264		43264 FACILITY ONLY		43265		43265 FACILITY ONLY	
3	<b>Meeting Date: April 2013</b> <b>Tab: 12 (ERCP)</b> <b>Specialty: Gastroenterology</b>	CMS Code	Staff Type	ERCP, calculi removal		ERCP, calculi removal		ERCP, calculi destruction		ERCP, calculi destruction	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	000	000	000	000
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	22.0	0.0	22.0	0.0	22.0	0.0	22.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	19.0	0.0	19.0	0.0	19.0	0.0	19.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	3.0	0.0	3.0	0.0	3.0	0.0	3.0
10	PRE-SERVICE										
11	Start: Following visit when decision for surgery or procedure made										
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		3		3		3		3
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA		5		5		5		5
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3		3		3
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5		5		5
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		3		3		3		3
17	*Other Clinical Activity - specify:										
18	End: When patient enters office/facility for surgery/procedure										
19	SERVICE PERIOD										
20	Start: When patient enters office/facility for surgery/procedure:										
21	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA								
22	Obtain vital signs	L037D	RN/LPN/MTA								
23	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA								
24	Prepare room, equipment, supplies	L037D	RN/LPN/MTA								
25	Setup scope (non facility setting only)	L037D	RN/LPN/MTA								
26	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA								
27	Sedate/apply anesthesia	L051A	RN								
28	*Other Clinical Activity - specify:										
29	Intra-service										
30	Assist physician in performing procedure	L037D	RN/LPN/MTA								
31	Post-Service										
32	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MTA								
33	Clean room/equipment by physician staff	L037D	RN/LPN/MTA								
34	Clean Scope	L037D	RN/LPN/MTA								
35	Clean Surgical Instrument Package	L037D	RN/LPN/MTA								
36	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA								
37	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA								
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA								
39	*Other Clinical Activity - specify:										
40	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			n/a		n/a		n/a		n/a	
41	Dischrg mgmt (1.0 x 99238) (enter 12 min)			n/a		n/a		n/a		n/a	
42	Dischrg mgmt (1.0 x 99239) (enter 15 min)			n/a		n/a		n/a		n/a	
43	End: Patient leaves office										
44	POST-SERVICE Period										
45	Start: Patient leaves office/facility										
46	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA		3		3		3		3
47	Office visits: List Number and Level of Office Visits			# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits
48	99211 16 minutes		16								
49	99212 27 minutes		27								
50	99213 36 minutes		36								
51	99214 53 minutes		53								
52	99215 63 minutes		63								
53	Total Office Visit Time			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
54	*Other Clinical Activity - specify:										
55	End: with last office visit before end of global period										
56	MEDICAL SUPPLIES**			CODE	UNIT						
57	NONE - FACILITY ONLY										
58	EQUIPMENT			CODE							
59	NONE - FACILITY ONLY										

	A	B	C	AB	AC	AD	AE	AF	AG	AH	AI	
1	Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.											
2				43274 FACILITY ONLY		43275 FACILITY ONLY		43276 FACILITY ONLY		43277 FACILITY ONLY		
3	Meeting Date: April 2013 Tab: 12 (ERCP) Specialty: Gastroenterology	CMS Code	Staff Type	ERCP, stent placement		ERCP, foreign body		ERCP, stent exchange		ERCP, balloon dilation		
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	
5	GLOBAL PERIOD			000	000	000	000	000	000	000	000	
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	22.0	0.0	22.0	0.0	22.0	0.0	22.0	
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	19.0	0.0	19.0	0.0	19.0	0.0	19.0	
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	3.0	0.0	3.0	0.0	3.0	0.0	3.0	
10	PRE-SERVICE											
11	Start: Following visit when decision for surgery or procedure made											
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		3		3		3		3	
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA		5		5		5		5	
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3		3		3	
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5		5		5	
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		3		3		3		3	
17	*Other Clinical Activity - specify:											
18	End: When patient enters office/facility for surgery/procedure											
19	SERVICE PERIOD											
20	Start: When patient enters office/facility for surgery/procedure:											
21	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA									
22	Obtain vital signs	L037D	RN/LPN/MTA									
23	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA									
24	Prepare room, equipment, supplies	L037D	RN/LPN/MTA									
25	Setup scope (non facility setting only)	L037D	RN/LPN/MTA									
26	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA									
27	Sedate/apply anesthesia	L051A	RN									
28	*Other Clinical Activity - specify:											
29	Intra-service											
30	Assist physician in performing procedure	L037D	RN/LPN/MTA									
31	Post-Service											
32	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MTA									
33	Clean room/equipment by physician staff	L037D	RN/LPN/MTA									
34	Clean Scope	L037D	RN/LPN/MTA									
35	Clean Surgical Instrument Package	L037D	RN/LPN/MTA									
36	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA									
37	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA									
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA									
39	*Other Clinical Activity - specify:											
40	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			n/a		n/a		n/a		n/a		
41	Dischrg mgmt (1.0 x 99238) (enter 12 min)			n/a		n/a		n/a		n/a		
42	Dischrg mgmt (1.0 x 99239) (enter 15 min)			n/a		n/a		n/a		n/a		
43	End: Patient leaves office											
44	POST-SERVICE Period											
45	Start: Patient leaves office/facility											
46	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA		3		3		3		3	
47	Office visits: List Number and Level of Office Visits			# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	
48	99211 16 minutes		16									
49	99212 27 minutes		27									
50	99213 36 minutes		36									
51	99214 53 minutes		53									
52	99215 63 minutes		63									
53	Total Office Visit Time			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
54	*Other Clinical Activity - specify:											
55	End: with last office visit before end of global period											
56	MEDICAL SUPPLIES**			CODE	UNIT							
57	NONE - FACILITY ONLY											
58	EQUIPMENT			CODE								
59	NONE - FACILITY ONLY											

	A	B	C	AJ	AK	AL	AM	AN	AO
1	REFERENCE CODE								
2	<div>Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.</div>			43278 FACILITY ONLY		43273		43273 FACILITY ONLY	
3	Meeting Date: April 2013 Tab: 12 (ERCP) Specialty: Gastroenterology	CMS Code	Staff Type	ERCP, ablation		ERCP, cannulation		ERCP, cannulation	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	000	000
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	22.0	0.0	0.0	0.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	19.0	0.0	0.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	0.0	0.0	0.0	0.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	3.0	0.0	0.0	0.0	0.0
10	PRE-SERVICE								
11	Start: Following visit when decision for surgery or procedure made								
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		3				
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA		5				
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3				
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5				
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		3				
17	*Other Clinical Activity - specify:								
18	End: When patient enters office/facility for surgery/procedure								
19	SERVICE PERIOD								
20	Start: When patient enters office/facility for surgery/procedure:								
21	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA						
22	Obtain vital signs	L037D	RN/LPN/MTA						
23	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA						
24	Prepare room, equipment, supplies	L037D	RN/LPN/MTA						
25	Setup scope (non facility setting only)	L037D	RN/LPN/MTA						
26	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA						
27	Sedate/apply anesthesia	L051A	RN						
28	*Other Clinical Activity - specify:								
29	Intra-service								
30	Assist physician in performing procedure	L037D	RN/LPN/MTA						
31	Post-Service								
32	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MTA						
33	Clean room/equipment by physician staff	L037D	RN/LPN/MTA						
34	Clean Scope	L037D	RN/LPN/MTA						
35	Clean Surgical Instrument Package	L037D	RN/LPN/MTA						
36	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA						
37	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA						
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA						
39	*Other Clinical Activity - specify:								
40	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)				n/a		n/a		n/a
41	Dischrg mgmt (1.0 x 99238) (enter 12 min)				n/a		n/a		n/a
42	Dischrg mgmt (1.0 x 99239) (enter 15 min)				n/a		n/a		n/a
43	End: Patient leaves office								
44	POST-SERVICE Period								
45	Start: Patient leaves office/facility								
46	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA		3				
47	Office visits: List Number and Level of Office Visits			# visits	# visits	# visits	# visits	# visits	# visits
48	99211 16 minutes		16						
49	99212 27 minutes		27						
50	99213 36 minutes		36						
51	99214 53 minutes		53						
52	99215 63 minutes		63						
53	Total Office Visit Time			0.0	0.0	0.0	0.0	0.0	0.0
54	*Other Clinical Activity - specify:								
55	End: with last office visit before end of global period								
56	MEDICAL SUPPLIES**			CODE	UNIT				
57	NONE - FACILITY ONLY								
58	EQUIPMENT			CODE					
59	NONE - FACILITY ONLY								

AMA/Specialty Society RVS Update Committee Summary of Recommendations  
*Codes Reported Together 75% or More screen*

April 2013

**Cystourethroscopy**

In September 2011, the Relativity Assessment Workgroup identified CPT codes 52353 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)* and 52332 *Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)* as part of the Codes Reported Together 75% or More screen and recommended a bundled code solution. In February 2013, the CPT Editorial Panel established a bundled code, 52356 *Cystourethroscopy, with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double-J type)* to combine the services described by CPT codes 52353 and 52332.

***52332 Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)***

The RUC reviewed the recommendations from April 2010 for CPT code 52332 and agreed to reaffirm the current value, as it maintains relativity for this family of services. In April 2010, the RUC reviewed the survey responses from 39 urologists for code 52332 and agreed with the specialty society that there is no compelling evidence that the work for this service has changed. For additional support, the RUC also compared this service to CPT codes 49452 *Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (work RVU = 2.86 and 30 minutes pre-service time, 20 minutes intra-service time and 10 minutes immediate post-service time) and 51102 *Aspiration of bladder; with insertion of suprapubic catheter* (work RVU = 2.70 and 25 minutes pre-service time, 20 minutes intra-service time and 15 minutes immediate post-service time) which require similar physician time, intensity and complexity. **The RUC recommends reaffirming the current work RVU of 2.82 for CPT code 52332.**

***52353 Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)***

The RUC reviewed the recommendations from October 2011 for CPT code 52353 and agreed to reaffirm the current value, as it maintains relativity for this family of services. In October 2011, the RUC reviewed the survey results from 86 urologists for CPT code 52353 and agreed that the survey respondents accurately estimated the physician work. The RUC noted that for the 2012 Physician Fee Schedule, CMS reduced the RVU from 7.88 to 7.50 work RVUs. **The RUC recommends reaffirming the current work RVU of 7.50 for CPT code 52353.**



**52356 Cystourethroscopy, with lithotripsy including insertion if indwelling ureteral stent (eg, Gibbons or double-J type)**

The RUC reviewed the survey results from 153 urologists and determined that a work RVU of 8.00, the survey 25<sup>th</sup> percentile appropriately accounts for the physician work to perform this service. The RUC noted that this service is not separately reported with fluoroscopy. . There was consensus among the RUC that the following physician time components are appropriate: pre-time of 53 minutes, intra service time of 60 minutes and post service time of 20 minutes. The RUC also agreed that an additional 2 minutes is appropriate to place the patient in a dorsal lithotomy position. The committee reviewed key reference code 52352 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)* (work RVU=6.75) and agreed that 52356 requires more physician time, 45 minutes and 60 minutes intra-service time, respectively, and was rated higher by the survey respondents on all intensity and complexity measures. Therefore, 52356 requires more physician work than 52352. The RUC also reviewed 52346 *Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU=8.58) and noted that although these two services require similar physician work, the intensity of 52346 is greater. **The RUC recommends a work RVU of 8.00, the survey 25<sup>th</sup> percentile for CPT code 52356.**

**Practice Expense:**

The RUC accepted the direct PE inputs with minor modifications as recommended by the PE Subcommittee.

**Work Neutrality**

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

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<b>Category I</b> <b>Surgery</b> <b>Urinary System</b> <b>Kidney</b> <b>Other Procedures</b>				
50590		Lithotripsy, extracorporeal shock wave		
<b>Ureter</b> <b>Incision</b>				
50610		Ureterolithotomy; upper one-third of ureter		
50620		middle one-third of ureter		
50630		lower one-third of ureter (For laparoscopic approach, use 50945) (For transvesical ureterolithotomy, use 51060) (For cystotomy with stone basket extraction of ureteral calculus, use 51065) (For endoscopic extraction or manipulation of ureteral calculus, see 50080, 50081, 50561, 50961, 50980, 52320-52330, 52352, 52353, 52356)		

**Bladder****Endoscopy-Cystoscopy, Urethroscopy,  
Cystourethroscopy**

52001            Cystourethroscopy with irrigation and evacuation of multiple obstructing clots  
(Do not report 52001 in conjunction with 52000)

**Coding Tips****Restrictions for Reporting Temporary Catheter Insertion and Removal with Cystourethroscopy**

The insertion and removal of a temporary ureteral catheter (52005) during diagnostic or therapeutic cystourethroscopic with ureteroscopy and/or pyeloscopy is included in 52320-~~52355~~ 52356 and should not be reported separately.

*CPT Coding Guidelines, Urinary System, Bladder Transurethral Surgery, Ureter and Pelvis*

Therapeutic cystourethroscopy always includes diagnostic cystourethroscopy. To report a diagnostic cystourethroscopy, use **52000**.

Therapeutic cystourethroscopy with ureteroscopy and/or pyeloscopy always includes diagnostic cystourethroscopy with ureteroscopy and/or pyeloscopy. To report a diagnostic cystourethroscopy with ureteroscopy and/or pyeloscopy, use 52351.

Do not report **52000** in conjunction with **52320- 52343**, 52356 .

Do not report 52351 in conjunction with **52344- 52346** , **52352- 52356 ~~52355~~** .

The insertion and removal of a temporary ureteral catheter ( **52005**) during diagnostic or therapeutic cystourethroscopic with ureteroscopy and/or pyeloscopy is included in **52320- 52356 ~~52355~~** and should not be reported separately.

To report insertion of a self-retaining, indwelling stent performed during diagnostic or therapeutic cystourethroscopy with ureteroscopy and/or pyeloscopy, report 52332 in addition to primary procedure(s) performed (**52320-52330**, **52334-52352**, 52354, **52355**), and append modifier 51. Code 52332 is used to report a unilateral procedure unless otherwise specified.

For bilateral insertion of self-retaining, indwelling ureteral stents, use code 52332, and append modifier **50**.

To report cystourethroscopic removal of a self-retaining, indwelling ureteral stent, see 52310, 52315, and append modifier **58**, if appropriate.

52320            Cystourethroscopy (including ureteral catheterization); with removal of ureteral calculus

52325            with fragmentation of ureteral calculus (eg, ultrasonic or electro-hydraulic technique)

52327            with subureteric injection of implant

52330 with manipulation, without removal of ureteral calculus				
52332	Z1	Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type) <u>(Do not report 52332 in conjunction with 52353, 52356)</u>	000	2.82 (No Change) (Request to reaffirm RUC Recommendation April 2010)
52334	Cystourethroscopy with insertion of ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde (For percutaneous nephrostolithotomy, see 50080, 50081; for establishment of nephrostomy tract only, use 50395) (For cystourethroscopy, with ureteroscopy and/or pyeloscopy, see 52351- <u>52356</u> <del>52355</del> ) (For cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves or obstructive hypertrophic mucosal folds, use 52400)			
52341	Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)			
52351	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic (For radiological supervision and interpretation, use 74485) (Do not report 52351 in conjunction with 52341-52346, 52352- <u>52356</u> <del>52355</del> )			
52352	with removal or manipulation of calculus (ureteral catheterization is included)			
52353	Z2	with lithotripsy (ureteral catheterization is included) <u>(Do not report 52353 in conjunction with 52332, 52356 when performed together on the same side)</u>	000	7.50 (No Change) (Request to reaffirm RUC Recommendation October 2011)

#●52356	Z3	with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double-J type) <u>(Do not report 52356 in conjunction with 52332, 52353 when performed together on the same side)</u>	000	8.00
52354	with biopsy and/or fulguration of ureteral or renal pelvic lesion			
52355	with resection of ureteral or renal pelvic tumor			
#52356	Code is out of numerical sequence. See 52320-52355.			
<b>Radiology</b> <b>Diagnostic Radiology (Diagnostic Imaging)</b> <b>Urinary Tract</b>				
74480	Introduction of ureteral catheter or stent into ureter through renal pelvis for drainage and/or injection, percutaneous, radiological supervision and interpretation  (For transurethral surgery [ureter and pelvis], see 52320- <del>52355</del> -52356)			

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 52332  
Global Period: 000

Tracking Number

Specialty Society Recommended RVU: **2.83**  
RUC Recommended RVU: **2.82**

CPT Descriptor: Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 42 year old female presents to the Emergency Room with severe right flank pain for 24 hours. Urinalysis shows blood. A non-contrast CT shows an 8 mm stone at the right ureteropelvic junction with severe hydronephrosis. It is elected to place an indwelling J stent to relieve the hydronephrosis and pain.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 72%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 38%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? Yes

Description of Pre-Service Work: Includes services provided from the day before the surgery or diagnostic procedure until the time of the procedure and may include: (1) obtaining and reviewing records or previous history, laboratory studies and urologic x-rays before the procedure; (2) communicating with other health professionals (e.g. family physician, anesthesiologist); (3) communicating with the patient to explain the procedure, operative risks and benefits and to obtain informed consent; (4) dressing for surgery, waiting for anesthesia, positioning, prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery or procedure and any other non "skin-to-skin" work in the operating room or procedure suite. Does not include: The consultation or evaluation at which time the decision to provide the procedure is made.

Description of Intra-Service Work: The patient is placed in the lithotomy position and her perineum is prepped and draped. A 21 French cystoscope is placed at the meatus and passed into the bladder. Inspection of the bladder with the 30 & 70 degree lenses show a normal trigone and bladder wall with no stone debris in the bladder lumen. Under direct vision, an angle-tipped catheter is placed in the right orifice and a .035 guidewire passed through the catheter and up the ureter to the level of the stone. The guidewire is then carefully manipulated around the stone and into the right renal pelvis under fluoroscopy. Once the guidewire's position beyond the stone is confirmed, the angle-tipped catheter is removed leaving the guidewire in place. Under fluoroscopy, a 6 French by 26 cm open-ended J stent is then passed over the guidewire through the cystoscope and up the right ureter. At the level of the stone, the J stent is manipulated into the right renal pelvis being careful not to perforate the ureter. Once it is confirmed that the distal end of the J stent is in the renal pelvis and the proximized end is in the bladder, the guidewire is removed. Fluoroscopy is again used to make certain the J stent is coiled in the right renal pelvis and in the bladder thereby securing it in place and bypassing the obstructing stone. If the J

stent is not perfectly positioned, a grasping forcep is utilized to manipulate the distal end of the J stent and achieve the correct positioning. The bladder is then emptied and the cystoscope removed and a foley catheter is placed.

Description of Post-Service Work: Some of the following may apply: (1) all post procedure care on the day of the procedure and if applicable patient stabilization, post-operative orders, communication with the patient and/or family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the procedure suite; (2) other follow-up care and prescriptions, if applicable.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2010				
<b>Presenter(s):</b>	James Giblin, MD; Richard Gilbert, MD, William Gee, MD				
<b>Specialty(s):</b>	Urology				
<b>CPT Code:</b>	52332				
<b>Sample Size:</b>	176	<b>Resp N:</b>	39	<b>Response:</b> 22.1 %	
<b>Sample Type:</b>	Panel	<b>Additional Sample Information:</b>			
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	5.00	25.00	<b>50.00</b>	100.00	350.00
<b>Survey RVW:</b>	2.60	3.20	<b>3.51</b>	4.50	7.50
<b>Pre-Service Evaluation Time:</b>			<b>15.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>10.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>10.00</b>		
<b>Intra-Service Time:</b>	15.00	20.00	<b>25.00</b>	32.50	45.00
<b>Immediate Post Service-Time:</b>	<b>20.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x <b>0.00</b> 99292x <b>0.00</b>			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x <b>0.00</b> 99232x <b>0.00</b> 99233x <b>0.00</b>			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x <b>0.00</b> 99239x <b>0.00</b>			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x <b>0.00</b> 12x <b>0.00</b> 13x <b>0.00</b> 14x <b>0.00</b> 15x <b>0.00</b>			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x <b>0.00</b> 55x <b>0.00</b> 56x <b>0.00</b> 57x <b>0.00</b>			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 6 - NF Procedure with sedation/anesthesia care

<b>CPT Code:</b>	52332	<b>Recommended Physician Work RVU: 2.82</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments to Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>15.00</b>	<b>17.00</b>	<b>-2.00</b>
<b>Pre-Service Positioning Time:</b>		<b>1.00</b>	<b>1.00</b>	<b>0.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>5.00</b>	<b>5.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>25.00</b>		
<b>Immediate Post Service-Time:</b>	<b>10.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x <b>0.00</b> 99292x <b>0.00</b>		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x <b>0.00</b> 99232x <b>0.00</b> 99233x <b>0.00</b>		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x <b>0.0</b> 99239x <b>0.0</b>		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x <b>0.00</b> 12x <b>0.00</b> 13x <b>0.00</b> 14x <b>0.00</b> 15x <b>0.00</b>		
<b>Prolonged Services:</b>	<b>0.00</b>	99354x <b>0.00</b> 55x <b>0.00</b> 56x <b>0.00</b> 57x <b>0.00</b>		



Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
52007	000	3.02	RUC Time

CPT Descriptor Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with brush biopsy of ureter and/or renal pelvis

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
31622	000	2.78	RUC Time	90,741

CPT Descriptor 1 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
45378	000	3.69	RUC Time	915,402

CPT Descriptor 2 Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 28      % of respondents: 71.7 %**

**TIME ESTIMATES (Median)**

	<b>CPT Code: 52332</b>	<b>Key Reference CPT Code: 52007</b>	<b>Source of Time</b>
Median Pre-Service Time	21.00	38.00	
Median Intra-Service Time	25.00	45.00	
Median Immediate Post-service Time	10.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
<b>Median Total Time</b>	<b>56.00</b>	<b>113.00</b>	

Other time if appropriate		
---------------------------	--	--

**INTENSITY/COMPLEXITY MEASURES (Mean)**(of those that selected Key  
Reference code)**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.11	3.32
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.32	3.39
--	------	------

Urgency of medical decision making	3.68	3.00
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.57	3.29
--------------------------	------	------

Physical effort required	3.21	3.00
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.32	2.96
---	------	------

Outcome depends on the skill and judgment of physician	3.61	3.29
--	------	------

Estimated risk of malpractice suit with poor outcome	3.32	2.96
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.18	2.96
----------------------------------	------	------

Intra-Service intensity/complexity	3.32	3.18
------------------------------------	------	------

Post-Service intensity/complexity	2.96	2.79
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

According to RUC presumptions, the current work values of all CPT codes are correct. The AUA survey results reflect an increase in work RVU for the median (3.51) and the 25<sup>th</sup> percentile (3.20). Since there is no compelling evidence to support an increase in the work value, the AUA expert panel supports the current work RVU of 2.83.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 52332

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Urology                      How often? Commonly

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 280000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Educated estimate.

Specialty Urology                      Frequency 275940                      Percentage 98.55 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

124,420 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2008 Medicare data.

Specialty Urology                      Frequency 122615                      Percentage 98.54 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 52332

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 52353	Tracking Number	Original Specialty Recommended RVU: <b>7.88</b>
		Presented Recommended RVU: <b>7.88</b>
Global Period: 000		RUC Recommended RVU: <b>7.50</b>

CPT Descriptor: Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 57-year-old male presents to the emergency room with acute right flank pain, nausea and vomiting. A CT scan demonstrates a 6 millimeter right ureteral calculus impacted at the level of the iliac vessels with marked hydroureteronephrosis. After appropriate pre-operative preparation, he is taken to the operating room, where under general anesthesia, ureteroscopy with lithotripsy is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 7%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

**Description of Pre-Service Work:**

Preservice Description of Work: Includes services provided from the day of the surgery or diagnostic procedure until the time of the procedure and may include:

- Obtain and review records and previous history, laboratory studies and all imaging studies before the procedure;
- Communicate with other health professionals (e.g. family physician, anesthesiologist);
- Communicate with the patient and family to explain the procedure, operative risks and benefits and to obtain informed consent;
- Dress for surgery, sign the final form in prep area, wait for administration of anesthesia, mark the side of the patient, the patient is first placed in the dorsal lithotomy position; the elbows and shoulders are then padded and the table is then tilted into Trendelenberg (with the head down), prep and drape the patient, and scrub;
- Prepare and check needed equipment for surgery or procedure and any other non "skin-to-skin" work in the operating room or procedure suite;
- Adjust video and fluoroscopic equipment, "white balancing scopes";
- Does not include: The consultation or evaluation at which time the decision to provide the procedure is made.

**Description of Intra-Service Work:**

First, cystourethroscopy is performed with a rigid cystoscope. The bladder and ureteral orifices are inspected. The right ureteral orifice is visualized and a guide wire is manipulated past the stone to the kidney, a dilator is then passed over the wire enlarging the ureteral orifice. A second guidewire is placed in the ureter. The flexible ureteroscope is passed through the urethra into the bladder over the second guide wire. A ureteral access sheath is then placed into the ureter. The right

ureteral orifice is entered and the stone is visualized. The laser fiber is passed, laser power settings are adjusted as appropriate, the stone is fragmented. The basket is then passed through the ureteroscope and stone fragments are manipulated into the basket. The basket is closed and the ureteroscope and basket are withdrawn together. A second look is then performed within the ureter with the ureteroscope. If more stone fragments are seen they are similarly removed with the basket. The ureteroscope is removed. The wire is removed and the bladder drained. A Foley catheter may be placed.

Description of Post-Service Work:

- Accompany patient to post anesthesia recovery room
- Write post operative orders and prescriptions
- Communication with the patient's family; communication with other physicians as appropriate
- Dictate operative report
- Write further orders depending on the status of the patient: outpatient dismissal same day as surgery, 23 hour admission, outpatient admission, inpatient admission

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	09/2011				
<b>Presenter(s):</b>	Thomas Cooper, MD; Richard Gilbert, MD; Christopher Gonzalez, MD; Norman Smith, MD; Thomas Turk, MD				
<b>Specialty(s):</b>	Urology				
<b>CPT Code:</b>	52353				
<b>Sample Size:</b>	209	<b>Resp N:</b>	86	<b>Response:</b> 41.1 %	
<b>Sample Type:</b>	Random	<b>Additional Sample Information:</b>			
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	2.00	20.00	30.00	50.00	246.00
<b>Survey RVW:</b>	5.20	7.50	7.88	8.58	14.50
<b>Pre-Service Evaluation Time:</b>			15.00		
<b>Pre-Service Positioning Time:</b>			10.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			15.00		
<b>Intra-Service Time:</b>	40.00	56.25	60.00	75.00	120.00
<b>Immediate Post Service-Time:</b>	<u>20.00</u>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

3 -FAC Straightforward Patient/Difficult Procedure

<b>CPT Code:</b>	52353	<b>Recommended Physician Work RVU: 7.50</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		33.00	33.00	0.00
<b>Pre-Service Positioning Time:</b>		5.00	3.00	2.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		15.00	15.00	0.00
<b>Intra-Service Time:</b>		60.00		
<b>Immediate Post Service-Time:</b>	<u>20.00</u>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
52345	000	7.55	RUC Time

CPT Descriptor Cystourethroscopy with ureteroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
31600	000	7.17	RUC Time	37,788

CPT Descriptor 1 Tracheostomy, planned (separate procedure);

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
43269	000	8.20	RUC Time	20,220

CPT Descriptor 2 Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of foreign body and/or change of tube or stent

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code:** 31      **% of respondents:** 36.0 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 52353</b>	<b>Key Reference CPT Code: 52345</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	53.00	70.00	
Median Intra-Service Time	60.00	45.00	
Median Immediate Post-service Time	20.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	



Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>133.00</b>	<b>135.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)**(of those that selected Key  
Reference code)**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.45	3.74
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.68	3.74
Urgency of medical decision making	4.13	3.45

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.61	4.29
Physical effort required	3.87	3.65

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.10	4.03
Outcome depends on the skill and judgment of physician	4.45	4.29
Estimated risk of malpractice suit with poor outcome	3.84	3.77

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.58	3.61
Intra-Service intensity/complexity	4.23	4.00
Post-Service intensity/complexity	3.39	3.39

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUR analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

This code was identified through the Harvard screen and is now being reviewed by the RUC. CPT code 52353 Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included) is currently valued at 7.96 work RVUs.

The AUA expert panel believes that the ureteroscopy codes meet the compelling evidence argument that the technology used during this procedure has changed physician work. An additional letter for compelling evidence is attached for all five ureteroscopy codes under RUC review for this meeting.

For current Harvard valued codes, there are instances when the minutes allowed for each of the pre, intra, and post service times may differ, however, the AUA requests that the AUA recommended times be accepted. In addition, prior to 2008 there were no pre-service packages assigned by the RUC to CPT codes.

	CPT Code	Descriptor	Pre-service Time	Intra-service Time	Post-service Time	Total Time	Work RVU
<b>Current Harvard</b>	<b>52353</b>	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)	52	111	20	183	7.96
<b>AUA Recommendation</b>	52353	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)	53	60	20	133	7.88
<b>Key Reference Code RUC Reviewed April 2008</b>	52345	Cystourethroscopy with ureteroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)	70	45	20	135	7.55

The current procedure does not resemble the original Harvard procedure in either work or intensity. In spite of fewer intra-service minutes for this procedure than original Harvard time, there is considerably more intensity in the current ureteroscopy codes, which allow the ability to view the entire collecting system including the renal pelvis and renal calyx than the original Harvard ureteroscopy codes.

The AUA RUC expert panel recommends a total of five minutes positioning time for the safe placement of the patient in the dorsal lithotomy position (3 minutes pre-service package plus two additional minutes – straightforward patient/difficult procedure). This precedent was granted by the RUC during its October 2010 meeting.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 52353

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Urology                      How often? Sometimes

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 43953

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The majority of these patients are Medicare beneficiaries and the non-Medicare population comprises approximately 25% of the total population. There is no utilization data available on non-Medicare population to support an accurate estimate.

Specialty Urology                      Frequency 43610                      Percentage 99.21 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 35,163 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2010 RUC database information.

Specialty Urology                      Frequency 34948                      Percentage 99.38 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

**Professional Liability Insurance Information (PLI)**

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 52353

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 52356	Tracking Number Z3	Original Specialty Recommended RVU: <b>8.75</b>
		Presented Recommended RVU: <b>8.00</b>
Global Period: 000		RUC Recommended RVU: <b>8.00</b>

CPT Descriptor: Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double J type)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: : A 57-year-old male presents to the emergency room with acute right flank pain, nausea and vomiting. A CT scan demonstrates a 6 millimeter right ureteral calculus impacted at the level of the iliac vessels with marked hydroureteronephrosis. After appropriate pre-operative preparation, he is taken to the operating room, where under general anesthesia, ureteroscopy with laser lithotripsy and placement of indwelling double-J stent insertion is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Includes services provided from the day of the surgery or diagnostic procedure until the time of the procedure and may include:

- Obtain and review records and previous history, laboratory studies and all imaging studies before the procedure;
- Communicate with other health professionals (e.g. family physician, anesthesiologist);
- Communicate with the patient and family to explain the procedure, operative risks and benefits and to obtain informed consent;
- Dress for surgery, sign the final form in prep area, wait for administration of anesthesia, mark the side of the patient, the patient is first placed in the dorsal lithotomy position; the elbows and shoulders are then padded and the table is then tilted into Trendelenberg (with the head down), prep and drape the patient, and scrub;
- Prepare and check needed equipment for surgery or procedure and any other non "skin-to-skin" work in the operating room or procedure suite;
- Adjust video and fluoroscopic equipment, "white balancing scopes";
- Does not include: The consultation or evaluation at which time the decision to provide the procedure is made.

Description of Intra-Service Work: Ureteroscopic lithotripsy: First, cystourethroscopy is performed with a rigid cystoscope. The bladder and ureteral orifices are inspected. The right ureteral orifice is visualized and a guide wire is manipulated past the stone to the kidney, a dilator is then passed over the wire enlarging the ureteral orifice. A second guidewire is placed in the ureter. A ureteral access sheath is then placed into the ureter. The flexible ureteroscope is passed through the urethra into the bladder over the second guide wire. The right ureteral orifice is entered and the stone is visualized. The laser fiber is passed, laser power settings are adjusted as appropriate, and the stone is fragmented. The basket is then passed through

the ureteroscope and stone fragments are manipulated into the basket. The basket is closed and the ureteroscope and basket are withdrawn together. A second look is then performed within the ureter with the ureteroscope. If more stone fragments are seen they are similarly removed with the basket. The ureteroscope is removed.

Stent placement: The previously placed guidewire is removed and replaced if damaged. If the guidewire is not damaged it is left in place. A ureteral catheter is passed over the guide wire and the guidewire is removed. Contrast is injected to opacify the collecting system under fluoroscopy. The guidewire is replaced and then back-loaded through a rigid cystoscope sheath, a 30 degree lens is placed and the rigid cystoscope is inserted into the bladder. An appropriate size (length and diameter) double J ureteral stent is selected. Under fluoroscopy the stent is then passed over the guidewire through the cystoscope and up the right ureter. Once it is confirmed that the distal end of the J stent is in the renal pelvis, and the proximal end is in the bladder, the guidewire is removed. Fluoroscopy is again used to make certain the J stent is coiled in the renal pelvis and in the bladder appropriately. If the double J stent is not perfectly positioned, a grasping forceps is utilized to manipulate the distal end of the J stent and achieve correct positioning. The bladder is then emptied and the cystoscope removed. A Foley catheter is placed, and the patient is taken to the recovery room.

#### Description of Post-Service Work:

- Accompany patient to post anesthesia recovery room
- Write post operative orders and prescriptions
- Communication with the patient's family; communication with other physicians as appropriate
- Dictate operative report
- Write further orders depending on the status of the patient: outpatient dismissal same day as surgery, 23 hour admission, outpatient admission, inpatient admission

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Thomas Cooper, MD, Tom Turk, MD, Martin Dineen, MD				
<b>Specialty(s):</b>	Urology				
<b>CPT Code:</b>	52356				
<b>Sample Size:</b>	308	<b>Resp N:</b>	153	<b>Response:</b>	49.6 %
<b>Description of Sample:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>		30.00	<b>50.00</b>	90.00	400.00
<b>Survey RVW:</b>	5.35	8.00	<b>8.75</b>	9.50	22.10
<b>Pre-Service Evaluation Time:</b>			<b>55.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>10.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>10.00</b>		
<b>Intra-Service Time:</b>	40.00	60.00	<b>60.00</b>	75.00	160.00
<b>Immediate Post Service-Time:</b>	<b>20.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

3 -FAC Straightforward Patient/Difficult Procedure

<b>CPT Code:</b>	52356	<b>Recommended Physician Work RVU: 8.00</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>33.00</b>	<b>33.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>5.00</b>	<b>3.00</b>	<b>2.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>15.00</b>	<b>15.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>60.00</b>		
<b>Immediate Post Service-Time:</b>	<b>20.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
52352	000	6.75	RUC Time

CPT Descriptor Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
15004	000	4.58	RUC Time	20,050

CPT Descriptor 1 Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2 See Additional Rationale

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
52346	000	8.58	RUC Time

CPT Descriptor Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 59      % of respondents: 38.5 %

**TIME ESTIMATES (Median)**

	CPT Code: 52356	Key Reference CPT Code: 52352	Source of Time RUC Time
Median Pre-Service Time	53.00	53.00	
Median Intra-Service Time	60.00	45.00	
Median Immediate Post-service Time	20.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>133.00</b>	<b>118.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.46	3.19
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.56	3.41
--	------	------

Urgency of medical decision making	3.71	3.49
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.22	3.64
--------------------------	------	------

Physical effort required	3.63	3.20
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.54	3.24
---	------	------

Outcome depends on the skill and judgment of physician	4.03	3.69
--	------	------

Estimated risk of malpractice suit with poor outcome	3.54	3.27
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.36	3.20
----------------------------------	------	------

Intra-Service intensity/complexity	4.05	3.53
------------------------------------	------	------

Post-Service intensity/complexity	3.08	2.93
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*



**Additional Rationale and Comments 52356**

The AUA requested a random sampling of email addresses from our membership database. The identified members were sent a “do you do and will you complete” email asking for participation in the RUC survey process. The individuals who responded affirmatively were sent the survey instrument and password access. The survey data was reviewed by our RUC expert panel and the Summary of Recommendations was completed using this data.

Preservice time package “3” assigns three minutes for patient positioning. AUA added two additional minutes, for a total of five minutes as per previous RUC policy which assigns five minutes for positioning in the “dorsal lithotomy” position.

A search of the RUC MPC Database indicates there are 36 “000” global procedures ranging from a low of 0.39 RVW to a high of 4.58 RVW. In the past three years a number of “000” global procedures have been reviewed by the RUC. AUA selected recently reviewed procedures from the RUC Database to compile the table below to show where 52356 fits in relation not only to urologic procedures but also to cross specialty procedures.

Code	Code Descriptor	Pre service Pkg.	RVU	Pre Service Eval	Position time	Scrub, Dress & Wait	Intra service	Post service	Total Time	IWPUT	RUC Reviewed
52332	Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)	6	2.82	15	1	5	25	10	56	0.0879	Apr 2010
52353	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)	3	7.5	33	5	15	60	20	133	0.1013	Sept 2011
52346 Reference Code	Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)	No pre-service pkg	8.58	40	10	10	60	20	140	0.1155	Oct 2010
<b>52356</b>	<b>Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double J type)</b>	<b>3</b>	<b>8.75</b>	<b>33</b>	<b>5</b>	<b>15</b>	<b>60</b>	<b>20</b>	<b>133</b>	<b>0.122</b>	<b>Apr 2013</b>
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch	2b	10.1	33	1	5	68	30	137	0.1269	Jan 2012
92937	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel	2b	11.2	33	1	5	67	30	136	0.1452	Jan 2012

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 52353 and 52332

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Urology                      How often? Commonly

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 60000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimated utilization of commercial insurers

Specialty Urology                      Frequency 59642                      Percentage 99.40 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 30,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. CMS Utilization from RUC Database

Specialty Urology                      Frequency 29826                      Percentage 99.42 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

**Professional Liability Insurance Information (PLI)**

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 52353

## SS Rec Summary

	A	B	C										D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN
12	ISSUE:																																																
13	TAB:																																																
14						RVW					Total	PRE-TIME					INTRA-TIME					IMMD	FAC-inpt/same day					FAC-obs					Office					Prolonged											
15	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57									
16	REF	52352	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)		0.118			6.75			118	33	5	15			45			20																													
17	CURRENT				#DIV/0!						0																																						
18	SVY	52356	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double J type)	153	0.113	5.35	8.00	8.75	9.50	22.10	155	55	10	10			60			20																													
19	REC	52356	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double J type)		0.110	8.00					133	33	5	15			60			20																													
20																																																	
21																																																	
22																																																	
23																																																	
24																																																	
25																																																	

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor:

52356X Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double J type)

Global Period: 000

Meeting Date: April 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The AUA expert panel consists of ten urologists who represent urological practices, both academic and private settings, from across the United States. They represent the states of Washington, Illinois, New York, Kentucky, and Florida. The panel reviews current RUC practice expense information, requests input for supplies and equipment from several urology practices, reviews the information, makes recommendations and submits them to the AMA.

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

This new code 52356 is a combination of two existing CPT codes 52353 and 52332 as required by RUC and CMS through the two codes reported during the same encounter over 75% of the time.

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time: N/A

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence: N/A

5. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Complete pre-service diagnostic and referral forms

Coordinate pre-service surgery services

Schedule space and equipment in facility

Provide pre-service education/obtain consent

Intra-Service Clinical Labor Activities:

None

Post-Service Clinical Labor Activities:

Follow-up phone calls and prescriptions

	A	B	C	D	E	F	G	H	I
1	AMA Specialty Society Recommendation			REFERENCE CODE	REFERENCE CODE				
2				CPT Code # 52353	CPT Code # 52332	CPT Code # 52356			
3	Meeting Date: April 2013 Tab: 13 Specialty: American Urological Association	CMS Code	Staff Type	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)	Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double J type)			
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD				000		000		000
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	56.0	0.0	33.0	0.0	33.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	50.0	0.0	30.0	0.0	30.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	0.0	0.0	0.0	0.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	6.0	0.0	3.0	0.0	3.0
10	PRE-SERVICE								
11	Start: Following visit when decision for surgery or procedure made								
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5		5		5
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA		15		10		10
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8		5		5
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		15		7		7
16	Follow-up phone calls & prescriptions				7		3		3
17	*Other Clinical Activity - specify:								
18	End: When patient enters office/facility for surgery/procedure								
19	SERVICE PERIOD								
20	Start: When patient enters office/facility for surgery/procedure:			NA	NA	NA	NA	NA	
21	Greet patient, provide gowning, ensure appropriate medical records are available								
22	Obtain vital signs								
23	Provide pre-service education/obtain consent								
24	Prepare room, equipment, supplies								
25	Setup scope (non facility setting only)								
26	Prepare and position patient/ monitor patient/ set up IV								
27	Sedate/apply anesthesia								
28	*Other Clinical Activity - specify:								
29	Intra-service								
30	Assist physician in performing procedure								
31	Post-Service								
32	Monitor pt. following service/check tubes, monitors, drains								
33	Clean room/equipment by physician staff								
34	Clean Scope								
35	Clean Surgical Instrument Package								
36	Complete diagnostic forms, lab & X-ray requisitions								
37	Review/read X-ray, lab, and pathology reports								
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions								
39	*Other Clinical Activity - specify:								
40	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			n/a		n/a		n/a	
41	Dischrg mgmt (1.0 x 99238) (enter 12 min)			n/a		n/a		n/a	
42	Dischrg mgmt (1.0 x 99239) (enter 15 min)			n/a		n/a		n/a	
43	End: Patient leaves office								
44	POST-SERVICE Period								
45	Start: Patient leaves office/facility								
46	Conduct phone calls/call in prescriptions				6		3		3
47	Office visits: List Number and Level of Office Visits			# visits	# visits	# visits	# visits	# visits	# visits
48	99211 16 minutes		16						
49	99212 27 minutes		27						
50	99213 36 minutes		36						
51	99214 53 minutes		53						
52	99215 63 minutes		63						
53	Total Office Visit Time			0.0	0.0	0.0	0.0	0.0	0.0
54	*Other Clinical Activity - specify:								
55	End: with last office visit before end of global period								
56	MEDICAL SUPPLIES**	CODE	UNIT						
57	None								
58	EQUIPMENT	CODE							
59	None								



## AMA/Specialty Society RVS Update Committee Summary of Recommendations

January 2013

### Chemodenervation of Neck Muscles

In February 2012, the CPT Editorial Panel created one CPT code 64615 to describe a new injection paradigm for treatment of chronic migraine as current codes did not describe the totality of the work performed. In April 2012, the RUC reviewed the chemodenervation family of codes and 64613 was referred to the CPT Editorial panel to create two codes, one to describe chemodenervation for spasmodic torticollis and another to describe chemodenervation for spasmodic dysphonia. The panel determined that injecting the neck muscle versus injecting the larynx involves different levels of work and intensity and the code was divided into two separate codes.

#### **64616 Chemodenervation of muscle(s); neck muscle(s), excluding muscles of the larynx, unilateral (eg, for cervical dystonia, spasmodic torticollis)**

The RUC reviewed survey results from 80 neurologists and determined that the specialty recommended work RVU of 1.85 is not appropriate for this service. The specialty recommended this value based on a crosswalk to CPT code 64615 *Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)* (work RVU=1.85, 15 minutes pre-service, 15 minutes intra-service, and 5 minutes post-service) because 64615 requires the same physician time, is part of the chemodenervation family and was recently valued in April of 2012. However, the work RVU for CPT code 64615 is currently considered an interim value by CMS and involves 31 injections rather than the 8-10 that are typically required for the surveyed service. The RUC noted that this service will primarily be reported by neurology. The RUC agreed with the specialty recommended pre-service package 5 (Procedure without sedation/anesthesia care), with the addition of 3 minutes of pre-service time for mixing the toxin. The Physician work times are 15 minutes pre-service, 15 minutes intra-service and 5 minutes post-service. The RUC determined that the survey 25<sup>th</sup> percentile work RVU of 1.79 is an appropriate value for this service. The RUC compared 64616 to similar services CPT code 53855 *Insertion of a temporary prostatic urethral stent, including urethral measurement* (work RVU = 1.64, 15 minutes intra-service time) and 64425 *Injection, anesthetic agent; ilioinguinal, iliohypogastric nerves* (work RVU = 1.75, 15 minutes intra-service time) which both require the same intra-service physician work to perform. **The RUC recommends a work RVU of 1.79 and for CPT code 64616.**

#### **64617 Chemodenervation of muscle(s); larynx, unilateral, percutaneous (eg, for spasmodic dysphonia), includes guidance by needle electromyography, when performed**

The RUC reviewed survey results from 60 Otolaryngologists that perform this service and determined that the specialty recommended work RVU of 2.19 is not appropriate for this service and that a work RVU of 2.06, a direct crosswalk to CPT code 69801 *Labyrinthotomy, with perfusion of vestibuloactive drug(s); transcanal* (RVU = 2.06, 15 minutes intra, 43 total) is appropriate for this service. CPT code 64617 requires slightly less

total time, but the same intra-service time and it is a more intense service to perform. The RUC agreed that a work RVU of 1.82, the 25<sup>th</sup> percentile of the survey, does not appropriately account for the level of complexity and risk associated with this service. The RUC noted that this service will primarily be reported by otolaryngology. The RUC approved an adjustment to the intra-service time removing 5 minutes of scrub dress and wait time and adding 5 minutes to the intra-service time. Anesthesia related to this service is more appropriately placed in the intra-service time because the anesthesia is injected directly into the larynx, which can cause significant reaction. The physicians must stay at the bedside during this time. The RUC agreed with the specialty recommended pre-service package 6 (Procedure with sedation/anesthesia care), with an adjustment to the pre-service evaluation time of 2 minutes less resulting in 15 total minutes of pre-service evaluation time. The RUC recommends 16 minutes pre-service, 15 minutes intra-service and 5 minutes post-service time for a total time of 36 minutes. For additional support, the RUC compared 64617 to MPC code 57452 *Colposcopy of the cervix including upper/adjacent vagina*; (work RVU = 1.50, 15 minutes pre-service, 15 minutes intra-service, 10 minutes post-service), which requires the same intra-service time, but is less intense to perform and MPC code 52000 *Cystourethroscopy (separate procedure)* (work RVU=2.23, 17 minutes pre-service, 15 minutes intra-service, 10 minutes post-service), which requires the same intra-service time but is more intense to perform. **The RUC recommends a work RVU of 2.06 for CPT code 64617.**

#### Practice Expense:

The RUC accepted the direct practice expense inputs for both codes with the appropriate adjustments to reflect altered intra-service time and equipment time for CPT code 64617.

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
64612	S1	<u>Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (eg, for blepharospasm, hemifacial spasm)</u>	010	1.41  (Request to Reaffirm RUC Recommendation April 2012)
D64613		<del>Chemodenervation of muscle(s); neck muscle(s), (eg, for spasmodic torticollis)</del>  <u>(64613 has been deleted. To report, use 64616)</u>	010	N/A

●64616	S2	<p>Chemodenervation of muscle(s); neck muscle(s), excluding muscles of the larynx, unilateral (eg, for cervical dystonia, spasmodic torticollis)</p> <p><u>-(To report a bilateral procedure, use modifier 50)</u></p> <p><u>(For chemodenervation guided by needle electromyography or muscle electrical stimulation, see 95873, 95874)</u></p>	000	1.79
●64617	S3	<p>larynx, unilateral, percutaneous (eg, for spasmodic dysphonia), includes guidance by needle electromyography, when performed</p> <p><u>(To report a bilateral procedure, use modifier 50)</u></p> <p><u>(For diagnostic needle electromyography of the larynx use 95865)</u></p> <p><u>(For chemodenervation of the larynx performed with direct laryngoscopy, see 31570, 31571)</u></p> <p><u>(Do not report 64617 in conjunction with 95873, 95874)</u></p>	000	2.06

**Medicine**

**Neurology and Neuromuscular Procedures**

**Guidance for Chemodenervation and Ischemic Muscle Testing**

**✚ 95873**      Electrical stimulation for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)

(Do not report 95873 in conjunction with 64617, 95860-95870, 95874)

**✚95874**      Needle electromyography for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)

(Use 95873, 95874 in conjunction with 64612, ~~64613~~, 64616 ~~64614~~ ~~64642~~, 64643, 64644, 64645, 64646, 64647)

~~*(Do not report 95874 in conjunction with 95873)*~~

(Do not report ~~95873~~, 95874 in conjunction with 64617, 95860-95870, 95873)

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 64616	Tracking Number S2	Original Specialty Recommended RVU: <b>1.85</b>
		Presented Recommended RVU: <b>1.79</b>
Global Period: 000		RUC Recommended RVU: <b>1.79</b>

CPT Descriptor: Chemodenervation of muscle(s); neck muscle(s), excluding muscles of the larynx, unilateral (eg, for cervical dystonia, spasmodic torticollis)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 60-year-old female presents with a history of progressive involuntary head turn to the right associated with right tilt. The symptom is worse with certain activities and better if she touches her chin. She has significant neck and shoulder pain that interfere with her functioning and sleep. The exam is consistent with torticollis. Chemodenervation is recommended.

Percentage of Survey Respondents who found Vignette to be Typical: 99%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 6%

Description of Pre-Service Work: The medication is brought to room temperature and reconstituted with sterile saline by slowly injecting the diluents into the vial. The physician then gently mixes the toxin by rotating the vial. The drug is drawn into a syringe. The injection sites are cleaned using alcohol swabs and the neck is positioned for optimal medication delivery to the first injection site. The physician reviews the patient history, takes an interval history, reviews the patient's medications and allergies. The effect (e.g., benefit, duration of effect, any side effects) of any prior treatment is reviewed. To determine the muscles involved, a focused physical examination is performed. The patient is observed both at rest and walking to determine the pattern of torticollis (presence of anterocollis, tilt, turn and retrocollis along with any associated shoulder movements). Active and passive movements while palpating affected muscles are also used to determine injection sites. Optimal injection sites are determined and marked. Patient questions are answered and informed consent is obtained. The duration of expected treatment effect is discussed. A "time-out" is performed. The physician cleans the injection sites using alcohol swabs and puts on gloves

Description of Intra-Service Work: The toxin is injected. Injections are performed. Following the injection, pressure is held briefly to control any bleeding. The patients is then repositioned for each subsequent injection.

Description of Post-Service Work: Bandages are placed over injection sites. The expected results and follow-up plans are discussed with the patient. Drug accounting is completed. The procedure report is generated, reviewed, and signed

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)		01/2013				
Presenter(s):	Kevin Kerber, MD; Wayne Cornblath, MD; Janice Massey, MD					
Specialty(s):	American Academy of Neurology, American Association of Neuromuscular & Electrodiagnostic Medicine					
CPT Code:	64616					
Sample Size:	1093	Resp N:	80	Response: 7.3 %		
Description of Sample:	The societies used a combined a sample of members and physicians who indicated they perform the service.					
		Low	25 <sup>th</sup> pctl	Median*	75 <sup>th</sup> pctl	High
Service Performance Rate		0.00	10.00	25.00	84.00	400.00
Survey RVW:		0.88	1.79	2.25	3.00	10.00
Pre-Service Evaluation Time:				10.00		
Pre-Service Positioning Time:				5.00		
Pre-Service Scrub, Dress, Wait Time:				5.00		
Intra-Service Time:		5.00	10.00	15.00	30.00	55.00
Immediate Post Service-Time:	5.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00		
Discharge Day Mgmt:	0.00	99238x 0.00	99239x 0.00	99217x 0.00		
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00	15x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00	
Sub Obs Care:	0.00	99224x 0.00	99225x 0.00	99226x 0.00		

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

5 - NF Procedure without sedation/anesthesia care

CPT Code:	64616	Recommended Physician Work RVU: 1.79			
		Specialty Recommended Pre- Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:		10.00	7.00	3.00	
Pre-Service Positioning Time:		5.00	0.00	5.00	
Pre-Service Scrub, Dress, Wait Time:		0.00	0.00	0.00	
Intra-Service Time:		15.00			
Immediate Post Service-Time:	5.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	0.00	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00

Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00
---------------	-------------	-------------	-------------	-------------

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99244	XXX	3.02	RUC Time

CPT Descriptor Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
92004	XXX	1.82	RUC Time	2,151,572

CPT Descriptor 1 Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
64483	000	1.90	RUC Time	853,509

CPT Descriptor 2 Injection, anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 20      % of respondents: 25.0 %

**TIME ESTIMATES (Median)**

	<u>CPT Code:</u> 64616	<u>Key Reference CPT Code:</u> 99244	<u>Source of Time</u> RUC Time
Median Pre-Service Time	15.00	10.00	
Median Intra-Service Time	15.00	40.00	
Median Immediate Post-service Time	5.00	15.00	
Median Critical Care Time	0.0	0.00	

Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>35.00</b>	<b>65.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)**(of those that selected Key  
Reference code)**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.00	4.20
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.90	4.30
Urgency of medical decision making	3.60	3.90

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.85	4.15
Physical effort required	4.30	3.70

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.65	3.85
Outcome depends on the skill and judgment of physician	4.75	4.60
Estimated risk of malpractice suit with poor outcome	4.35	4.05

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.25	2.95
Intra-Service intensity/complexity	4.55	4.30
Post-Service intensity/complexity	2.75	3.10

---

**Additional Rationale and Comments**



Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The existing code 64613 describes multiple uses of the procedure (for treatment of spasmodic dysphonia and spasmodic torticollis). We believe these two uses are separate and distinct and involve different levels of work and intensity when injecting the neck muscle versus injecting the larynx.

The new code that will primarily be reported by neurology is 64616: Chemodenervation of muscle(s); neck muscle(s), excluding muscles of the larynx, unilateral (eg, for cervical dystonia, spasmodic torticollis). Otolaryngology will primarily report code 64617. Previously one unit of 64613 was reported regardless of the number of sites that were injected. The new code will be reported the same way.

This was a strong survey with 80 responses and 99% agreement with the vignette. The median work RVU of 2.25 is higher than the existing RVU and the societies felt a slightly lower value would be appropriate. The societies recommend pre-service evaluation time of 10 minutes and 5 minutes of positioning time. The time required to mix the toxin and position the patient support the time beyond the standard 7 minutes in the selected pre-service package. Respondents rated 64616 as requiring more technical skill, physical effort and psychological stress than the key reference service 99244.

The societies recommend a work RVU of 1.85 for new CPT code 64616 which falls between the existing RVU of 2.01 and above the survey's 25<sup>th</sup> percentile for a physician work value of 1.79. Our recommended times are 15/15/5. We believe this recommendation is supported by the crosswalk code, 64615 which has a work RVU of 1.85 and the same times. 64615 is part of the same chemodenervation family and was valued in April of 2012.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64613

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology

How often? Sometimes

Specialty PMR                      How often? Sometimes

Specialty                              How often?

Estimate the number of times this service might be provided nationally in a one-year period? 174519

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This number is three times the 2011 medicare claims reporting data for 64613, which we feel accurately represents the national reporting of this code for one year.

Specialty Neurology	Frequency 139615	Percentage 79.99 %
---------------------	------------------	--------------------

Specialty PMR	Frequency 20942	Percentage 11.99 %
---------------	-----------------	--------------------

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 58,173 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We used 2011 Medicare claims data for 64613 to develop the following estimates; taking into consideration Otolaryngology will not report the new code, rather use 64613XX.

Specialty Neurology	Frequency 46538	Percentage 79.99 %
---------------------	-----------------	--------------------

Specialty Physical Medicine and Rehabilitation	Frequency 6900	Percentage 11.86 %
--	----------------	--------------------

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 64613

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 64617	Tracking Number S3	Original Specialty Recommended RVU: <b>2.19</b>
		Presented Recommended RVU: <b>2.19</b>
Global Period: 000		RUC Recommended RVU: <b>2.06</b>

CPT Descriptor: Chemodenervation of muscle(s); larynx, unilateral, percutaneous (eg, for spasmodic dysphonia), includes guidance by needle electromyography, when performed

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 65 year old woman with spasmodic dysphonia presents with deterioration of vocal quality. She finds that her voice makes it difficult to communicate with those around her and interferes with her normal acts of daily living. Anesthesia is provided, as needed, and chemodenervation of laryngeal musculature on one side is performed by percutaneous injection. Needle electromyography is used for guidance.

Percentage of Survey Respondents who found Vignette to be Typical: 85%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 7%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Informed consent is obtained and the patient is positioned for laryngeal injection. The neck is prepared and topical anesthetic is injected into the skin and subcutaneous tissue overlying the planned injection site, and directly into the airway (laryngeal and tracheal); time is allotted for it to take effect. EMG grounding leads are placed and the appropriate dilution of botulinum toxin is prepared.

Description of Intra-Service Work: A hollow EMG needle is directed into the intended muscle and when correctly positioned the botulinum toxin is injected. The EMG signal is observed for the appropriate responses as the needle is positioned into the target muscle.

Description of Post-Service Work: The patient is observed for hemoptysis, hematoma, airway obstruction, and aspiration. A clinical note is documented in their file. The patient is counseled on post-procedure care and a follow up appointment is scheduled.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	01/2013				
<b>Presenter(s):</b>	Wayne Koch, MD				
<b>Specialty(s):</b>	AAO-HNS				
<b>CPT Code:</b>	64617				
<b>Sample Size:</b>	2003	<b>Resp N:</b>	60	<b>Response:</b> 2.9 %	
<b>Description of Sample:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	6.00	26.00	153.00	1000.00
<b>Survey RVW:</b>	0.88	1.82	2.30	2.96	9.25
<b>Pre-Service Evaluation Time:</b>			15.00		
<b>Pre-Service Positioning Time:</b>			5.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			5.00		
<b>Intra-Service Time:</b>	1.00	5.00	10.00	15.00	45.00
<b>Immediate Post Service-Time:</b>	<b>5.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

6 - NF Procedure with sedation/anesthesia care

<b>CPT Code:</b>	64617	<b>Recommended Physician Work RVU: 2.06</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		15.00	17.00	-2.00
<b>Pre-Service Positioning Time:</b>		1.00	1.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	5.00	-5.00
<b>Intra-Service Time:</b>		15.00		
<b>Immediate Post Service-Time:</b>	<b>5.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00		

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
64479	000	2.29	RUC Time

CPT Descriptor Injection, anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
57452	000	1.50	RUC Time	10,865

CPT Descriptor 1 Colposcopy of the cervix including upper/adjacent vagina;

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
52000	000	2.23	RUC Time	925,004

CPT Descriptor 2 Cystourethroscopy (separate procedure)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31579	000	2.26	RUC Time

CPT Descriptor Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code:** 16      **% of respondents:** 26.6 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 64617</b>	<b>Key Reference CPT Code: 64479</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	16.00	24.00	
Median Intra-Service Time	15.00	15.00	
Median Immediate Post-service Time	5.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

<b>Median Total Time</b>	<b>36.00</b>	<b>49.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.94	3.38
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.63	3.31
Urgency of medical decision making	2.56	2.69

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.63	4.06
Physical effort required	3.00	2.94

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.94	3.88
Outcome depends on the skill and judgment of physician	4.75	4.25
Estimated risk of malpractice suit with poor outcome	3.13	3.56

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.25	3.19
Intra-Service intensity/complexity	4.25	4.06
Post-Service intensity/complexity	3.06	2.94

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Why is this code being reviewed?**

The chemodenervation of neck muscle(s) family of codes (64612-64615) was originally brought forward to the CPT Editorial Panel during the February 2012 meeting by the American Academy of Neurology, the American Academy of Ophthalmology, the American Academy of Physical Medicine and Rehabilitation, and the American Society of Ophthalmic Plastic and Reconstructive Surgery. During that meeting they submitted a code change proposal requesting the creation of a new code (now CPT 64615) as well as the addition of instructional parentheticals to the other codes in this family. These modifications were accepted by the CPT Editorial Panel and the family of codes was referred for the RUC for survey for the April 2012 meeting. CPT 64613, chemodenervation of neck muscle(s) (eg, for spasmodic torticollis, spasmodic dysphonia) was then jointly surveyed by Neurology, Otolaryngology, AAPMR, and ASIPP. Upon conclusion of this survey, it was apparent that responses from AAO-HNS members were markedly different, in work and intensity, than those received from AAN, ASIPP, and AAPMR. The expert panel felt that this was due to the parenthetical for CPT 64613 which reflected two uses for the code, one for torticollis and one for dysphonia. Specifically, an Otolaryngologist is injecting the larynx whereas the other specialties are injecting a muscle in the neck. Therefore, expert panel agreed that injecting the larynx was substantially different work than injecting the neck muscle; and a letter was submitted to Dr. Levy, Chair of the RUC, requesting that CPT 64613 be removed from the April 2012 meeting agenda and referred to CPT for the October 2012 meeting to develop two separate codes for these distinct procedures. The RUC approved this request and new codes, 64617 and 64616, were approved by the CPT Editorial Panel at the October 2012 meeting. These new codes are now being brought back to the RUC for valuation during the January 2013 meeting.

### **Description of random survey**

The physician time and work recommendations were derived by conducting a random survey of our Membership using a slightly modified 000 global survey instrument. The Research Subcommittee approved a slight modification to the standard 000 global survey instrument to include a sentence in the pre-service instructions which indicated that respondents should include time for the application of anesthesia in the pre-service time. Surveys were sent to just over 2000 Otolaryngologists and Laryngologists, including the Academy's leadership and key committees, such as the Airway and Swallowing and Voice committees, which contain clinical who are most likely to be familiar with the service under review. 60 responses were received, the data for which is discussed below.

### **Pre Time**

Regarding physician time, our expert panel recommends that pre-service package 6 (Non-facility procedure with sedation/anesthesia care). Our expert panel felt this package was most appropriate given that the service is predominantly provided in the physician office and local anesthesia is injected to anesthetize the larynx. We recommend reducing the pre-service evaluation time from 17 minutes down to 15 minutes to maintain consistency with our survey data.

### **Intra Time and Post Time**

Our expert panel agreed with the median survey intra time of 10 minutes and post time of 5 minutes.

### **Physician Work**

**We recommend a physician work RVU of 2.19 for new CPT code 64617 which is between the 25<sup>th</sup> percentile and the median survey response.** This value was derived by taking the survey's 25<sup>th</sup> percentile value (1.82 RVUs) and adding in the work for the EMG guidance (i.e. 1.82 (survey 25<sup>th</sup> percentile) + 0.37 (95873 or 95874 existing value) = 2.19 RVUs. This results in a recommended total work value which is less than the existing value of the code combinations 64613 and 95873 or 95874 (2.01 and 0.37 RVUs, respectively) which totals 2.38 RVUs. We believe the above recommendation is supported by the key reference code, 64479, which has a higher RVW of 2.29, more intra service time of 15 minutes, and more total time of 49 minutes. The difference in time results in new code, 64617, having a slightly higher IWPUP than the key reference code which is consistent with survey respondents' comments that the new code was more intense and complex than the key reference code. We are also providing the following reference tables which include recently reviewed services which support our requested values for physician time and work for CPT 64617.

### **Comparison to key reference code**

<b><u>CPT Code</u></b>	<b><u>RVW</u></b>	<b><u>IWPUP</u></b>	<b><u>Total Time</u></b>	<b><u>Eval</u></b>	<b><u>Posit</u></b>	<b><u>SDW</u></b>	<b><u>INTRA</u></b>	<b><u>Post</u></b>
<b>64617</b>	2.19	0.1679	36	15	1	5	10	5
<b>64479</b>	2.29	0.1076	49	13	5	6	15	10

### **Comparison to MPC codes**

<u>CPT Code</u>	<u>Descriptor</u>	<u>RVW</u>	<u>IWPUT</u>	<u>Total Time</u>	<u>Eval</u>	<u>Posit</u>	<u>SDW</u>	<u>INTRA</u>	<u>Post</u>
<b>57452</b>	Colposcopy of the cervix including upper/adjacent vagina;	1.50	0.0627	40	15	0	0	15	10
<b>64617</b>	Chemodenervation of muscle(s); larynx, unilateral, percutaneous (eg, for spasmodic dysphonia), includes guidance by needle electromyography, when performed	2.19	0.1679	36	15	1	5	10	5
<b>52000</b>	Cystourethroscopy (separate procedure)	2.23	0.1131	42	10	2	5	15	10

The table below compares the surveyed code to other RUC reviewed codes of similar time and work, providing further support that the recommended value for 6461XX is appropriate.

<u>RUC Reviewed</u>	<u>CPT Code</u>	<u>Descriptor</u>	<u>RVW</u>	<u>IWPUT</u>	<u>Total Time</u>	<u>Eval</u>	<u>Posit</u>	<u>SDW</u>	<u>INTRA</u>	<u>Post</u>
2009	<b>67028</b>	Intravitreal injection of pharmacologic agent (separate procedure)	1.44	0.2261	22	6	1	5	5	5
1995	<b>65430</b>	Scraping of cornea, diagnostic, for smear and/or culture	1.47	0.1067	28	10	0	0	10	8
1995	<b>53620</b>	Dilation of urethral stricture by passage of filiform and follower, male; initial	1.62	0.1284	25	15	0	0	10	0
2009	<b>64490</b>	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level	1.82	0.0858	42	7	5	5	15	10
2006	<b>54150</b>	Circumcision, using clamp or other device with regional dorsal penile or ring block	1.90	0.0866	45	15	5	5	15	5
2010	<b>69801</b>	Labyrinthotomy, with perfusion of vestibuloactive drug(s); transcanal	2.06	0.1003	43	12	1	5	15	10
2005	<b>31579</b>	Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy	2.26	0.1059	45	10	5	0	15	15
2010	<b>90870</b>	Electroconvulsive therapy (includes necessary monitoring)	2.50	0.1071	36	10	1	0	20	5
2007	<b>93503</b>	Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes	2.91	0.1659	37	5	2	5	15	10

## SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)



2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) This service was previously reporting by CPT codes 64613 and either 95873 or 95874. These services have now been bundled into the new CPT code 64617.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otolaryngology                      How often? Sometimes

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 21570

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This is three times the 2011 medicare volume which we believe is a resonable estimate for national volume in a one year period.

Specialty Otolaryngology                      Frequency 21570                      Percentage 100.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 7,190

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The current CPT code 64613 is reported 11% of the time by Otolaryngologists based on the AMA RUC database. Therefore, took 11% of the existing volume for CPT 64613, which was reported 65,363 times in 2011, and used that value to estimate the expected medicare volume for new CPT code 64617.

Specialty Otolaryngology                      Frequency 7190                      Percentage 100.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

## Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 31513



SS Rec Summary

	A	B	C					D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	AF	AG	AH	AI	AJ
10	<div>ISSUE: 6461XX &amp; 64613X Chemodenervation of neck muscle(s);</div> <div>TAB: 11</div>																												
11																													
12																													
13																													
14						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	Office								
15	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	15	14	13	12	11				
16	REF	64479	Injection, anesthetic agent and/or steroid	16	0.1076			2.29			49	13	5	6			15			10									
17	ALT REF	31579	Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy		0.1059			2.26			45	10	5				15			15									
18	CURRENT	64613	Chemodenervation of muscle(s); neck muscle(s) (eg, for spasmodic torticollis, spasmodic dysphonia)		0.0558			2.01			53	10					21			6					1				
19	CURRENT	95873	Electrical stimulation for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)		0.0185			0.37			20						20												
20	SVY	64617	Chemodenervation of muscle(s); larynx, unilateral, percutaneous (eg, for spasmodic dysphonia), includes guidance by needle electromyography, when performed	60	0.1700	0.88	1.82	2.30	2.96	9.25	40	15	5	5	1	5	10	15	45	5									
21	REC	64617	Chemodenervation of muscle(s); larynx		0.1060	2.06					36	15	1	0			15			5									
22																													
23																													
24						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	Office								
25	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	15	14	13	12	11				
26	REF	99244	Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or		0.0615			3.02			65	10					40			15									
27	CURRENT	64613	Chemodenervation of muscle(s); neck muscle(s) (eg, for spasmodic torticollis, spasmodic dysphonia)		0.0558			2.01			53	10					21			6					1				
28	SVY	64616	Chemodenervation of muscle(s); neck muscle(s), excluding muscles of the larynx, unilateral (eg, for cervical dystonia, spasmodic torticollis)	80	0.1174	0.88	1.79	2.25	3.00	10.00	40	10	5	5	5	10	15	30	55	5									
29	REC	64616	Chemodenervation of muscle(s); neck muscle(s), excluding muscles of the larynx, unilateral		0.089	1.79					35	10	5	0			15			5									
30	Crosswalk	64615	Chemodenervation; chronic migraine		0.093	1.85					35	15					15			5									
31	MPC	92004	Eye exam new patient		0.059	1.82					40	5					25			10									
32	MPC	64483	Inj formen epidural L/S		0.082	1.90					49	13	5	6			15			10									

Chemodenervation Family												
CPT	Descriptor	RVW Source	RVW	Global	Pre eval	Pre Posi	Pre SDW	Intra	Post	Post-Op	Total	IWPUT
64612	Destroy nerve face muscle	Existing - 2012 RUC Review	1.41	010	10			10	5	16	41	0.059
64613	Destroy nerve neck muscle	To be deleted	2.01	010	10			21	6	16	53	0.0558
64617	Destroy nerve larynx	Proposed	2.19	000	15	1	5	10	5		36	0.168
64616	Destroy nerve neck, other than larynx	Proposed	1.85	000	10	5		15	5		35	0.093
64614	Destroy nerve extrem and/or trunk musc	To be deleted	2.20	010	15			20	15		50	0.0763
64642	1 extremity; 1-4 musc	Proposed	2.13	000	10	5		20	5		40	0.084
64643	each addl extremity, 1-4 musc	Proposed	1.68	ZZZ				20			20	0.084
64644	1 extremity; 5 or more musc	Proposed	2.55	000	10	5		25	5		45	0.084
64645	each addl extremity, 5 or more musc	Proposed	2.10	ZZZ				25			25	0.084
64646	Trunk musc; 1-5 musc	Proposed	2.11	000	10	5		20	5		40	0.083
64647	Trunk musc; 6 or more musc	Proposed	2.64	000	10	5		25	10		50	0.083
64615	Chemodenerv for chronic migraine	Existing - 2012 RUC Review	1.85	010	15			15	5		35	0.093

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor: Chemodenervation of muscle(s); larynx, unilateral, percutaneous (eg, for spasmodic dysphonia), includes guidance by needle electromyography, when performed.

Global Period: 000 Meeting Date: January 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Our society convened an expert panel comprised of our RUC Advisors and members of our Physician Payment Policy (3P) workgroup who are familiar with this service, to derive recommendations for the direct practice expense inputs and clinical staff time for CPT 64617 Chemodenervation of neck muscle(s); larynx.

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

We selected CPT codes 64613 and 95873 as our reference codes when determining our recommendations for practice expense for the new bundled code 64617, and used the existing inputs for the two former codes now represented by 64617 (64613 and 95873) for comparison.

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:

We are recommending 2 minutes of pre-service time, which is above the PEAC standard of 0 minutes pre-service time for 000 globals. This recommendation is based on the need for clinical staff to write an order to the pharmacy requesting the botulinum toxin (botox) required for the procedure. We are also recommending 3 minutes for the staff to schedule space and equipment in the facility for this procedure. 5 minutes was previously assigned by the PEAC for scheduling, however, we believe 3 minutes is sufficient for this activity recognizing that the standard for 000 globals is 0 for this activity.

4. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The pre-service work in facility setting for CPT 64617 includes 2 minutes for the clinical staff to write an order to the pharmacy requesting the botox required for the procedure as well as 3 minutes, reduced from the 5 minutes previously assigned for this activity by the PEAC, to schedule space and equipment in the facility.

Intra-Service Clinical Labor Activities:

The only intra service clinical labor time required in the facility for CPT 64617 is 6 minutes for discharge management.

Post-Service Clinical Labor Activities:

There are no post-service clinical labor activities for CPT 64617.

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor: Chemodenervation of muscle(s); larynx, unilateral, percutaneous (eg, for spasmodic dysphonia), includes guidance by needle electromyography, when performed.

Global Period: 000 Meeting Date: January 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Our society convened an expert panel comprised of our RUC Advisors and members of our Physician Payment Policy (3P) workgroup who are familiar with this service, to derive recommendations for the direct practice expense inputs and clinical staff time for CPT 64617 Chemodenervation of neck muscle(s); larynx.

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

We selected CPT codes 64613 and 95873 as our reference codes when determining our recommendations for practice expense for the new bundled code 64617, and used the existing inputs for the two former codes now represented by 64617 (64613 and 95873) for comparison.

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:

We are recommending 2 minutes of pre-service time, which is above the PEAC standard of 0 minutes pre-service time for 000 globals. This recommendation is based on the need for clinical staff to write an order to the pharmacy requesting the botulinum toxin (botox) required for the procedure.

4. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The only pre-service work in office setting for CPT 64617 is 2 minutes for the clinical staff to write an order to the pharmacy requesting the botox required for the procedure.

Intra-Service Clinical Labor Activities:

During the intra-service period, the clinical labor performed includes: greeting and gowning the patient, ensuring appropriate medical recodes are available, obtaining 1-3 vital signs, providing pre-service education and obtaining consent, preparing the room equipment, and supplies, positioning the patient for the procedure, assisting the physician with the application of the local anesthesia, assisting the physician in performing the procedure, and cleaning the room and equipment.

Post-Service Clinical Labor Activities:

There is no post-service clinical labor time in the office setting for CPT 64617.

	A	B	C	D	E	F	G	H	I
1				REFERENCE CODE					
2	Note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.			64613		64615		64616	
3	Meeting Date: January 2013 Tab: 11 Specialty: AAN, AANEM	CMS Code	Staff Type	Chemodenervation of muscle(s); neck muscle(s) (eg, for spasmodic torticollis, spasmodic dysphonia)		Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal an daccessory nerves, bilateral (eg, for chronic migraine)		Chemodenervation of muscle(s); neck muscle(s), excluding muscles of the larynx, unilateral (eg, for cervical dystonia, spasmodic torticollis)	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			010	010	000	000	000	000
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	57.0	43.0	24.0	12.0	28.0	18.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	5.0	10.0	3.0	9.0	3.0	9.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	25.0	6.0	18.0	0.0	22.0	6.0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	27.0	27.0	3.0	3.0	3.0	3.0
10	PRE-SERVICE								
11	Start: Following visit when decision for surgery or procedure made								
12	Complete pre-service diagnostic & referral forms			5	5		3		3
13	Coordinate pre-surgery services								
14	Schedule space and equipment in facility				5		3		3
15	Provide pre-service education/obtain consent					3	3	3	3
16	Follow-up phone calls & prescriptions								
17	Other Clinical Activity - specify:								
18	End: When patient enters office/facility for surgery/procedure								
19	SERVICE PERIOD								
20	Start: When patient enters office/facility for surgery/procedure:								
21	Review charts			2					
22	Greet patient, provide gowning, ensure appropriate medical records are available			3		2		2	
23	Obtain vital signs			3		3		3	
24	Provide pre-service education/obtain consent			3					
25	Prepare room, equipment, supplies			2		2		2	
26	Setup scope (non facility setting only)								
27	Prepare and position patient/ monitor patient/ set up IV			2				2	
28	Sedate/apply anesthesia			2					
29	Intra-service								
30	Assist physician in performing procedure			7				5	
31	Post-Service								
32	Monitor pt. following service/check tubes, monitors, drains								
33	Clean room/equipment by physician staff			3		3		3	
34	Clean Scope								
35	Clean Surgical Instrument Package								
36	Complete diagnostic forms, lab & X-ray requisitions								
37	Review/read X-ray, lab, and pathology reports								
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions					5		5	
39	Other Clinical Activity - specify: complete Botox log					3		0	
40	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)	L037D	RN/LPN/MTA	n/a	6	n/a		n/a	6
41	Dischrg mgmt (1.0 x 99238) (enter 12 min)			n/a		n/a		n/a	
42	Dischrg mgmt (1.0 x 99239) (enter 15 min)			n/a		n/a		n/a	
43	End: Patient leaves office								
44	POST-SERVICE Period								
45	Start: Patient leaves office/facility								
46	Conduct phone calls/call in prescriptions					3	3	3	3
47	Office visits: List Number and Level of Office Visits			# visits	# visits	# visits	# visits	# visits	# visits
48	99211 16 minutes		16						
49	99212 27 minutes		27	1	1				
50	99213 36 minutes		36						
51	99214 53 minutes		53						
52	99215 63 minutes		63						
53	Total Office Visit Time			27.0	27.0	0.0	0.0	0.0	0.0
54	Other Clinical Activity - specify:								
55	End: with last office visit before end of global period								

	A	B	C	D	E	F	G	H	I
1				REFERENCE CODE					
2	<b>Note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.</b>			<b>64613</b>		<b>64615</b>		<b>64616</b>	
3	<b>Meeting Date: January 2013</b> <b>Tab: 11</b> <b>Specialty: AAN, AANEM</b>	<b>CMS Code</b>	<b>Staff Type</b>	Chemodenervation of muscle(s); neck muscle(s) (eg, for spasmodic torticollis, spasmodic dysphonia)		Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal an daccessory nerves, bilateral (eg, for chronic migraine)		Chemodenervation of muscle(s); neck muscle(s), excluding muscles of the larynx, unilateral (eg, for cervical dystonia, spasmodic torticollis)	
4	<b>LOCATION</b>			<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>
5	<b>GLOBAL PERIOD</b>			<b>010</b>	<b>010</b>	<b>000</b>	<b>000</b>	<b>000</b>	<b>000</b>
56	<b>MEDICAL SUPPLIES</b>	<b>CODE</b>	<b>UNIT</b>						
57	pack, minimum multi-specialty visit	SA048	pack			<b>1</b>	<b>1</b>	<b>1</b>	
58	syringe, 1ml	SC052	item	<b>2</b>		<b>6</b>		<b>1</b>	
59	mask, surgical	SB033	item	<b>1</b>				<b>1</b>	
60	syringe 5-6ml	SC057	item	<b>1</b>				<b>3</b>	
61	needle, 18-27g	SC029	item	<b>1</b>		<b>2</b>		<b>9</b>	
62	bandage, strip 0.75in x 3in (Bandaid)	SG021	item	<b>2</b>		<b>1</b>		<b>4</b>	
63	gauze, non-sterile 4in x 4in	SG051	item	<b>2</b>		<b>1</b>		<b>4</b>	
64	swab-pad, alcohol	SJ053	item	<b>2</b>		<b>3</b>		<b>12</b>	
65	phosphate buffered saline solution	SL107	ml	<b>1</b>		<b>3</b>		<b>3</b>	
66	needle, 30g	SC031	item			<b>6</b>			
67	syringe 3ml	SC055	item			<b>2</b>			
68	<b>EQUIPMENT</b>	<b>CODE</b>							
69	table, exam	EF023		<b>54</b>	<b>27</b>	<b>24</b>		<b>24</b>	



	A	B	C	D	E	F	G	H	I
1				<b>REFERENCE CODE REFERENCE CODE</b>				<b>AAO-HNS Recommendations</b>	
2				<b>PEAC 2005 CPT Code 64613</b>	<b>PEAC 2005 CPT Code 95873</b>	<b>CPT Code 64617</b>			
3	<b>REVISED 1.24.2013</b> <b>Date: January 2013</b> <b>Tab: 11 Chemodenervation of Muscle(s); Larynx</b> <b>Specialty: AAO-HNS</b>	<b>CMS Code</b>	<b>Staff Type</b>	Chemodenervation of muscle(s); neck muscle(s) (eg, for spasmodic torticollis, spasmodic dysphonia)	Electrical stimulation for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)	Chemodenervation of muscle(s); larynx, unilateral, percutaneous (eg, for spasmodic dysphonia), includes guidance by needle electromyography, when performed			
4	<b>LOCATION</b>			<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>
5	<b>GLOBAL PERIOD</b>			<b>010</b>	<b>010</b>	<b>ZZZ</b>	<b>ZZZ</b>	<b>000</b>	<b>000</b>
6	<b>TOTAL CLINICAL LABOR TIME</b>	L037D	RN/LPN/MTA	<b>59.0</b>	<b>43.0</b>	<b>5.0</b>	<b>0.0</b>	<b>35.0</b>	<b>11.0</b>
7	<b>TOTAL PRE-SERV CLINICAL LABOR TIME</b>	L037D	RN/LPN/MTA	<b>5.0</b>	<b>10.0</b>	<b>0.0</b>	<b>0.0</b>	<b>2.0</b>	<b>5.0</b>
8	<b>TOTAL SERVICE PERIOD CLINICAL LABOR TIME</b>	L037D	RN/LPN/MTA	<b>27.0</b>	<b>6.0</b>	<b>5.0</b>	<b>0.0</b>	<b>33.0</b>	<b>6.0</b>
9	<b>TOTAL POST-SERV CLINICAL LABOR TIME</b>	L037D	RN/LPN/MTA	<b>27.0</b>	<b>27.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>
10	<b>PRE-SERVICE</b>								
11	<b>Start: Following visit when decision for surgery or procedure made</b>								
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	<b>5</b>	<b>5</b>	<b>0</b>	<b>0</b>	<b>2</b>	<b>2</b>
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA	<b>0</b>	<b>5</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>3</b>
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
17	Other Clinical Activity - <i>specify:</i>			<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
18	<b>End: When patient enters office/facility for surgery/procedure</b>								
19	<b>SERVICE PERIOD</b>								
20	<b>Start: When patient enters office/facility for surgery/procedure:</b>								
21	Review charts	L037D	RN/LPN/MTA	<b>2</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
22	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	<b>3</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>3</b>	<b>0</b>
23	Obtain vital signs	L037D	RN/LPN/MTA	<b>3</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>3</b>	<b>0</b>
24	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	<b>3</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>3</b>	<b>0</b>
25	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	<b>2</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2</b>	<b>0</b>
26	Setup scope (non facility setting only)	L037D	RN/LPN/MTA	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
27	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	<b>2</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2</b>	<b>0</b>
28	Sedate/apply anesthesia	L037D	RN/LPN/MTA	<b>2</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2</b>	<b>0</b>
29	<b>Intra-service</b>								
30	Assist physician in performing procedure	L037D	RN/LPN/MTA	<b>7</b>	<b>0</b>	<b>5</b>	<b>0</b>	<b>15</b>	<b>0</b>
31	<b>Post-Service</b>								
32	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MTA	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
33	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	<b>3</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>3</b>	<b>0</b>
34	Clean Scope	L037D	RN/LPN/MTA	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
35	Clean Surgical Instrument Package	L037D	RN/LPN/MTA	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
36	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
37	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
39	Other Clinical Activity - <i>specify:</i>			<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
40	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)	L037D	RN/LPN/MTA	<b>n/a</b>	<b>6</b>			<b>n/a</b>	<b>6</b>
41	Dischrg mgmt (1.0 x 99238) (enter 12 min)			<b>n/a</b>				<b>n/a</b>	
42	Dischrg mgmt (1.0 x 99239) (enter 15 min)			<b>n/a</b>				<b>n/a</b>	
43	<b>End: Patient leaves office</b>								
44	<b>POST-SERVICE Period</b>								
45	<b>Start: Patient leaves office/facility</b>								
46	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA		<b>0</b>	<b>0</b>	<b>0</b>		<b>0</b>
47	<b>Office visits: List Number and Level of Office Visits</b>			<b># visits</b>	<b># visits</b>	<b># visits</b>	<b># visits</b>	<b># visits</b>	<b># visits</b>
48	99211 16 minutes		16						
49	99212 27 minutes		27	<b>1</b>	<b>1</b>				
50	99213 36 minutes		36						
51	99214 53 minutes		53						
52	99215 63 minutes		63						
53	<b>Total Office Visit Time</b>			<b>27.0</b>	<b>27.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>
54	Other Clinical Activity - <i>specify:</i>								
55	<b>End: with last office visit before end of global period</b>								

	A	B	C	D	E	F	G	H	I
1				REFERENCE CODE REFERENCE CODE				AAO-HNS Recommendations	
2				PEAC 2005 CPT Code 64613		PEAC 2005 CPT Code 95873		CPT Code 64617	
3	REVISED 1.24.2013 Date: January 2013 Tab: 11 Chemodenervation of Muscle(s); Larynx Specialty: AAO-HNS	Meeting   							

## AMA/Specialty Society RVS Update Committee Summary of Recommendations

January 2013

### Chemodenervation of Extremity and Trunk Muscles

In October 2012, the CPT Editorial Panel established six new codes and instructional guidelines to more accurately describe and report chemodenervation of extremity and trunk muscles.

#### **64642 Chemodenervation of one extremity; 1-4 muscle(s)**

The RUC reviewed the survey results from 44 physicians for 64642 and determined that the specialty recommended work RVU of 1.85 between the survey 25<sup>th</sup> percentile and median is not appropriate for this service. The Physician work times are 15 minutes pre-service, 20 minutes intra-service and 5 minutes post-service. The specialty recommended a work RVU of 1.85 based on a crosswalk to CPT code 64615 *Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)* (work RVU=1.85, and 15 minutes pre-service, 15 minutes intra-service, and 5 minutes immediate post-service) because 64615 has the same time, is part of the chemodenervation family and was valued in April of 2012, however this code is still a CMS interim value and involves 31 injections rather than the 8-10 that are typical in this service. The RUC determined that a work RVU of 1.65, the survey 25<sup>th</sup> percentile is appropriate. The RUC compared 64642 to CPT codes 16025 *Dressings and/or debridement of partial-thickness burns, initial or subsequent; medium (eg, whole face or whole extremity, or 5% to 10% total body surface area)* (work RVU = 1.74, 15 minutes pre-service, 20 minutes intra-service, 3 minutes post-service) and 51784 *Dressings and/or debridement of partial-thickness burns, initial or subsequent; medium (eg, whole face or whole extremity, or 5% to 10% total body surface area)* (work RVU = 1.53 and 10 minutes pre-service, 20 minutes intra-service, 10 minutes post-service) and agreed that the time and intensity components were similar. **The RUC recommends a work RVU of 1.65 for CPT code 64642.**

#### **64643 Chemodenervation of one extremity; each additional extremity, 1-4 muscle(s) (List separately in addition to code for primary procedure)**

The RUC approved an adjustment to the pre-service positioning time to include 1 minute. Although this is an add-on code there is positioning time associated with an additional extremity that was not accounted for in the specialty recommendation. The RUC reviewed the survey results from 44 physicians for 64643 and determined that the specialty recommended work RVU of 1.43 is not appropriate for this service. The Physician work times are 1 minutes pre-service and 20 minutes intra-service. The RUC discussed the survey 25<sup>th</sup> percentile of 1.00, however this value does not account for the work of additional muscles associated with performing this service. The RUC determined that a direct crosswalk to CPT code 31633 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), each additional lobe (List separately in addition to code for primary procedure)* (RVU = 1.32, 20 minutes intra-service) is appropriate for this service. The RUC noted that these two services have the same intra-service time. For additional support the RUC compared 64643 to CPT code 49412 *Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), open, intra-abdominal, intrapelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple (List separately in addition to code for primary procedure)* (work

RVU = 1.50, 20 minutes intra-service) and CPT code 11046 *Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 1.03, 20 minutes intra-service) and determined that the time and complexity were similar. **The RUC recommends a work RVU of 1.32 for CPT code 64643.**

**64644 Chemodenervation of one extremity; 5 or more muscle(s)**

The RUC reviewed the survey results from 44 physicians for 64644, and determined that, the specialty recommended work RVU of 2.20 between the survey 25<sup>th</sup> and median is not appropriate for this service. The Physician work times are 15 minutes pre-service, 25 minutes intra-service and 5 minutes post-service. The RUC determined that the survey 25<sup>th</sup> percentile work RVU of 1.82 is appropriate for this service relative to other similar services. The RUC compared 64644 to CPT code 12005 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 12.6 cm to 20.0 cm* (work RVU = 1.97, 11 minutes pre-service, 25 minutes intra-service and 5 minutes post-service) and CPT code 60100 *Biopsy thyroid, percutaneous core needle* (work RVU = 1.56, 15 minutes pre-service, 25 minutes intra-service, 10 minutes post-service) and determined that the time and complexity components were similar. **The RUC recommends a work RVU of 1.82 for CPT code 64644.**

**64645 Chemodenervation of one extremity; each additional extremity, 5 or more muscle(s) (List separately in addition to code for primary procedure)**

The RUC approved an adjustment to the pre-service positioning time to include 1 minute. Although this is an add-on code there is positioning time associated with an additional extremity that was not accounted for in the specialty recommendation. The RUC also approved an adjustment to the intra-service time to add 5 minutes to be consistent with the base code reported with the add-on code. The RUC reviewed the survey results from 43 physicians for 64645 and determined that the specialty recommended work RVU of 1.70 is not appropriate for this service. The Physician times are 1 minute pre-service, and 25 minutes intra-service. There was consensus among the RUC that a work RVU of 1.20, the survey 25<sup>th</sup> percentile does not appropriately account for the work of additional extremities associated with performing this service. The RUC determined that the increment of 0.20, which corresponds with the increment between the survey 25<sup>th</sup> percentile of 64643 and the survey 25<sup>th</sup> percentile of 64645, can be applied to this code to account for the intensity and work of additional extremities. The work RVU was determined by starting with the RUC recommended value of 64643, work RVU of 1.32 and adding the increment of 0.20 for a total work RVU of 1.52. For additional support, the RUC referenced codes 12005 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 12.6 cm to 20.0 cm* (work RVU = 1.97, 11 minutes pre-service, 25 minutes intra-service and 5 minutes post-service) and CPT code 60100 *Biopsy thyroid, percutaneous core needle* (work RVU = 1.56, 15 minutes pre-service, 25 minutes intra-service and 10 minutes post-service). **The RUC recommends a work RVU of 1.52 for CPT code 64645.**

**64646 Chemodenervation of trunk muscle(s); 1-5 muscle(s)**

The RUC reviewed the survey results from 32 physicians for 64646 and determined that the specialty recommended work RVU of 1.80, the survey 25<sup>th</sup> percentile is appropriate for this service. The Physician times are 15 minutes pre-service, 20 minutes intra-service and 5 minutes post-service. The RUC compared 64646 to CPT code 56820 *Colposcopy of the vulva*; (work RVU = 1.05, 15 minutes pre-service, 15 minutes intra-service, 10 minutes post-service) and CPT code 51784 *Electromyography studies (EMG) of anal or urethral sphincter, other than needle, any technique* (work RVU = 1.53, 10 pre-service, 20 intra-service, 10 post-service) and determined that these services require similar physician work to perform. **The RUC recommends a work RVU of 1.80 for CPT code 64646.**

**64647 Chemodenervation of trunk muscle(s); 6 or more muscle(s)**

The RUC reviewed the survey results from 31 physicians for 64647 and approved times of 15 minutes pre-service, 25 minutes intra-service and 5 minutes post-service time. The RUC determined that the survey 25<sup>th</sup> percentile work RVU of 2.11 appropriately accounts for the physician work required to perform this service. The RUC compared 64647 to CPT code 12005 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 12.6 cm to 20.0 cm* (work RVU = 1.97, 11 minutes pre-service, 25 minutes intra-service and 5 minutes post-service) and CPT code 57460 *Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix* (work RVU = 2.83, 15 minutes pre-service, 25 minutes intra-service and 10 minutes post-service) and determined that the recommended work RVU of 2.11 is appropriate relative to other similar services. **The RUC recommends a work RVU of 2.11 for CPT code 64647.**

**Practice Expense:**

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

**Work Neutrality:**

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

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<b>Front Matter</b> <b>Procedural Illustrations</b> <b>Surgery</b> <b>Digestive System</b> <b>Anus</b> <b>Introduction</b>  46505 Chemodenervation of internal anal sphincter (For chemodenervation of other muscles, see 64612, <del>64613</del> , <u>64616</u> , <del>64614</del> <del>64617</del> , 64642, 64643, 64644, 64645, 64646, <u>64647</u> . For destruction of nerve by neurolytic agent, <del>see</del> <u>use</u> 64630, <del>64640</del> )				
D64614		<del>Chemodenervation of muscle(s); extremity and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis)</del> <del>(Report 61614 only once per session)</del>	010	N/A
64615	R1	muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine) <u>(Report 64615 only once per session)</u> (Do not report 64615 in conjunction with 64612, <del>64613</del> , <u>64616</u> , <del>64614</del> <del>64642</del> , <del>64643</del> , <del>64644</del> , <del>64645</del> , <del>64646</del> , <del>64647</del> )	010	1.85 (Request to reaffirm RUC Recommendation April 2012)

Report 64642, 64643, 64644, 64645 once per extremity. Codes 64642, 64643, 64644, 64645 can be reported together up to a combined total of four units of service per patient when all four extremities are injected. Report only one base code (64642 or 64644) per session. Report one or more units of additional extremity code(s) (64643 or 64645) for each additional extremity injected

Report 64646 or 64647 for chemodenervation of muscles of the trunk.

Trunk muscles include the erector spinae and paraspinal muscles, rectus abdominus and obliques. All other somatic muscles are extremity muscles, head muscles, or neck muscles

(For chemodenervation guided by needle electromyography or muscle electrical stimulation, see 95873, 95874. Do not report more than one guidance code for each corresponding chemodenervation of extremity or trunk code)

(Do not report modifier 50 in conjunction with 64642, 64643, 64644, 64645, 64646, 64647)

●64642	R2	Chemodenervation of one extremity; 1-4 muscle(s)	000	1.65
●+64643	R3	each additional extremity, 1-4 muscle(s) (List separately in addition to code for primary procedure) <u>(Use 64643 in conjunction with 64642, 64644)</u>	ZZZ	1.32
●64644	R4	Chemodenervation of one extremity; 5 or more muscle(s)	000	1.82
●+64645	R5	each additional extremity, 5 or more muscle(s) (List separately in addition to code for primary procedure) <u>(Use 64645 in conjunction with 64644)</u>	ZZZ	1.52
●64646	R6	Chemodenervation of trunk muscle(s); 1-5 muscle(s)	000	1.80

●64647	R7	6 or more muscle(s) (Report either 64646 or 64647 only once per session)	000	2.11
<b>Medicine</b> <b>Neurology and Neuromuscular Procedures</b> <b>Guidance for Chemodenervation and Ischemic Muscle Testing</b>				
✚95873	Electrical stimulation for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure) (Do not report 95873 in conjunction with 64617, 95860-95870, 95874)			
✚95874	Needle electromyography for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure) (Use 95873, 95874 in conjunction with 64612, <del>64613</del> , <u>64616</u> <del>64614</del> <u>64642</u> , 64643, 64644, 64645, 64646, 64647) <del>(Do not report 95874 in conjunction with 95873)</del> (Do not report <del>95873</del> , 95874 in conjunction with <u>64617</u> , 95860-95870, <u>95873</u> )			



**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 64642	Tracking Number R1	Original Specialty Recommended RVU: <b>2.13</b>
		Presented Recommended RVU: <b>1.85</b>
Global Period: 000		RUC Recommended RVU: <b>1.65</b>

CPT Descriptor: Chemodenervation of one extremity; 1-4 muscle(s)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A patient has marked flexion at the left elbow and at the left wrist after a stroke. This interferes with activities of daily living. The patient failed medical management and chemodenervation is performed to treat affected muscles. Injections are made to 1-4 muscle(s) in the left arm.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 5%

Description of Pre-Service Work: The physician reviews the patient history, takes an interval history, reviews the patient's medications and allergies. The effect (e.g., benefit, duration of effect, any side effects) of any prior treatment is reviewed. To determine the muscles involved, a focused physical examination of the involved extremity(ies) is performed using active and passive movements while palpating the affected muscles. Optimal injection sites are determined and marked. Patient questions are answered and informed consent is obtained. The duration of expected treatment effect is discussed. A "time-out" is performed. The physician cleans the injection sites using alcohol swabs and puts on gloves. The medication is brought to room temperature and reconstituted with sterile saline by slowly injecting the diluents into the vial. The physician then gently mixes the toxin by rotating the vial. The drug is drawn into the syringe. The injection sites are cleaned using alcohol swabs and the limb is positioned and for optimal medication delivery to the first injection site.

Description of Intra-Service Work: The toxin is injected. Following the injection, pressure is held briefly to control any bleeding. The limb is then repositioned for each subsequent injection.

Description of Post-Service Work: Bandages are placed over injection sites. The expected results and follow-up plans are discussed with the patient. Drug accounting is completed. The procedure report is generated, reviewed, and signed.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	01/2013				
<b>Presenter(s):</b>	Kevin Kerber, MD; Wayne Cornblath, MD; Janice Massey, MD; Barry Smith, MD				
<b>Specialty(s):</b>	American Academy of Neurology, American Association of Neuromuscular & Electrodiagnostic Medicine, American Academy of Physical Medicine and Rehabilitation				
<b>CPT Code:</b>	64642				
<b>Sample Size:</b>	1428	<b>Resp N:</b>	44	<b>Response:</b> 3.0 %	
<b>Description of Sample:</b>	The societies used a combined a sample of members and physicians who indicated they perform the service and names supplied by a pharmaceutical company				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	14.00	47.00	100.00	400.00
<b>Survey RVW:</b>	1.00	1.65	2.13	2.50	5.00
<b>Pre-Service Evaluation Time:</b>			10.00		
<b>Pre-Service Positioning Time:</b>			5.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			5.00		
<b>Intra-Service Time:</b>	5.00	10.00	20.00	21.00	30.00
<b>Immediate Post Service-Time:</b>	<b>5.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

5 - NF Procedure without sedation/anesthesia care

<b>CPT Code:</b>	64642	<b>Recommended Physician Work RVU: 1.65</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		10.00	7.00	3.00
<b>Pre-Service Positioning Time:</b>		5.00	0.00	5.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	0.00	0.00
<b>Intra-Service Time:</b>		20.00		
<b>Immediate Post Service-Time:</b>	<b>5.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

<b>Sub Obs Care:</b>	<b><u>0.00</u></b>	99224x <b>0.00</b>	99225x <b>0.00</b>	99226x <b>0.00</b>
----------------------	--------------------	--------------------	--------------------	--------------------

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99215	XXX	2.11	RUC Time

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
92004	XXX	1.82	RUC Time	2,151,572

CPT Descriptor 1 Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
52000	000	2.23	RUC Time	925,004

CPT Descriptor 2 Cystourethroscopy (separate procedure)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 12      % of respondents: 27.2 %**

**TIME ESTIMATES (Median)**

	<b>CPT Code:</b> <b>64642</b>	<b>Key Reference CPT Code:</b> <b>99215</b>	<b>Source of Time</b> <b>RUC Time</b>
Median Pre-Service Time	15.00	5.00	
Median Intra-Service Time	20.00	35.00	
Median Immediate Post-service Time	5.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	

Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>40.00</b>	<b>55.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.83	4.17
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.67
--	------	------

Urgency of medical decision making	3.33	3.67
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.92	3.25
--------------------------	------	------

Physical effort required	3.83	2.58
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.08	3.58
---	------	------

Outcome depends on the skill and judgment of physician	4.83	4.25
--	------	------

Estimated risk of malpractice suit with poor outcome	3.75	3.25
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.25	3.08
----------------------------------	------	------

Intra-Service intensity/complexity	4.67	4.17
------------------------------------	------	------

Post-Service intensity/complexity	2.50	3.42
-----------------------------------	------	------

---

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The AMA requested the society establish a new chemodenervation code for the treatment of chronic migraine. At the CPT Editorial Panel several additional changes were made to parentheses for the other codes within the family. This led to the existing coding proposals to clarify all of the different work captured in 64614.

Code 64614 (chemodenervation of extremity and/or trunk muscles) is being broken out into 6 new codes 64642-64647. Previously one unit of 64614 was reported regardless of the number of injections performed, with a modifier 50 reported for bilateral procedures. The new coding structure separates the codes into extremity-specific and trunk-specific codes. For extremity-specific codes, two base codes (64642, 64644) were created to separate work by the number of injections to the extremity (64642 for  $\leq 4$  injections, 64644 for  $\geq 5$  injections). “Add-on” codes (64643, 64645) were also created to account for cases of injections in multiple extremities. For trunk-specific codes (64646, 64647), two codes were similarly created to separate work by the number of injections (64646 for  $\leq 5$  injections, 64647 for  $\geq 6$  injections).

This new coding structure is expected to better account for the significant difference in work that is currently performed using only the 64614 code.

We surveyed the codes in two groups: the extremity codes (64642-64645) in one group and trunk codes (64646-64647) in a second group. Many of the names provided by the pharmaceutical company were also members of the surveying societies. Of the 44 survey responses, 1 response came from the names provided by the manufacturer.

An expert panel of representatives from the AAN, AANEM and AAPMR reviewed the survey results and developed the following recommendations.

**64642:** The societies recommend that the survey median value of 2.13 be accepted. The survey has a total of 44 respondents. The 25<sup>th</sup> percentile value of 1.65 is not accurate because it would create a rank order anomaly within the chemodenervation code family. Chemodenervation for chronic migraine (64615, RVU 1.85) was RUC valued in 2012 and is a less intense procedure than 64642. Compared to 64615, the muscles injected in 64642 are deeper and less easily identified and isolated for injection (e.g. hand muscles). In addition, the potential for adverse effects of injections are greater for 64642 than for 64615. Finally, 64615 injections have a defined injection pattern and dose. Conversely, extremity injections of 64642 are different for each patient and frequently change from one injection session to the next. This requires deciding on the muscles to be injected and the dose in each muscle during the procedure. Frequently the doses and patterns from two or three previous injections are also reviewed. A thorough search for a crosswalk code was completed by the surveying societies without a reasonable match. We recommend the survey median times of 10/20/5 be accepted. The pre-service evaluation time of 10 minutes exceeds the standard 7 minutes in our selected pre-service package, as does the 5 minutes of positioning time; however the additional minutes are necessary to allow for the time to mix the toxin and for positioning the patient.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain )

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64614

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology                      How often? Sometimes

Specialty PMR                              How often? Sometimes

Specialty                                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 75024

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This number is three times the 2011 medicare claims reporting data for 64614, which we feel accurately represents the national reporting of this code for one year.

Specialty Neurology                      Frequency 35261                      Percentage 46.99 %

Specialty PMR                              Frequency 33760                      Percentage 44.99 %

Specialty                                      Frequency                                      Percentage                                      %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 25,008 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate 45% of the existing utilization of 64614 (55,574) will now be billed by 64642

Specialty Neurology                      Frequency 11754                      Percentage 47.00 %

Specialty PMR                              Frequency 11254                      Percentage 45.00 %

Specialty                                      Frequency                                      Percentage                                      %

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 64614

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 64643	Tracking Number R2	Original Specialty Recommended RVU: <b>1.68</b>
		Presented Recommended RVU: <b>1.43</b>
Global Period: ZZZ		RUC Recommended RVU: <b>1.32</b>

CPT Descriptor: Chemodenervation of one extremity; each additional extremity, 1-4 muscle(s)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A patient presents with distal left sided spasticity after a stroke. This limits gait and activities of daily living. The patient failed medical management and chemodenervation is performed to treat the spasticity of the left arm (coded using 64642). Additional chemodenervation is now performed to treat the affected muscles in an additional limb, the left leg. Injections are made to 1-4 muscle(s) in the left leg.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 2%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 2%

Description of Pre-Service Work: The patient is repositioned for injection in the additional limb.

Description of Intra-Service Work: Examination of the additional limb is performed to determine the optimal injection sites, which are then marked. The injection sites are cleaned using alcohol swabs and the limb is positioned for optimal medication delivery to the first injection site. The toxin is injected. Following the injection, pressure is held briefly to control any bleeding. The limb is then repositioned for each subsequent injection. Bandages are placed over injection sites.

Description of Post-Service Work:

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)		01/2013				
Presenter(s):	Kevin Kerber, MD; Wayne Cornblath, MD; Janice Massey,MD; Barry Smith, MD					
Specialty(s):	American Academy of Neurology, American, American Association of Neuromuscular & Electrodiagnostic Medicine, American Academy of Physical Medicine and Rehabilitation					
CPT Code:	64643					
Sample Size:	1428	Resp N:	44	Response: 3.0 %		
Description of Sample:	The societies used a combined a sample of members and physicians who indicated they perform the service and names supplied by a pharmaceutical company.					
		<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
Service Performance Rate		0.00	10.00	22.00	50.00	324.00
Survey RVW:		0.35	1.00	1.43	1.80	6.00
Pre-Service Evaluation Time:				0.00		
Pre-Service Positioning Time:				0.00		
Pre-Service Scrub, Dress, Wait Time:				0.00		
Intra-Service Time:		5.00	15.00	20.00	30.00	90.00
Immediate Post Service-Time:		0.00				
Post Operative Visits		Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):		0.00	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):		0.00	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:		0.00	99238x 0.00	99239x 0.00	99217x 0.00	
Office time/visit(s):		0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:		0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:		0.00	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:  
ZZZ Global Code

CPT Code:	64643	Recommended Physician Work RVU: 1.32				
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package		Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:		0.00	0.00		0.00	
Pre-Service Positioning Time:		1.00	0.00		1.00	
Pre-Service Scrub, Dress, Wait Time:		0.00	0.00		0.00	
Intra-Service Time:		20.00				
Immediate Post Service-Time:	0.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00		
Discharge Day Mgmt:	0.00	99238x 0.0	99239x 0.0	99217x 0.00		
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00	15x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00	



Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00
---------------	-------------	-------------	-------------	-------------

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
95886	ZZZ	0.70	RUC Time

CPT Descriptor Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels (List separately in addition to code for primary procedure)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent</u>
13122	ZZZ	1.44	RUC Time	Medicare Utilization
				17,093

CPT Descriptor 1 Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent</u>
13133	ZZZ	2.19	RUC Time	Medicare Utilization
				11,736

CPT Descriptor 2 Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (List separately in addition to code for primary procedure)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 9 % of respondents: 20.4 %

**TIME ESTIMATES (Median)**

	<u>CPT Code:</u> 64643	<u>Key Reference</u> <u>CPT Code:</u> 95886	<u>Source of Time</u> <u>RUC Time</u>
Median Pre-Service Time	1.00	0.00	
Median Intra-Service Time	20.00	30.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	

Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>21.00</b>	<b>30.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.78	3.89
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.56	3.78
--	------	------

Urgency of medical decision making	3.00	3.00
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.67	3.89
--------------------------	------	------

Physical effort required	3.44	2.89
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.33	2.78
---	------	------

Outcome depends on the skill and judgment of physician	4.44	4.33
--	------	------

Estimated risk of malpractice suit with poor outcome	3.11	2.33
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	0.00	0.00
----------------------------------	------	------

Intra-Service intensity/complexity	3.89	4.00
------------------------------------	------	------

Post-Service intensity/complexity	0.00	0.00
-----------------------------------	------	------

---

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The AMA requested the society establish a new chemodenervation code for the treatment of chronic migraine. At the CPT Editorial Panel several additional changes were made to parentheses for the other codes within the family. This led to the existing coding proposals to clarify all of the different work captured in 64614.

Code 64614 (chemodenervation of extremity and/or trunk muscles) is being broken out into 6 new codes 64642-64647. Previously one unit of 64614 was reported regardless of the number of injections performed, with a modifier 50 reported for bilateral procedures. The new coding structure separates the codes into extremity-specific and trunk-specific codes. For extremity-specific codes, two base codes (64642, 64644) were created to separate work by the number of injections to the extremity (64642 for  $\leq 4$  injections, 64644 for  $\geq 5$  injections). "Add-on" codes (64643, 64645) were also created to account for cases of injections in multiple extremities. For trunk-specific codes (64646, 64647), two codes were similarly created to separate work by the number of injections (64646 for  $\leq 5$  injections, 64647 for  $\geq 6$  injections).

This new coding structure is expected to better account for the significant difference in work that is currently performed using only the 64614 code.

We surveyed the codes in two groups: the extremity codes (64642-64645) in one group and trunk codes (64646-64647) in a second group. Many of the names provided by the pharmaceutical company were also members of the surveying societies. Of the 44 survey responses, 1 response came from the names provided by the manufacturer.

An expert panel of representatives from the AAN, AANEM and AAPMR reviewed the survey results and developed the following recommendations.

**64643:** The societies recommend a value of 1.68 for this code which was calculated by using the same intra service RVU for the base code 64642 and subtracting the RVU of the pre and post intra service. There are no efficiencies gained when performing this service on multiple extremities. The physician must spend time in between the base code injections and the add-on code injections to reposition the patient. In patients with spasticity, positioning of the limb to make the injection site available is difficult and time consuming. Further, due to the short shelf life of botox, providers frequently need to reconstitute additional toxin and prepare syringes in between the base code injections and the add-on code injections. We recommend the survey median time 20 minutes be accepted.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. See attached reference table 1

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64614

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
 If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology                      How often? Sometimes

Specialty AAPM&R                      How often? Sometimes

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 25008

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This number is three times the 2011 medicare claims reporting data for 64614, which we feel accurately represents the national reporting of this code for one year

Specialty Neurology                      Frequency 11754                      Percentage 47.00 %

Specialty PMR                      Frequency 11254                      Percentage 45.00 %

Specialty                      Frequency                      Percentage                      %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 8,336

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate 15% of the existing utilization of 64614 (55,574) will now be billed by 64643

Specialty Neurology                      Frequency 3918                      Percentage 47.00 %

Specialty PMR                      Frequency 3751                      Percentage 44.99 %

Specialty                      Frequency                      Percentage                      %

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 64614

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 64644	Tracking Number R3	Original Specialty Recommended RVU: <b>2.55</b>
		Presented Recommended RVU: <b>2.20</b>
Global Period: 000		RUC Recommended RVU: <b>1.82</b>

CPT Descriptor: Chemodenervation of one extremity; 5 or more muscle(s)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A patient presents with disabling cramping of right wrist, fingers and thumb while writing, typing and holding a fork. The patient failed medical management and chemodenervation is performed to treat affected muscles in one limb, the right arm. Injections are made to 5 or more muscles in the right arm.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 2%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 2%

Description of Pre-Service Work: The physician reviews the patient history, takes an interval history, reviews the patient's medications and allergies. The effect (e.g., benefit, duration of effect, any side effects) of any prior treatment is reviewed. To determine the muscles involved, a focused physical examination of the involved extremity(ies) is performed using active and passive movements while palpating the affected muscles. Optimal injection sites are determined and marked. Patient questions are answered and informed consent is obtained. The duration of expected treatment effect is discussed. A "time-out" is performed. The physician cleans the injection sites using alcohol swabs and puts on gloves. The medication is brought to room temperature and reconstituted with sterile saline by slowly injecting the diluents into the vial. The physician then gently mixes the toxin by rotating the vial. The drug is drawn into a syringe. The injection sites are cleaned using alcohol swabs and the limb is positioned for optimal medication delivery to the first injection site.

Description of Intra-Service Work: The toxin is injected. Following the injection, pressure is held briefly to control any bleeding. The limb is then repositioned for each subsequent injection.

Description of Post-Service Work: Bandages are placed over injection sites. The expected results and follow-up plans are discussed with the patient. Drug accounting is completed. The procedure report is generated, reviewed, and signed.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	01/2013				
<b>Presenter(s):</b>	Kevin Kerber, MD; Wayne Cornblath, MD; Janice Massey, MD; Barry Smith, MD				
<b>Specialty(s):</b>	American Academy of Neurology, American Association of Neuromuscular & Electrodiagnostic Medicine, American Academy of Physical Medicine and Rehabilitation				
<b>CPT Code:</b>	64644				
<b>Sample Size:</b>	1428	<b>Resp N:</b>	44	<b>Response:</b> 3.0 %	
<b>Description of Sample:</b>	The societies used a combined a sample of members and physicians who indicated they perform the service and names supplied by a pharmaceutical company.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	11.00	20.00	50.00	200.00
<b>Survey RVW:</b>	1.10	1.82	2.48	3.00	6.00
<b>Pre-Service Evaluation Time:</b>			10.00		
<b>Pre-Service Positioning Time:</b>			5.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			5.00		
<b>Intra-Service Time:</b>	5.00	15.00	20.00	30.00	45.00
<b>Immediate Post Service-Time:</b>	<b>5.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

5 - NF Procedure without sedation/anesthesia care

<b>CPT Code:</b>	64644	<b>Recommended Physician Work RVU: 1.82</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		10.00	7.00	3.00
<b>Pre-Service Positioning Time:</b>		5.00	0.00	5.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	0.00	0.00
<b>Intra-Service Time:</b>		25.00		
<b>Immediate Post Service-Time:</b>	<b>5.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

<b>Sub Obs Care:</b>	<b><u>0.00</u></b>	99224x <b>0.00</b>	99225x <b>0.00</b>	99226x <b>0.00</b>
----------------------	--------------------	--------------------	--------------------	--------------------

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99244	XXX	3.02	RUC Time

CPT Descriptor Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
36556	000	2.50	RUC Time	499,821

CPT Descriptor 1 Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
95810	XXX	2.50	RUC Time	308,438

CPT Descriptor 2 Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11      % of respondents: 25.0 %

**TIME ESTIMATES (Median)**

	<b>CPT Code:</b> <b>64644</b>	<b>Key Reference CPT Code:</b> <b>99244</b>	<b>Source of Time</b> <b>RUC Time</b>
Median Pre-Service Time	15.00	10.00	
Median Intra-Service Time	25.00	40.00	
Median Immediate Post-service Time	5.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	

Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>45.00</b>	<b>65.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.27	4.45
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.27	4.45
Urgency of medical decision making	3.55	3.82

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.45	4.00
Physical effort required	3.91	3.27

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.36	4.00
Outcome depends on the skill and judgment of physician	4.82	4.45
Estimated risk of malpractice suit with poor outcome	3.73	3.18

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.18	3.82
Intra-Service intensity/complexity	4.73	4.64
Post-Service intensity/complexity	3.45	3.45

---

**Additional Rationale and Comments**



Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The AMA requested the society establish a new chemodenervation code for the treatment of chronic migraine. At the CPT Editorial Panel several additional changes were made to parentheses for the other codes within the family. This led to the existing coding proposals to clarify all of the different work captured in 64614.

Code 64614 (chemodenervation of extremity and/or trunk muscles) is being broken out into 6 new codes 64642-64647. Previously one unit of 64614 was reported regardless of the number of injections performed, with a modifier 50 reported for bilateral procedures. The new coding structure separates the codes into extremity-specific and trunk-specific codes. For extremity-specific codes, two base codes (64642, 64644) were created to separate work by the number of injections to the extremity (64642 for  $\leq 4$  injections, 64644 for  $\geq 5$  injections). "Add-on" codes (64643, 64645) were also created to account for cases of injections in multiple extremities. For trunk-specific codes (64646, 64647), two codes were similarly created to separate work by the number of injections (64646 for  $\leq 5$  injections, 64647 for  $\geq 6$  injections).

This new coding structure is expected to better account for the significant difference in work that is currently performed using only the 64614 code.

We surveyed the codes in two groups: the extremity codes (64642-64645) in one group and trunk codes (64646-64647) in a second group. Many of the names provided by the pharmaceutical company were also members of the surveying societies. Of the 44 survey responses, 1 response came from the names provided by the manufacturer.

An expert panel of representatives from the AAN, AANEM and AAPMR reviewed the survey results and developed the following recommendations.

**64644:** The societies recommend a value of 2.55 for this code. Our recommended times are 10/25/5. It was expected that breaking 64614 into 6 codes would result in some codes of lower values and some of higher values. These differences in time and intensity were not incorporated into the original code of 64614. Since the 64614 code was first developed and RUC valued in 2000, the technique and patient populations for Botox injections in the limbs has expanded substantially. Botox injections were initially used in a few large muscles for post-stroke spasticity in one limb. Over time the populations treated has expanded to patients with writer's cramp, musician's dystonia, spasticity from multiple sclerosis, cerebral palsy, generalized dystonia, etc. Injections are used in smaller, difficult to inject muscles. In addition, experience with higher dosages has also lead to the ability to treat more than one limb at a time. Thus for the reasons of technique, patient population, and increased physician time, there is compelling evidence that 64644 differs substantially from the original 64614 code. The recommended value of 2.55 was based on the additional 5 minutes of intra-service work in 64644 compared with 64642. We believe that the survey median intra-service time of 20 minutes was erroneous because the respondents 64644 requires more time than 64642 and the survey respondents indicated 25 minutes as the intra-service time for the corresponding add-on code (64645).

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64614

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology                      How often? Sometimes

Specialty PMR                      How often? Sometimes

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 33345

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This number is three times the 2011 medicare claims reporting data for 64614, which we feel accurately represents the national reporting of this code for one year

Specialty Neurology                      Frequency 15672                      Percentage 46.99 %

Specialty PMR                      Frequency 15005                      Percentage 44.99 %

Specialty                      Frequency                      Percentage                      %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 11,115 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate 20% of the existing utilization of 64614 (55,574) will now be billed by 64644

Specialty Neurology                      Frequency 5224                      Percentage 46.99 %

Specialty PMR                      Frequency 5002                      Percentage 45.00 %

Specialty                      Frequency                      Percentage                      %

Do many physicians perform this service across the United States? Yes

**Professional Liability Insurance Information (PLI)**

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 64614

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 64645	Tracking Number R4	Original Specialty Recommended RVU: <b>2.10</b>
		Presented Recommended RVU: <b>1.70</b>
Global Period: ZZZ		RUC Recommended RVU: <b>1.52</b>

CPT Descriptor: Chemodenervation of one extremity; each additional extremity, 5 or more muscle(s)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A patient has marked bilateral upper extremity spasticity, both distal and proximal, from multiple sclerosis. The patient failed medical management and chemodenervation is performed in the left upper limb (coded using 64644). Additional chemodenervation is now performed to treat the affected muscles in an additional limb, the right arm. Injections are made to 5 or more muscles in the right arm.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The injection sites are cleaned using alcohol swabs and the limb is positioned for optimal medication delivery to the first injection site.

Description of Intra-Service Work: The toxin is injected. Following the injection, pressure is held briefly to control any bleeding. The limb is then repositioned for each subsequent injection. Bandages are placed over injection sites.

Description of Post-Service Work:

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)		01/2012				
Presenter(s):	Kevin Kerber, MD; Wayne Cornblath, MD; Janice Massey,MD; Barry Smith, MD					
Specialty(s):	American Academy of Neurology, American, American Association of Neuromuscular & Electrodiagnostic Medicine, American Academy of Physical Medicine and Rehabilitation					
CPT Code:	64645					
Sample Size:	1428	Resp N:	43	Response: 3.0 %		
Description of Sample:	The societies used a combined a sample of members and physicians who indicated they perform the service and names supplied by a pharmaceutical company.					
		Low	25 <sup>th</sup> pctl	Median*	75th pctl	High
Service Performance Rate		0.00	7.00	18.00	14.00	250.00
Survey RVW:		0.35	1.20	1.70	2.20	6.00
Pre-Service Evaluation Time:				0.00		
Pre-Service Positioning Time:				0.00		
Pre-Service Scrub, Dress, Wait Time:				0.00		
Intra-Service Time:		7.00	15.00	25.00	35.00	120.00
Immediate Post Service-Time:	0.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00				
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00				
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00				
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00				
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00				
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00				

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: ZZZ Global Code

CPT Code:	64645	Recommended Physician Work RVU: 1.52			
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:		0.00	0.00	0.00	
Pre-Service Positioning Time:		1.00	0.00	1.00	
Pre-Service Scrub, Dress, Wait Time:		0.00	0.00	0.00	
Intra-Service Time:		25.00			
Immediate Post Service-Time:	0.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	0.00	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00

Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00
---------------	-------------	-------------	-------------	-------------

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
95979	ZZZ	1.64	RUC Time

CPT Descriptor Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; each additional 30 minutes after first hour (List separately in addition to code for primary procedure)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
13122	ZZZ	1.44	RUC Time	17,093

CPT Descriptor 1 Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
13133	ZZZ	2.19	RUC Time	11,736

CPT Descriptor 2 Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (List separately in addition to code for primary procedure)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 7      % of respondents: 16.2 %

**TIME ESTIMATES (Median)**

	<u>CPT Code:</u> 64645	<u>Key Reference CPT Code:</u> 95979	<u>Source of Time</u> RUC Time
Median Pre-Service Time	1.00	0.00	
Median Intra-Service Time	25.00	30.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	

Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>26.00</b>	<b>30.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.00	4.29
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.71	4.00
--	------	------

Urgency of medical decision making	3.71	4.29
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.57	4.71
--------------------------	------	------

Physical effort required	3.71	3.43
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.14	4.14
---	------	------

Outcome depends on the skill and judgment of physician	4.71	4.57
--	------	------

Estimated risk of malpractice suit with poor outcome	3.57	3.57
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity		
----------------------------------	--	--

Intra-Service intensity/complexity	4.57	4.71
------------------------------------	------	------

Post-Service intensity/complexity		
-----------------------------------	--	--

---

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The AMA requested the society establish a new chemodenervation code for the treatment of chronic migraine. At the CPT Editorial Panel several additional changes were made to parentheses for the other codes within the family. This led to the existing coding proposals to clarify all of the different work captured in 64614.

Code 64614 (chemodenervation of extremity and/or trunk muscles) is being broken out into 6 new codes 64642-64647. Previously one unit of 64614 was reported regardless of the number of injections performed, with a modifier 50 reported for bilateral procedures. The new coding structure separates the codes into extremity-specific and trunk-specific codes. For extremity-specific codes, two base codes (64642, 64644) were created to separate work by the number of injections to the extremity (64642 for  $\leq 4$  injections, 64644 for  $\geq 5$  injections). "Add-on" codes (64643, 64645) were also created to account for cases of injections in multiple extremities. For trunk-specific codes (64646, 64647), two codes were similarly created to separate work by the number of injections (64646 for  $\leq 5$  injections, 64647 for  $\geq 6$  injections).

This new coding structure is expected to better account for the significant difference in work that is currently performed using only the 64614 code.

We surveyed the codes in two groups: the extremity codes (64642-64645) in one group and trunk codes (64646-64647) in a second group. Many of the names provided by the pharmaceutical company were also members of the surveying societies. Of the 44 survey responses, 0 responses came from the names provided by the manufacturer.

An expert panel of representatives from the AAN, AANEM and AAPMR reviewed the survey results and developed the following recommendations.

**64645:** The societies recommend a value of 2.10 for this code which was calculated by using the same intra service RVU for the base code 64644 and subtracting the RVU of the pre and post intra service. We recommend the survey median times of 25 be accepted. There are no efficiencies gained when performing this service on multiple extremities. The physician must spend time in between the base code injections and the add-on code injections to reposition the patient. In patients with spasticity, positioning of the limb to make the injection site available is difficult and time consuming. Further, due to the short shelf life of Botox, providers frequently need to reconstitute additional toxin and prepare syringes in between the base code injections and the add-on code injections.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. See attached Reference table 2

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64614

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology                      How often? Sometimes

Specialty AAPM&R                      How often? Sometimes

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 16671

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This number is three times the 2011 medicare claims reporting data for 64614, which we feel accurately represents the national reporting of this code for one year.

Specialty Neurology                      Frequency 7835                      Percentage 46.99 %

Specialty PMR                      Frequency 7502                      Percentage 45.00 %

Specialty                      Frequency                      Percentage                      %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 5,557

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate 10% of the existing utilization of 64614 (55,574) will now be billed by 64645

Specialty Neurology                      Frequency 2612                      Percentage 47.00 %

Specialty PMR                      Frequency 2501                      Percentage 45.00 %

Specialty                      Frequency                      Percentage                      %

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 64614



**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 64646	Tracking Number R5	Original Specialty Recommended RVU: <b>2.11</b>
		Presented Recommended RVU: <b>1.80</b>
Global Period: 000		RUC Recommended RVU: <b>1.80</b>

CPT Descriptor: Chemodenervation of trunk muscle(s); 1-5 muscle(s)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A patient presents with trunk dystonia caused by multiple sclerosis. The patient failed medical management and chemodenervation is performed to treat the affected trunk muscles. Injections are made to 1-5 muscle(s) in the trunk.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The physician reviews the patient history, takes an interval history, reviews the patient's medications and allergies. The effect (e.g., benefit, duration of effect, any side effects) of any prior treatment is reviewed. To determine the muscles involved, a focused physical examination is performed while palpating the affected muscles. Optimal injection sites are determined and marked. Patient questions are answered and informed consent is obtained. The duration of expected treatment effect is discussed. A "time-out" is performed. The physician cleans the injection sites using alcohol swabs and puts on gloves. The medication is brought to room temperature and reconstituted with sterile saline by slowly injecting the diluents into the vial. The physician then gently mixes the toxin by rotating the vial. The drug is drawn into a syringe. The injection sites are cleaned using alcohol swabs and the patient is positioned for optimal medication delivery to the first injection site.

Description of Intra-Service Work: The toxin is injected. Following the injection, pressure is held briefly to control any bleeding. The patient is then repositioned for each subsequent injection.

Description of Post-Service Work: Bandages are placed over injection sites. The expected results and follow-up plans are discussed with the patient. Drug accounting is completed. The procedure report is generated, reviewed, and signed.

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)		01/2013				
Presenter(s):	Kevin Kerber, MD; Wayne Cornblath, MD; Janice Massey,MD; Barry Smith, MD					
Specialty(s):	American Academy of Neurology, American, American Association of Neuromuscular & Electrodiagnostic Medicine, American Academy of Physical Medicine and Rehabilitation					
CPT Code:	64646					
Sample Size:	1608	Resp N:	32	Response: 1.9 %		
Description of Sample:	The societies used a combined a sample of members and physicians who indicated they perform the service and names supplied by a pharmaceutical company.					
		Low	25 <sup>th</sup> pctl	Median*	75th pctl	High
Service Performance Rate		0.00	4.00	11.00	25.00	150.00
Survey RVW:		0.88	1.80	2.11	2.56	6.00
Pre-Service Evaluation Time:				10.00		
Pre-Service Positioning Time:				5.00		
Pre-Service Scrub, Dress, Wait Time:				5.00		
Intra-Service Time:		5.00	15.00	20.00	26.00	45.00
Immediate Post Service-Time:	5.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00		
Discharge Day Mgmt:	0.00	99238x 0.00	99239x 0.00	99217x 0.00		
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00	15x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00	
Sub Obs Care:	0.00	99224x 0.00	99225x 0.00	99226x 0.00		

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

5 - NF Procedure without sedation/anesthesia care

CPT Code:	64646	Recommended Physician Work RVU: 1.80					
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package		Adjustments/Recommended Pre-Service Time		
Pre-Service Evaluation Time:		10.00	7.00		3.00		
Pre-Service Positioning Time:		5.00	0.00		5.00		
Pre-Service Scrub, Dress, Wait Time:		0.00	0.00		0.00		
Intra-Service Time:		20.00					
Immediate Post Service-Time:	5.00						
Post Operative Visits	Total Min**	CPT Code and Number of Visits					
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00				
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.0	99239x 0.0	99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00	15x 0.00	
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00		

<b>Sub Obs Care:</b>	<b>0.00</b>	99224x <b>0.00</b>	99225x <b>0.00</b>	99226x <b>0.00</b>
----------------------	-------------	--------------------	--------------------	--------------------

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99215	XXX	2.11	RUC Time

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
92004	XXX	1.82	RUC Time	2,151,572

CPT Descriptor 1 Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
52000	000	2.23	RUC Time	925,004

CPT Descriptor 2 Cystourethroscopy (separate procedure)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 7      % of respondents: 22.5 %

**TIME ESTIMATES (Median)**

	<u>CPT Code:</u> <b>64646</b>	<u>Key Reference CPT Code:</u> <u>99215</u>	<u>Source of Time</u> <u>RUC Time</u>
Median Pre-Service Time	15.00	5.00	
Median Intra-Service Time	20.00	35.00	
Median Immediate Post-service Time	5.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	

Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>40.00</b>	<b>55.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.86	4.29
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.57	4.00
--	------	------

Urgency of medical decision making	4.00	4.00
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.71	3.43
--------------------------	------	------

Physical effort required	3.86	2.71
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.86	3.86
---	------	------

Outcome depends on the skill and judgment of physician	4.86	4.71
--	------	------

Estimated risk of malpractice suit with poor outcome	3.29	3.29
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.43	3.14
----------------------------------	------	------

Intra-Service intensity/complexity	4.43	4.14
------------------------------------	------	------

Post-Service intensity/complexity	3.00	3.43
-----------------------------------	------	------

---

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The AMA requested the society establish a new chemodenervation code for the treatment of chronic migraine. At the CPT Editorial Panel several additional changes were made to parentheses for the other codes within the family. This led to the existing coding proposals to clarify all of the different work captured in 64614.

Code 64614 (chemodenervation of extremity and/or trunk muscles) is being broken out into 6 new codes 64642-64647. Previously one unit of 64614 was reported regardless of the number of injections performed, with a modifier 50 reported for bilateral procedures. The new coding structure separates the codes into extremity-specific and trunk-specific codes. For extremity-specific codes, two base codes (64642, 64644) were created to separate work by the number of injections to the extremity (64642 for  $\leq 4$  injections, 64644 for  $\geq 5$  injections). "Add-on" codes (64643, 64645) were also created to account for cases of injections in multiple extremities. For trunk-specific codes (64646, 64647), two codes were similarly created to separate work by the number of injections (64646 for  $\leq 5$  injections, 64647 for  $\geq 6$  injections).

This new coding structure is expected to better account for the significant difference in work that is currently performed using only the 64614 code. Many of the names provided by the pharmaceutical company were also members of the surveying societies. Of the 31 survey responses, 2 response came from the names provided by the manufacturer.

We surveyed the codes in two groups: the extremity codes (64642-64645) in one group and trunk codes (64646-64647) in a second group.

An expert panel of representatives from the AAN, AANEM and AAPMR reviewed the survey results and developed the following recommendations.

**64646:** The societies recommend a value of 2.11 for this code, which is the survey median. We recommend the survey median times of 15/20/5 be accepted. The pre-service evaluation time of 15 minutes exceeds the standard 7 minutes in our selected pre-service package, as does the 5 minutes of positioning time; however the additional minutes are necessary to allow for time to mix the toxin and position the patient.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64614

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology                      How often? Sometimes

Specialty AAPM&R                      How often? Sometimes

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 8337

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This number is three times the 2011 medicare claims reporting data for 64614, which we feel accurately represents the national reporting of this code for one year

Specialty Neurology	Frequency 1251	Percentage 15.00 %
---------------------	----------------	--------------------

Specialty PMR	Frequency 6253	Percentage 75.00 %
---------------	----------------	--------------------

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,779

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate 5% of the existing utilization of 64614 (55,574) will now be billed by 64646

Specialty Neurology	Frequency 417	Percentage 15.00 %
---------------------	---------------	--------------------

Specialty PMR	Frequency 2084	Percentage 74.99 %
---------------	----------------	--------------------

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 64614

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 64647	Tracking Number R6	Original Specialty Recommended RVU: <b>2.64</b>
		Presented Recommended RVU: <b>2.11</b>
Global Period: 000		RUC Recommended RVU: <b>2.11</b>

CPT Descriptor: Chemodenervation of trunk muscle(s); 6 or more muscle(s)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A patient with cerebral palsy presents with generalized idiopathic dystonia mainly involving bilateral trunk muscles. The patient has failed medical management and chemodenervation is performed to treat the affected trunk muscles. Injections are made to 6 or more muscles in the trunk.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The physician reviews the patient history, takes an interval history, reviews the patient's medications and allergies. The effect (e.g., benefit, duration of effect, any side effects) of any prior treatment is reviewed. To determine the muscles involved, a focused physical examination is performed while palpating the affected muscles. Optimal injection sites are determined and marked. Patient questions are answered and informed consent is obtained. The duration of expected treatment effect is discussed. A "time-out" is performed. The physician cleans the injection sites using alcohol swabs and puts on gloves. The medication is brought to room temperature and reconstituted with sterile saline by slowly injecting the diluents into the vial. The physician then gently mixes the toxin by rotating the vial. The drug is drawn into a syringe. The injection sites are cleaned using alcohol swabs and the patient is positioned for optimal medication delivery to the first injection site.

Description of Intra-Service Work: The toxin is injected. Following the injection, pressure is held briefly to control any bleeding. The patient is then repositioned for each subsequent injection.

Description of Post-Service Work: Bandages are placed over injection sites. The expected results and follow-up plans are discussed with the patient. Drug accounting is completed. The procedure report is generated, reviewed, and signed.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		01/2013				
<b>Presenter(s):</b>	Kevin Kerber, MD; Wayne Cornblath, MD; Janice Massey,MD; Barry Smith, MD					
<b>Specialty(s):</b>	American Academy of Neurology, American, American Association of Neuromuscular & Electrodiagnostic Medicine, American Academy of Physical Medicine and Rehabilitation					
<b>CPT Code:</b>	64647					
<b>Sample Size:</b>	1608	<b>Resp N:</b>	31	<b>Response:</b> 1.9 %		
<b>Description of Sample:</b>	The societies used a combined a sample of members and physicians who indicated they perform the service and names supplied by a pharmaceutical company.					
		<b><u>Low</u></b>	<b><u>25<sup>th</sup> pctl</u></b>	<b><u>Median*</u></b>	<b><u>75th pctl</u></b>	<b><u>High</u></b>
<b>Service Performance Rate</b>		0.00	2.00	<b>9.00</b>	14.00	75.00
<b>Survey RVW:</b>		1.40	2.11	<b>2.58</b>	3.00	6.00
<b>Pre-Service Evaluation Time:</b>				<b>10.00</b>		
<b>Pre-Service Positioning Time:</b>				<b>5.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>5.00</b>		
<b>Intra-Service Time:</b>		5.00	15.00	<b>25.00</b>	38.00	45.00
<b>Immediate Post Service-Time:</b>	<b><u>10.00</u></b>					
<b>Post Operative Visits</b>	<b><u>Total Min**</u></b>	<b><u>CPT Code and Number of Visits</u></b>				
<b>Critical Care time/visit(s):</b>	<b><u>0.00</u></b>	99291x 0.00	99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b><u>0.00</u></b>	99231x 0.00	99232x 0.00	99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b><u>0.00</u></b>	99238x 0.00	99239x 0.00	99217x 0.00		
<b>Office time/visit(s):</b>	<b><u>0.00</u></b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00	15x 0.00
<b>Prolonged Services:</b>	<b><u>0.00</u></b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00	
<b>Sub Obs Care:</b>	<b><u>0.00</u></b>	99224x 0.00	99225x 0.00	99226x 0.00		

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

5 - NF Procedure without sedation/anesthesia care

CPT Code:	64647	Recommended Physician Work RVU: 2.11					
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package		Adjustments/Recommended Pre-Service Time		
Pre-Service Evaluation Time:		10.00	7.00		3.00		
Pre-Service Positioning Time:		5.00	0.00		5.00		
Pre-Service Scrub, Dress, Wait Time:		0.00	0.00		0.00		
Intra-Service Time:		25.00					
Immediate Post Service-Time:	5.00						
Post Operative Visits	Total Min**	CPT Code and Number of Visits					
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00				
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.0	99239x 0.0	99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00	15x 0.00	
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00		



<b>Sub Obs Care:</b>	<b><u>0.00</u></b>	99224x <b>0.00</b>	99225x <b>0.00</b>	99226x <b>0.00</b>
----------------------	--------------------	--------------------	--------------------	--------------------

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99244	XXX	3.02	RUC Time

CPT Descriptor Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
95810	XXX	2.50	RUC Time	308,438

CPT Descriptor 1 Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
31622	000	2.78	RUC Time	83,622

CPT Descriptor 2 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 12      % of respondents: 38.7 %**

**TIME ESTIMATES (Median)**

	<u>CPT Code:</u> <b>64647</b>	<u>Key Reference CPT Code:</u> <u>99244</u>	<u>Source of Time</u> <u>RUC Time</u>
Median Pre-Service Time	15.00	10.00	
Median Intra-Service Time	25.00	40.00	
Median Immediate Post-service Time	5.00	15.00	
Median Critical Care Time	0.0	0.00	

Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>45.00</b>	<b>65.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.00	4.42
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.33	4.58
Urgency of medical decision making	3.92	4.08

**Technical Skill/Physical Effort (Mean)**

Technical skill required	5.00	4.25
Physical effort required	4.75	3.75

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.33	4.25
Outcome depends on the skill and judgment of physician	4.83	4.58
Estimated risk of malpractice suit with poor outcome	4.00	3.83

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.92	3.92
Intra-Service intensity/complexity	4.83	4.50
Post-Service intensity/complexity	3.67	4.00

---

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Code 64614 (chemodenervation of extremity and/or trunk muscles) is being broken out into 6 new codes 64642-64647. Previously one unit of 64614 was reported regardless of the number of injections performed, with a modifier 50 reported for bilateral procedures. The new coding structure separates the codes into extremity-specific and trunk-specific codes. For extremity-specific codes, two base codes (64642, 64643) were created to separate work by the number of injections to the extremity (64642 for  $\leq 4$  injections, 64644 for  $\geq 5$  injections). "Add-on" codes (64643, 64645) were also created to account for cases of injections in multiple extremities. For trunk-specific codes (64646, 64647), two codes were similarly created to separate work by the number of injections (64646 for  $\leq 5$  injections, 64647 for  $\geq 6$  injections).

This new coding structure is expected to better account for the significant difference in work that is currently performed using only the 64614 code.

We surveyed the codes in two groups: the extremity codes (64642-64645) in one group and trunk codes (64646-64647) in a second group. Many of the names provided by the pharmaceutical company were also members of the surveying societies. Of the 31 survey responses, 1 response came from the names provided by the manufacturer.

An expert panel of representatives from the AAN, AANEM and AAPMR reviewed the survey results and developed the following recommendations.

**64647:** The societies recommended a value of 2.64 for this code. Our recommended times are 10/25/5. As stated in the rationale for the recommended value for 64644, it was expected that breaking 64614 into 6 codes would result in some codes of lower values and some of higher values. These differences in time and intensity were not incorporated into the original code of 64614. Since the 64614 code was first developed and RUC valued in 2000, the technique and patient populations for Botox injections has expanded substantially. It is now clear that there is a patient population that requires more injections and time represented by this code. Thus for the reasons of technique, patient population, and increased physician time, there is compelling evidence that 64644 differs substantially from the prior standard 64614 code. The recommended value for 64647 was calculated by adding an additional 5 minutes of intra-service work to the RVU value of 64646.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64614

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology                      How often? Sometimes

Specialty AAPM&R                      How often? Sometimes

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 8337

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This number is three times the 2011 medicare claims reporting data for 64614, which we feel accurately represents the national reporting of this code for one year.

Specialty Neurology	Frequency 1251	Percentage 15.00 %
---------------------	----------------	--------------------

Specialty PMR	Frequency 6253	Percentage 75.00 %
---------------	----------------	--------------------

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,779

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate 5% of the existing utilization of 64614 (55,574) will now be billed by 64647

Specialty Neurology	Frequency 417	Percentage 15.00 %
---------------------	---------------	--------------------

Specialty PMR	Frequency 2084	Percentage 74.99 %
---------------	----------------	--------------------

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 64614

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
12	ISSUE: Chemodenervation of Extremity and Trunk Muscles																			
13	TAB: 10																			
14						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
15	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	
16	REF	99215	Office/outpatient visit est	12	0.047			2.11			55	5					35			15
17	RUC	64614	Destroy nerve extrem and/or trunk musc		0.076			2.20			50	15					20			15
18	SVY	64642	Chemodenervation of one extrem: 1-4 musc	44	0.082	1.00	1.65	2.13	2.50	5.00	45	10	5	5			20			5
19	REC	64642	Chemodenervation of one extrem: 1-4 musc		0.060	1.65					40	10	5				20			5
20																				
21																				
22						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
23	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	
24	REF	95886	Musc test done w/n test comp	9	0.031			0.92			30						30			
25	RUC	64614	Destroy nerve extrem and/or trunk musc		0.076			2.20			50	15					20			15
26	SVY	64643	Chemodenervation of one extrem; each addtl extrem; 1-4 musc	44	0.072	0.35	1.00	1.43	1.80	3.00	20						20			
27	REC	64643	Chemodenervation of one extrem: each addtl extrem:		0.065	1.32					21		1				20			
28																				
29																				
30						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
31	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	
32	REF	99244	Office consultation	11	0.062			3.02			65	10					40			15
33	RUC	64614	Destroy nerve extrem and/or trunk musc		0.076			2.20			50	15					20			15
34	SVY	64644	Chemodenervation of one extrem; 5 or more musc	44	0.100	1.10	1.82	2.48	3.00	6.00	45	10	5	5			20			5
35	REC	64644	Chemodenervation of one extrem: 5 or more musc		0.055	1.82					45	10	5				25			5
36																				
37																				
38						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
39	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	
40	REF	95979	Analyz neurostim brain addon	7	0.055			1.64			30						30			
41	RUC	64614	Destroy nerve extrem and/or trunk musc		0.076			2.20			50	15					20			15
42	SVY	64645	Chemodenervation of one extrem; each addtl extrem; 5 or more musc	43	0.068	0.35	1.20	1.70	2.20	6.00	25						25			
43	REC	64645	Chemodenervation of one extrem: each addtl extrem:		0.060	1.52					26	1					25			
44																				
45																				
46						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
47	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	
48	REF	99215	Office/outpatient visit est	7	0.047			2.11			55	5					35			15
49	RUC	64614	Destroy nerve extrem and/or trunk musc		0.076			2.20			50	15					20			15
50	SVY	64646	Chemodenervation of trunk: 1-5 musc	32	0.081	0.88	1.80	2.11	2.56	6.00	45	10	5	5			20			5
51	REC	64646	Chemodenervation of trunk: 1-5 musc		0.068	1.80					40	10	5				20			5
52																				
53																				
54						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
55	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	
56	REF	99244	Office consultation	12	0.062			3.02			65	10					40			15
57	RUC	64614	Destroy nerve extrem and/or trunk musc		0.076			2.20			50	15					20			15
58	SVY	64647	Chemodenervation of trunk: 6 or more musc	31	0.079	1.40	2.11	2.58	3.00	6.00	55	10	5	5			25			10
59	REC	64647	Chemodenervation of trunk: 6 or more musc		0.066	2.11					45	10	5				25			5

Chemodenervation Family												
CPT	Descriptor	RVW Source	RVW	Global	Pre eval	Pre Posi	Pre SDW	Intra	Post	Post-Op	Total	IWPUT
64612	Destroy nerve face muscle	Existing - 2012 RUC Review	1.41	010	10			10	5	16	41	0.059
64613	Destroy nerve neck muscle	To be deleted	2.01	010	10			21	6	16	53	0.0558
64617	Destroy nerve larynx	Proposed	2.19	000	15	1	5	10	5		36	0.168
64616	Destroy nerve neck, other than larynx	Proposed	1.85	000	10	5		15	5		35	0.093
64614	Destroy nerve extrem and/or trunk musc	To be deleted	2.20	010	15			20	15		50	0.0763
64642	1 extremity; 1-4 musc	Proposed	2.13	000	10	5		20	5		40	0.084
64643	each addl extremity, 1-4 musc	Proposed	1.68	ZZZ				20			20	0.084
64644	1 extremity; 5 or more musc	Proposed	2.55	000	10	5		25	5		45	0.084
64645	each addl extremity, 5 or more musc	Proposed	2.10	ZZZ				25			25	0.084
64646	Trunk musc; 1-5 musc	Proposed	2.11	000	10	5		20	5		40	0.083
64647	Trunk musc; 6 or more musc	Proposed	2.64	000	10	5		25	10		50	0.083
64615	Chemodenerv for chronic migraine	Existing - 2012 RUC Review	1.85	010	15			15	5		35	0.093

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor:

Chemodenervation of one extremity; 1-4 muscle(s)

Global Period: .000 Meeting Date: January 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

**The AAN, AAPM&R and AANEM convened a consensus panel via telephone and email to develop the inputs for this code.**

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

**We used the existing PE inputs for 64614 from 2005 as a starting point and made updates to reflect new time standards and changes in technology.**

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:

**A number of insurances require preauthorization for Botox. This time accounts for the additional minutes to complete pre service forms. (line 12)**

**This service is performed in a procedure room or EMG lab and needs to be booked which accounts for the additional minutes to schedule space and equipment in facility. (line 14)**

**The patient needs to be counseled before procedure on the need for someone else to accompany them to procedure which accounts for the additional minutes to provide pre service education / obtain consent. (line 15)**

4. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Order necessary labs and phone in preoperative medications. Counsel patient re: logistics. Consent documents reviewed and signed. Advise patient re: anticipated outcomes and possible side effects. Make phone call(s) to answer last minute questions and confirm understanding.

Intra-Service Clinical Labor Activities:

Greet and gown. Check vital signs. Prepare room. Position patient. Assist doctor during procedure (including stabilization of the extremity to protect against injury to vital structures in the neck during multiple needle passes). Assist patient with dressing and wheelchair (if necessary), escort to the waiting room. Clean room and instruments.

**CPT Code: 64642**  
**Specialty Society('s) AAN, AAPM&R, AANEM**

Post-Service Clinical Labor Activities:

As part of the post-op service: prepare prescriptions forms; instructions and counseling; make necessary telephone calls; check supplies; coordinate home or outpatient care.



**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor:

Chemodenervation of one extremity; each additional extremity, 1-4 muscle(s)

Global Period: ZZZ Meeting Date: January 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

**The AAN, AAPM&R and AANEM convened a consensus panel via telephone and email to develop the inputs for this code.**

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

**We used the existing PE inputs for 64614 from 2005 as a starting point and made updates to reflect new time standards and changes in technology.**

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:

4. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

Greet and gown. Check vital signs. Prepare room. Position patient. Assist doctor during procedure (including stabilization of the extremity(ies) to protect against injury to vital structures in the neck during multiple needle passes). Assist patient with dressing and wheelchair (if necessary), escort to the waiting room. Clean room and instruments.

Post-Service Clinical Labor Activities:

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor: Chemodenervation of one extremity; 5 or more muscle(s)

Global Period: \_000\_ Meeting Date: \_January 2013\_

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

**The AAN, AAPM&R and AANEM convened a consensus panel via telephone and email to develop the inputs for this code.**

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

**We used the existing PE inputs for 64614 from 2005 as a starting point and made updates to reflect new time standards and changes in technology.**

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:

**A number of insurances require preauthorization for Botox. This time accounts for the additional minutes to complete pre service forms. (line 12)**

**This service is performed in a procedure room or EMG lab and needs to be booked which accounts for the additional minutes to schedule space and equipment in facility. (line 14)**

**The patient needs to be counseled before procedure on the need for someone else to accompany them to procedure which accounts for the additional minutes to provide pre service education / obtain consent. (line 15)**

4. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Order necessary labs and phone in preoperative medications. Counsel patient re: logistics. Consent documents reviewed and signed. Advise patient re: anticipated outcomes and possible side effects. Make phone call(s) to answer last minute questions and confirm understanding.

Intra-Service Clinical Labor Activities:

Greet and gown. Check vital signs. Prepare room. Position patient. Assist doctor during procedure (including stabilization of the extremity to protect against injury to vital structures in the neck during multiple needle passes). Assist patient with dressing and wheelchair (if necessary), escort to the waiting room. Clean room and instruments.

Post-Service Clinical Labor Activities:

**CPT Code: 64644**  
**Specialty Society('s) AAN, AAPM&R, AANEM**

As part of the post-op service: prepare prescriptions forms; instructions and counseling; make necessary telephone calls; check supplies; coordinate home or outpatient care.

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor: Chemodenervation of one extremity; 5 or more muscle(s)  
each additional extremity, 5 or more muscle(s)

Global Period: ZZZ Meeting Date: January 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

**The AAN, AAPM&R and AANEM convened a consensus panel via telephone and email to develop the inputs for this code**

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

**We used the existing PE inputs for 64614 from 2005 as a starting point and made updates to reflect new time standards and changes in technology**

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:

4. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

Greet and gown. Check vital signs. Prepare room. Position patient. Assist doctor during procedure (including stabilization of the extremity(ies) to protect against injury to vital structures in the neck during multiple needle passes). Assist patient with dressing and wheelchair (if necessary), escort to the waiting room. Clean room and instruments.

Post-Service Clinical Labor Activities:

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor: Chemodenervation of trunk muscle(s); 1-5 muscle(s)

Global Period: \_000\_ Meeting Date: \_January 2013\_

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

**The AAN, AAPM&R and AANEM convened a consensus panel via telephone and email to develop the inputs for this code**

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

**We used the existing PE inputs for 64614 from 2005 as a starting point and made updates to reflect new time standards and changes in technology**

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:

**A number of insurances require preauthorization for Botox. This time accounts for the additional minutes to complete pre service forms. (line 12)**

**This service is performed in a procedure room or EMG lab and needs to be booked which accounts for the additional minutes to schedule space and equipment in facility. (line 14)**

**The patient needs to be counseled before procedure on the need for someone else to accompany them to procedure which accounts for the additional minutes to provide pre service education / obtain consent. (line 15)**

4. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Order necessary labs and phone in preoperative medications. Counsel patient re: logistics. Consent documents reviewed and signed. Advise patient re: anticipated outcomes and possible side effects. Make phone call(s) to answer last minute questions and confirm understanding.

Intra-Service Clinical Labor Activities:

Greet and gown. Check vital signs. Prepare room. Position patient. Assist doctor during procedure (including stabilization of the trunk to protect against injury to vital structures during multiple needle passes). Assist patient with dressing and wheelchair (if necessary), escort to the waiting room. Clean room and instruments

Post-Service Clinical Labor Activities:

**CPT Code: 64646**  
**Specialty Society('s) AAN, AAPM&R, AANEM**

As part of the post-op service: prepare prescriptions forms; instructions and counseling; make necessary telephone calls; check supplies; coordinate home or outpatient care.

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor: Chemodenervation of trunk muscle(s); 6 or more muscle(s)

Global Period: \_000\_ Meeting Date: \_January 2013\_

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

**The AAN, AAPM&R and AANEM convened a consensus panel via telephone and email to develop the inputs for this code**

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

**We used the existing PE inputs for 64614 from 2005 as a starting point and made updates to reflect new time standards and changes in technology**

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:

**A number of insurances require preauthorization for Botox. This time accounts for the additional minutes to complete pre service forms. (line 12)**

**This service is performed in a procedure room or EMG lab and needs to be booked which accounts for the additional minutes to schedule space and equipment in facility. (line 14)**

**The patient needs to be counseled before procedure on the need for someone else to accompany them to procedure which accounts for the additional minutes to provide pre service education / obtain consent. (line 15)**

4. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Order necessary labs and phone in preoperative medications. Counsel patient re: logistics. Consent documents reviewed and signed. Advise patient re: anticipated outcomes and possible side effects. Make phone call(s) to answer last minute questions and confirm understanding.

Intra-Service Clinical Labor Activities:

Greet and gown. Check vital signs. Prepare room. Position patient. Assist doctor during procedure (including stabilization of the trunk to protect against injury to vital structures during multiple needle passes). Assist patient with dressing and wheelchair (if necessary), escort to the waiting room. Clean room and instruments

**CPT Code: 64647**  
**Specialty Society('s) AAN, AAPM&R, AANEM**

Post-Service Clinical Labor Activities:

As part of the post-op service: prepare prescriptions forms; instructions and counseling; make necessary telephone calls; check supplies; coordinate home or outpatient care.



	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
1				REFERENCE CODE															
2	Note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.			64614		64615		64642		64643		64644		64645		64646		64647	
3	Meeting Date: January 2013 Tab: 10 Specialty: AAN, AAPM&R, AANEM	CMS Code	Staff Type	Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis)		Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)		Chemodenervation of one extremity; 1-4 muscle(s)		Chemodenervation of one extremity; each additional extremity, 1-4 muscle(s)		Chemodenervation of one extremity; 5 or more muscle(s)		Chemodenervation of one extremity; each additional extremity, 5 or more muscle(s)		Chemodenervation of trunk muscle(s); 1-5 muscle(s)		Chemodenervation of trunk muscle(s); 6 or more muscle(s)	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			010	010	010	010	000	000	ZZZ	ZZZ	000	000	ZZZ	ZZZ	000	000	000	000
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	60.0	43.0	24.0	12.0	44.0	12.0	20.0	0.0	49.0	12.0	25.0	0.0	44.0	12.0	49.0	12.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	5.0	10.0	3.0	9.0	3.0	9.0	0.0	0.0	3.0	9.0	0.0	0.0	3.0	9.0	3.0	9.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	28.0	6.0	18.0	0.0	38.0	0.0	20.0	0.0	43.0	0.0	25.0	0.0	38.0	0.0	43.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	27.0	27.0	3.0	3.0	3.0	3.0	0.0	0.0	3.0	3.0	0.0	0.0	3.0	3.0	3.0	3.0
10	PRE-SERVICE																		
11	Start: Following visit when decision for surgery or procedure made																		
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	5	5		3		3				3				3		3
13	Coordinate pre-surgery services																		
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		5		3		3				3				3		3
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA			3	3	3	3			3	3			3	3	3	3
16	Follow-up phone calls & prescriptions																		
17	Other Clinical Activity - specify:																		
18	End: When patient enters office/facility for surgery/procedure																		
19	SERVICE PERIOD																		
20	Start: When patient enters office/facility for surgery/procedure:																		
21	Review charts			2															
22	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	3		2		3				3				3		3	
23	Obtain vital signs	L037D	RN/LPN/MTA	3		3		3				3				3		3	
24	Provide pre-service education/obtain consent			3															
25	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2		2		2				2				2		2	
26	Setup scope (non facility setting only)																		
27	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	2				2				2				2		2	
28	Sedate/apply anesthesia			2															
29	Intra-service																		
30	Assist physician in performing procedure	L037D	RN/LPN/MTA	10				20		20		25		25		20		25	
31	Post-Service																		
32	Monitor pt. following service/check tubes, monitors, drains																		
33	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	3		3		3				3				3		3	
34	Clean Scope																		
35	Clean Surgical Instrument Package																		
36	Complete diagnostic forms, lab & X-ray requisitions																		
37	Review/read X-ray, lab, and pathology reports																		
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA			5		5				5				5		5	
39	Other Clinical Activity - specify: complete botox log	L037D	RN/LPN/MTA			3		0				0				0		0	
40	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			n/a	6	n/a		n/a		n/a		n/a		n/a		n/a		n/a	
41	Dischrg mgmt (1.0 x 99238) (enter 12 min)			n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a	
42	Dischrg mgmt (1.0 x 99239) (enter 15 min)			n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a	
43	End: Patient leaves office																		

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S			
1				REFERENCE CODE																		
2	Note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.			64614		64615		64642		64643		64644		64645		64646		64647				
3	Meeting Date: January 2013 Tab: 10 Specialty: AAN, AAPM&R, AANEM			CMS Code	Staff Type	Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis)		Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)		Chemodenervation of one extremity; 1-4 muscle(s)		Chemodenervation of one extremity; each additional extremity, 1-4 muscle(s)		Chemodenervation of one extremity; 5 or more muscle(s)		Chemodenervation of one extremity; each additional extremity, 5 or more muscle(s)		Chemodenervation of trunk muscle(s); 1-5 muscle(s)		Chemodenervation of trunk muscle(s); 6 or more muscle(s)		
4	LOCATION					Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility			
5	GLOBAL PERIOD					010	010	010	010	000	000	ZZZ	ZZZ	000	000	ZZZ	ZZZ	000	000	000	000	
44	POST-SERVICE Period																					
45	Start: Patient leaves office/facility																					
46	Conduct phone calls/call in prescriptions		L037D	RN/LPN/MTA			3	3	3	3			3	3			3	3	3	3		
47	Office visits: List Number and Level of Office Visits			# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits		
48	99211 16 minutes			16																		
49	99212 27 minutes			27		1		1														
50	99213 36 minutes			36																		
51	99214 53 minutes			53																		
52	99215 63 minutes			63																		
53	Total Office Visit Time					27.0		27.0		0.0		0.0		0.0		0.0		0.0		0.0		
54	Other Clinical Activity - specify:																					
55	End: with last office visit before end of global period																					
56	MEDICAL SUPPLIES			CODE	UNIT																	
57	pack, minimum multi-specialty visit			SA048	pack			1		1		1						1		1		
58	syringe, 1ml			SC052	item	4		6				2				2		6		6		
59	gauze, non-sterile 4in x 4in			SG051	item	10		1				8				8		24		24		
60	bandage, strip 0.75in x 3in (Bandaid)			SG021	item	5		1				4				4		12		12		
61	syringe 5-6ml			SC057	item	1						2				2		6		6		
62	needle, 18-27g			SC029	item	2		2				2				2		6		6		
63	swab-pad, alcohol			SJ053	item	10		3				8				8		24		24		
64	phosphate buffered saline solution			SL107	ml	2		3				2				2		6		6		
65	needle, 30g			SC031	item			6														
66	syringe 3ml			SC055	item			2														
67	EQUIPMENT			CODE																		
68	table, exam			EF023			57		24				38				20		43		25	
69																		38		43		

## AMA/Specialty Society RVS Update Committee Summary of Recommendations

January/April 2013

### Insertion of Anterior Segment Device

In October 2012, the CPT Editorial Panel approved to convert category III code, 0192T *Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach* to a category I code, 66183 due to widespread use and adequate published peer reviewed articles supporting the safety and effectiveness of the procedure.

#### **66183 *Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach***

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

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

#### **Practice Expense:**

The RUC approved the practice expense inputs as reviewed and approved by the PE Subcommittee.

**New Technology**

CPT code 66183 will be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
0191T		Insertion of anterior segment aqueous drainage device, without extraocular reservoir; internal approach, into the trabecular meshwork	XXX	N/A
#0253T		internal approach, into the subrachoroidal space	YYY	N/A
D0192T		<del>external approach</del> (0192T has been deleted. To report insertion of drainage device by external approach, use 66183)	XXX	N/A
<b>Category I Surgery Eye and Ocular Adnexa Anterior Sclera Aqueous Shunt</b>				
●66183	J1	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach	090	13.20

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 66183      Tracking Number J1      Original Specialty Recommended RVU: **13.20**  
 Presented Recommended RVU: **13.20**  
 Global Period: 090      RUC Recommended RVU: **13.20**

CPT Descriptor: Insertion of anterior segment aqueous drainage device, without extraocular reservoir; external approach

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 62 year old male presents with chronic open angle glaucoma and intraocular pressure that is uncontrolled in the right eye with current treatment.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 34% , In the ASC 66%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 46%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 3%

Description of Pre-Service Work: Review is conducted of past surgical history, medical history, and the surgical plan. Required paperwork is completed. The patient is positioned in preparation for local anesthetic block anesthesia, the surgical eye is confirmed with the patient, surgical and anesthesia team, and the forehead is marked to indicate the operative eye. A local anesthetic block is performed while the patient is monitored with pulse oximetry and electrocardiography.

Description of Intra-Service Work: The operative eye is confirmed by the surgeon. A lid speculum is placed. A partial thickness corneal traction suture is placed and secured to the drape for superior conjunctival exposure. A limbal- or fornix-based conjunctival incision for 5-6 mm is performed followed by deep subconjunctival dissection into the superior temporal and superior nasal fornices to free Tenon's capsule from its attachments to the underlying sclera. Bleeding is controlled with cautery. Next, a 3 mm by 3 mm partial-thickness scleral flap is created with a base at the limbus. An antifibrotic agent is applied to the sclera and the conjunctiva is draped over the applicator sponges for 2-5 minutes. The surgical area is rinsed copiously with balanced salt solution and dried with sponges. A paracentesis is created through temporal clear cornea and the anterior chamber is inflated with balanced salt solution. A 27 gauge needle is bent to allow for easier maneuverability, the needle is placed posterior to the blue line underneath the scleral flap and advanced through the tissue into the anterior chamber while avoiding contact with cornea or iris. The aqueous drainage device is implanted through this needle-entry sclerostomy site under the scleral flap in order to maintain the aqueous flow out of the eye. The device is rotated and confirmed to be stable in the proper orientation and position, and the inserter is released. The scleral flap is reapproximated over the external flange of the device and secured with interrupted 10-0 nylon sutures. The anterior chamber is reinflated with balanced salt solution through the paracentesis and the aqueous flow beneath the scleral flap is observed. If necessary, additional 10-0 nylon sutures are placed in the scleral flap. The conjunctiva is reapproximated and carefully sutured to create a water-tight seal. The conjunctival wound is then tested for integrity by inspecting with fluorescein dye. Injections of antibiotics and steroids are performed. The traction suture and lid speculum are removed.

Description of Post-Service Work: The eye is dressed with topical ointment, patched and a shield is placed. The patient is given detailed postoperative care instructions. The IV is removed. Postoperative pain control is reviewed. An operative report is generated, and required paperwork completed.

Postoperative visits begin on the first postoperative day and continue regularly throughout the postoperative period to assess vision, wound integrity, aqueous flow through the drainage device into the subconjunctival filtration bleb, optic nerve appearance, extraocular and intraocular inflammation, edema of the cornea and/or retina, and intraocular pressure control. Anti-inflammatory and glaucoma medications are adjusted at each post-operative visit based on the clinical appearance. Suture removal either by releasing temporary sutures or laser lysis is performed as needed throughout the post-operative period to modulate flow of aqueous from the eye to titrate intraocular pressure.

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)		04/2013					
Presenter(s):		Stephen A. Kamenetzky, MD and Cindie Mattox, MD					
Specialty(s):		Ophthalmology/Glaucoma					
CPT Code:		66183					
Sample Size:		900	Resp N:	56	Response: 6.2 %		
Description of Sample:		Random sample of members were pulled from the AAO and American Glaucoma Society database					
			Low	25 <sup>th</sup> pctl	Median*	75 <sup>th</sup> pctl	High
Service Performance Rate			0.00	0.00	5.00	25.00	250.00
Survey RVW:			8.50	13.20	15.01	17.00	43.50
Pre-Service Evaluation Time:					10.00		
Pre-Service Positioning Time:					7.50		
Pre-Service Scrub, Dress, Wait Time:					10.00		
Intra-Service Time:			30.00	40.00	45.00	60.00	90.00
Immediate Post Service-Time:		10.00					
Post Operative Visits		Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):		0.00	99291x 0.00	99292x 0.00			
Other Hospital time/visit(s):		0.00	99231x 0.00	99232x 0.00	99233x 0.00		
Discharge Day Mgmt:		19.00	99238x 0.50	99239x 0.00	99217x 0.00		
Office time/visit(s):		186.00	99211x 0.00	12x 3.00	13x 6.00	14x 0.00	15x 0.00
Prolonged Services:		0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00	
Sub Obs Care:		0.00	99224x 0.00	99225x 0.00	99226x 0.00		

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1b-FAC Straightforw Pat Procedure(w sedate/anes)

CPT Code:	66183	Recommended Physician Work RVU: 13.20			
		Specialty Recommended Pre- Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:		10.00	19.00	-9.00	
Pre-Service Positioning Time:		5.00	1.00	4.00	
Pre-Service Scrub, Dress, Wait Time:		5.00	5.00	0.00	
Intra-Service Time:		45.00			
Immediate Post Service-Time:	10.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	19.00	99238x 0.5	99239x 0.0	99217x 0.00	
Office time/visit(s):	163.00	99211x 0.00	12x 3.00	13x 5.00	14x 0.00 15x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	0.00	99224x 0.00	99225x 0.00	99226x 0.00	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? Yes

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
65756	090	16.84	RUC Time

CPT Descriptor Keratoplasty (corneal transplant); endothelial**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
58660	090	11.59	RUC Time	1,800

CPT Descriptor 1 Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
33249	090	15.17	RUC Time	50,309

CPT Descriptor 2 Insertion or replacement of permanent pacing cardioverter-defibrillator system with transvenous lead(s), single or dual chamber

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
66175	090	13.60	RUC Time

CPT Descriptor Transluminal dilation of aqueous outflow canal; with retention of device or stent**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 13      % of respondents: 23.2 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 66183</b>	<b>Key Reference CPT Code: 65756</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	20.00	39.00	
Median Intra-Service Time	45.00	60.00	
Median Immediate Post-service Time	10.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	163.0	117.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	



<b>Median Total Time</b>	<b>257.00</b>	<b>255.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.69	3.92
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.62	3.92
--	------	------

Urgency of medical decision making	4.46	3.85
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.92	4.77
--------------------------	------	------

Physical effort required	4.62	4.31
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.85	4.38
---	------	------

Outcome depends on the skill and judgment of physician	4.85	4.62
--	------	------

Estimated risk of malpractice suit with poor outcome	4.85	4.46
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.54	4.08
----------------------------------	------	------

Intra-Service intensity/complexity	4.62	4.46
------------------------------------	------	------

Post-Service intensity/complexity	4.77	4.31
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An issue was raised at the January meeting about the number of postoperative visits for this code. The society recognizes that the number is higher than typical for many surgical procedures. Patients with

glaucoma severe enough for surgical intervention require intense care for the entire 90-day global period, more so than for any other ophthalmological procedure. The patient is in danger of further visual loss from the intraocular pressure being either too high or too low postoperatively. In addition, this procedure creates a fistula which must remain open after healing is complete for the procedure to be successful.

### **Post-operative Care**

The aqueous drainage device is covered by a layer of sclera that must be tightly closed to prevent the immediate postoperative pressure from being too low. Because this device has no external reservoir, it is then covered by a layer of conjunctiva. The aqueous drains from the eye via the device, percolates between the edges of the scleral flap and is then captured under the conjunctival bleb. The thin conjunctiva overlying the bleb can retract or develop weak areas that leak. The scleral flap is closed with several sutures that are sequentially released (usually by releasing a temporary suture) depending on the pressure. These sutures have to be specially placed because the conjunctiva overlying them cannot be opened or the bleb will leak. These are typically 2-3 in number and are released on sequential office visits so that the pressure can be titrated.

Failure of the fistula to remain open due to scarring can occur at the device, the margins of the scleral flap and the conjunctiva reservoir. Careful and frequent examinations are needed to monitor for this issue which would result in failure of the surgery and persistent elevation of the pressure. The fistula is at risk of closure throughout the entire 90-day global period. Treatment at the postoperative examination includes special contact lenses if the pressure becomes too low or the bleb leaks. Massage of the eye, suture release, needling of the scleral flap and/or the conjunctiva is performed if the pressure is too high. In addition topical medications for both pressure control and postoperative inflammation need careful management. Timing of the interventions is critical and evaluations must be performed frequently to prevent irreversible scarring and failure of the procedure with resultant elevated intraocular pressure. Unlike most surgical procedures where the intensity of the postoperative care decreases as time passes, the care for this procedure remains complex for the duration of the global period.

Canaloplasty with or without a stent was recently (2010) reviewed by the RUC (CPT 66175 and 66174, respectively). Six postoperative visits were approved for both procedures. Neither procedure creates an external fistula that has to be monitored; the primary care for these frequent visits to monitor pressure and adjust medications. Postoperative care for this procedure is much more intense and needs more frequent visits. There are orthopedic procedures, such as CPT 24300 (elbow) and 25259(wrist)) which deal with joint contractures and have six visits the global period because continued monitoring and therapy is needed to prevent recurrence of the "frozen" joint.

### **CPT 66183 Survey Analysis**

The AAO survey produced 56 responses. The vignette was felt to be typical by 91% of the respondents. The 25<sup>th</sup> percentile for WRVU was 13.2 and the median 15.01. Median IST was 45 minutes. Pre-service package 1B was recommended with slight modification. The survey indicated that there were six 99213 and three 99212 postoperative visits reflecting the frequent monitoring of pressure and optic nerve appearance that is needed in glaucoma patients to detect pressure elevation from shunt obstruction. The key reference service *CPT 65765 Keratoplasty (corneal transplant); endothelial* was valued by the RUC in 2008. It has a WRVU of 16.84. Survey respondents consistently valued the intensity and complexity of the surveyed code as being greater than or equal to the reference code which has an IST of 60 minutes. The survey respondents felt that the surveyed coded was greater in intensity and complexity than the reference code for all categories.

### **CPT 66183 Recommendation**

The expert panel of the AAO Health Policy Committee aided by representatives of the American Glaucoma Society reviewed the survey results. All participants were familiar with the RUC process. The panel felt that the survey results were strong and accurately reflected the physician work of the procedure. The key reference service has a longer IST but the respondents felt that the intensity and complexity were less than the surveyed code. With that in mind, the expert panel believes that the 25<sup>th</sup> percentile WRVU accurately reflected these differences and the society is recommending that value of 13.2 WRVU for this procedure.

The specialty is aware that this WRVU is significantly higher than other codes with 45 minutes of IST. However the total time for this procedure is significantly greater than for most of those procedures. In

addition, ophthalmology procedures, in general, have this relationship between WRVU and time because of the nature of the surgical approach. There is no time spent in getting to the operative site. The higher intensity work of the procedure (as opposed to lower-intensity work of obtaining access to be able to begin the procedure) starts immediately. This concentrates high intensity work in a shorter period of time and the RUC has recognized this in the past. If this 25<sup>th</sup> percentile WRVU is accepted, the IWPUT will be 0.102. In April 2010 the RUC accepted IWPUTs in this range for two other glaucoma operations: CPT 66174 (IWPUT = 0.131) and 66175 (0.127). In addition, these codes have WRVU of 12.85 and 13.6 respectively with fewer, lower intensity postoperative visits. Another glaucoma invasive procedure CPT 65850 *Trabeculotomy ab externo* has an IWPUT of 0.111. It also requires less postoperative work than the surveyed code. Laser surgery for glaucoma (CPT 65855 (*Trabeculoplasty by laser surgery, 1 or more sessions (defined treatment series)*) is a 10 day global period and has an IWPUT of 0.13.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0192T

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology

How often? Sometimes

Specialty

How often?

Specialty

How often?

Estimate the number of times this service might be provided nationally in a one-year period? 16000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Data from manufacturer

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 5,000  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC database

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? Yes

---

**Professional Liability Insurance Information (PLI)**

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 65850

## SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AF	AG	AH	AI	AJ
12	ISSUE: 6618X1 Insertion of Anterior Chamber Drainage Device; Without Extraocular Reservoir																															
13	TAB: 14																															
14						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day					Office						
15	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	15	14	13	12	11
16	REF	65756	Keratoplasty; endothelia	51	0.177			16.84			255	33	1	5			60			20						0.5				3	3	
18	SVY	66183	Aqueous shunt w/o extraocular reservoir	56	0.143	8.50	13.20	15.01	17.00	43.50	288	10	7.5	10	30	40	45	60	90	10						0.5				6	3	
19	REC	66183			0.124	13.20					262	15	5	5			45			10						0.5	5 3					
20																																
21																																
22																																
23																																
24																																
25																																

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor: 66183 Insertion of anterior segment drainage device

Global Period: 090                      Meeting Date: 4/2013

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Academy convenes a Consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. Additionally we use other physicians who have the appropriate expertise. The consensus committee considered the survey data and PE details in order to determine clinical time and applicable standard packages were also applied. The physicians on the consensus panel familiar with the service provided input on the supplies and equipment needed.

If you have provided any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:

This code is a new code in the glaucoma shunt family.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Standard 90-day global times to: Complete pre-service diagnostic & referral forms; Coordinate pre-surgery services; Schedule space and equipment in facility; Provide pre-service education/obtain consent, and follow-up phone calls & prescriptions.

Intra-Service Clinical Labor Activities:

Standard 6 minutes for discharge day management coordination.

Post-Service Clinical Labor Activities:

Standard times for 9 post-operative office visits at the appropriate levels.

	A	B	C	D	E	F	G	H	I	J	K	L	M	
1				REFERENCE CODE		Tab 25		REFERENCE CODE		Tab 25		Tab 12 (In the family as 66180/66185)		
2	Note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.			66180		66180		66185		66185		66183		
3	Meeting Date: 1/2013 Tab: 12/25 Specialty: Ophthalmology		CMS Code	Staff Type	Aqueous shunt to extraocular reservoir		Aqueous shunt to extraocular reservoir		Revision of Aqueous shunt to extraocular reservoir		Revision of Aqueous shunt to extraocular reservoir		Insertion of anterior segment drainage device, without extraocular reservoir	
4	LOCATION				Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD				N/A	90	N/A	90	N/A	90	N/A	90	N/A	90
6	TOTAL CLINICAL LABOR TIME					264	0.0	327.0		228.0	0.0	291.0	0.0	327.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME					60	0.0	60.0		60.0	0.0	60.0	0.0	60.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME					6	0.0	6.0		6.0	0.0	6.0	0.0	6.0
9	TOTAL POST-SERV CLINICAL LABOR TIME					198	0.0	261.0		162.0	0.0	225.0	0.0	261.0
10	PRE-SERVICE													
11	Start: Following visit when decision for surgery or procedure made													
12	Complete pre-service diagnostic & referral forms	L038A	COMT/COT/RN/CST		5		5		5		5		5	
13	Coordinate pre-surgery services	L038A	COMT/COT/RN/CST		20		20		20		20		20	
14	Schedule space and equipment in facility	L038A	COMT/COT/RN/CST		8		8		8		8		8	
15	Provide pre-service education/obtain consent	L038A	COMT/COT/RN/CST		20		20		20		20		20	
16	Follow-up phone calls & prescriptions	L038A	COMT/COT/RN/CST		7		7		7		7		7	
17	Other Clinical Activity - specify:													
18	End: When patient enters office/facility for surgery/procedure													
19	SERVICE PERIOD													
20	Start: When patient enters office/facility for surgery/procedure:													
30	Post-Service													
38	Other Clinical Activity - specify:													
39	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)					6	n/a	6		6	n/a	6	n/a	6
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)						n/a			n/a		n/a		
41	Dischrg mgmt (1.0 x 99239) (enter 15 min)						n/a			n/a		n/a		
42	End: Patient leaves office													
43	POST-SERVICE Period													
44	Start: Patient leaves office/facility													
45	Conduct phone calls/call in prescriptions													
46	Office visits: List Number and Level of Office Visits				# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	
47	99211 16 minutes		16											
48	99212 27 minutes		27				3				3		3	
49	99213 36 minutes		36		5.5		5		4.5		4		5	
50	99214 53 minutes		53											
51	99215 63 minutes		63											
52	Total Office Visit Time	L038A	COMT/COT/RN/CST		198	0.0	261.0		162.0	0.0	225.0	0.0	261.0	
53	Other Clinical Activity - specify:													
54	End: with last office visit before end of global period													
55	MEDICAL SUPPLIES													
56	pack, ophthalmology visit (w dilation)	SA082	pack		5.5		8		4.5		7		8	
57	Povidone soln (Betadine)	SJ041	ml		24				24					
58	Blade, surgical, super	SF006	each		1				1					
59	lidocaine 2% w-epi inj	SH049	ml		20				20					
60	prednisolone acet 1% oph soln (5ml)	SJ041	5ml		1				1					
61	EQUIPMENT													
62	Lane, exam (oph)	EL005	minutes		198		261		162		225		261	
63														
64														
65														
66														

AMA/Specialty Society RVS Update Committee Summary of Recommendations  
*CMS High Expenditure Screen*

January 2013

**Removal of Cerumen**

This code was identified through the CMS High Expenditure Screen within the Proposed Rule for the 2012 Medicare Fee Schedule. In response, the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) submitted an action plan during the January 2012 RUC meeting indicating they would perform a survey of CPT 69210 for the April 2012 RUC meeting. During its review of the action plan, the Relativity Assessment Workgroup (RAW) questioned whether the existing value for 69210 represented payment for the physician work for one or both ears and noted that the descriptor, in its current state, was unclear in this regard. The AAO-HNS responded to the RAW's concern by submitting a code change proposal (CCP) to the CPT Editorial Panel, for its October 2012 meeting, which revised the code to more accurately describe the removal of cerumen with instrumentation and to specify that it should be reported as unilateral. The revised CPT code 69210 was surveyed for the April 2013 RUC meeting.

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

The RUC reviewed the survey data from 312 otolaryngologists and family physicians and recommends the following physician time components: pre-service time of 5 minutes, intra-service time of 10 minutes and post-service time of 2 minutes.

The RUC noted that this procedure was previously billed as either unilateral or bilateral and has now been revised to report only unilateral. Therefore, since there is no compelling evidence that this procedure is currently misvalued, the RUC recommends applying work neutrality to CPT code 69210. To determine work neutrality, the specialty society discussed that it is anticipated that 10% of the current utilization is billed as bilateral. Given these assumptions, the RUC recommends a work neutral work RVU of 0.58. To validate this value, the RUC compared the surveyed code to CPT code 11000 *Debridement of extensive eczematous or infected skin; up to 10% of body surface* (work RVU= 0.60) and agreed that both codes have identical intra-service time, 10 minutes, and comparable physician work; therefore, the two codes should be valued similarly. The RUC also reviewed CPT code 29580 *Strapping; Unna boot* (work RVU= 0.55) and noted that, while the reference code has two additional minutes of intra-service time compared to the surveyed code, the two codes should be valued similarly since 69210 is a slightly more intense procedure. **The RUC recommends a work RVU of 0.58 for CPT code 69210.**

**Practice Expense:**

The RUC reviewed and accepted the modifications to the equipment, which were deemed indirect, as recommended by the Practice Expense Subcommittee.



**Work Neutrality:**

Under current reporting, CPT code 69210 cannot be billed with the bilateral modifier (52). Therefore, there is no available claims data to substantiate accurate reporting. The RUC will review one year of Medicare claims data, once available, to determine if the 10% bilateral usage assumption is accurate.

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲69210	L1	Removal impacted cerumen <u>requiring instrumentations</u> ( <del>separate procedure</del> ), <del>1 or both ears</del> <u>unilateral</u> <u>(To report bilateral procedure, report 69210 with modifier 50)</u> <u>(For cerumen removal that is not impacted or does not require instrumentations, eg, by irrigation only, see E/M service code, which may include new or established patient office or other outpatient services (99201-99215), hospital observation services (99217-99220, 99224-99226), hospital care (99221-99223, 99231-99233), consultations (99241-99255), emergency department services (99281-99285), nursing facility services (99304-99318), domiciliary, rest home, or custodial care services (99324-99337), home services(99341-99350), or preventive medicine services (99381-99429)</u>	000	0.58

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 69210	Tracking Number L1	Original Specialty Recommended RVU: <b>0.60</b>
		Presented Recommended RVU: <b>0.58</b>
Global Period: 000		RUC Recommended RVU: <b>0.58</b>

CPT Descriptor: Removal impacted cerumen requiring instrumentation, unilateral

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 69 year old male presents with a recent worsening of hearing in the left ear over a several day period. He is found to have a cerumen impaction filling the entire external auditory canal. The physician physically removes the cerumen from the canal with instrumentation and magnification.

Percentage of Survey Respondents who found Vignette to be Typical: 81%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 11%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 1%

Description of Pre-Service Work: The patient's records are reviewed, particularly any medications that might promote bleeding. The patient is questioned, noting any history of abnormality of the pinna, external auditory canals, tympanic membranes, balance and hearing. The procedure is explained and questions of the patient and/or family are answered. The patient is positioned, instrumentation checked and hands cleaned.

Description of Intra-Service Work: The pinna and external auditory canal are examined. The pinna is grasped and the external auditory canal exposed and opened. The instrument of magnification is positioned. The cerumen is removed using a variety of instrumentation including cerumen curettes, spoons, suctions and micro forceps. Occasionally concurrent irrigations are required along with the suction. Care is taken not to injure the external auditory canal or tympanic membrane. After the removal is completed, the external auditory canal and tympanic membranes are examined, status noted, and hearing grossly assessed.

Description of Post-Service Work: The patient is counseled regarding future cerumen management strategies and given instructions regarding what to do in the event of repeated impaction. Any necessary medications are given. The appropriate procedure note and referral letter is dictated.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	01/2013				
<b>Presenter(s):</b>	Wayne Koch, MD, John Lanza, MD and Thomas Felger, MD				
<b>Specialty(s):</b>	AAO-HNS and AAFP				
<b>CPT Code:</b>	69210				
<b>Sample Size:</b>	5454	<b>Resp N:</b>	312	<b>Response:</b>	5.7 %
<b>Description of Sample:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	75.00	200.00	400.00	2500.00
<b>Survey RVW:</b>	0.18	0.60	0.85	1.00	3.00
<b>Pre-Service Evaluation Time:</b>			5.00		
<b>Pre-Service Positioning Time:</b>			2.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.00		
<b>Intra-Service Time:</b>	0.00	6.00	10.00	15.00	30.00
<b>Immediate Post Service-Time:</b>	<u>2.00</u>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

5 - NF Procedure without sedation/anesthesia care

<b>CPT Code:</b>	69210	<b>Recommended Physician Work RVU: 0.58</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		3.00	7.00	-4.00
<b>Pre-Service Positioning Time:</b>		2.00	0.00	2.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	0.00	0.00
<b>Intra-Service Time:</b>		10.00		
<b>Immediate Post Service-Time:</b>	<u>2.00</u>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
11100	000	0.81	RUC Time

CPT Descriptor Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
46600	000	0.55	RUC Time	98,091

CPT Descriptor 1 Anoscopy; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
20553	000	0.75	RUC Time	182,962

CPT Descriptor 2 Injection(s); single or multiple trigger point(s), 3 or more muscle(s)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
11305	000	0.67	RUC Time

CPT Descriptor Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 68      % of respondents: 21.7 %

**TIME ESTIMATES (Median)**

	CPT Code: 69210	Key Reference CPT Code: 11100	Source of Time RUC Time
Median Pre-Service Time	5.00	5.00	
Median Intra-Service Time	10.00	12.00	
Median Immediate Post-service Time	2.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>17.00</b>	<b>22.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.19	2.62
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.68	2.16
--	------	------

Urgency of medical decision making	2.01	2.24
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.54	2.97
--------------------------	------	------

Physical effort required	3.12	2.69
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.31	2.22
---	------	------

Outcome depends on the skill and judgment of physician	3.04	2.78
--	------	------

Estimated risk of malpractice suit with poor outcome	1.85	2.25
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	1.69	2.18
----------------------------------	------	------

Intra-Service intensity/complexity	3.19	3.03
------------------------------------	------	------

Post-Service intensity/complexity	1.49	2.03
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Why is this code being reviewed?**

This code was captured by the CMS “high expenditure procedural codes” screen within the 2012 Medicare Physician Fee Schedule final rule. In response, the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) submitted an action plan during the January 2012 RUC meeting indicating they would perform a survey of CPT 69210 for the April 2013 RUC meeting. During its review of the action plan, the RAW questioned whether the existing value for 69210 represented reimbursement for the work of one or both ears and noted that the descriptor, in its current state, was unclear in this regard. The AAO-HNS responded to the RAW’s concern by submitting a code change proposal to the CPT Editorial Panel, for its October 2012 meeting, which revised the code to more accurately describe the removal of cerumen with instrumentation and to specify that it should be reported as unilateral. The revised 69210 is now being surveyed and presented to the RUC for the January 2013 meeting.

### **Description of random survey sample:**

The physician work RVU recommendations were derived by conducting a random survey of the Otolaryngology and Family Medicine memberships. The standard 000 global survey instrument was distributed to 750 Family Medicine physicians and 4704 Otolaryngologists. The Otolaryngology sample included general Otolaryngologists, pediatric Otolaryngologists, Otologists, Neurotologists, as well as the Academy’s leadership and key committees which contain clinicians who were most likely to be familiar with the service. The Family Medicine sample was a straight random sample of all Active AAFP members and excluded students, residents, and certain miscellaneous membership categories (e.g. international and retired members). The survey’s total sample size included 5454 physicians. Survey responses were primarily provided by Otolaryngologists, accounting for 303 of the 312 responses.

### **Physician Time**

#### **Pre-Time**

Following a review of the pre-time survey data, our expert panel determined that preservice package 5 (Non-facility procedure without sedation/anesthesia care) was most appropriate. The expert panel reviewed the survey pre times and determined that the pre-service evaluation time of 5 minutes was excessive given that this procedure is performed following an evaluation and management (E/M) visit 70 percent of the time. The panel, therefore, recommends a reduction in the pre-service evaluation time from 7 minutes down to 3 minutes. In contrast, the expert panel felt that although the preservice package does not assign time for positioning, that 2 minutes of positioning time are necessary for this procedure. During this time the physician typically must ask the patient to move to a new exam room which contains the appropriate equipment. They must also position the patient in a supine position on the exam table and ensure that the microscope, or other magnification equipment, is functional before performing the procedure. Therefore, our panel felt 2 minutes of positioning time was justified.

#### **Intra Time**

Our expert panel agreed with our survey respondents regarding the time for intra service work and are recommending the survey’s median time of 10 minutes for intra service work.

#### **Post Time**

Similarly, our experts felt the survey respondents’ assignment of 2 minutes for post service work was appropriate for this service. While we recognize the policy of the RUC to reduce both pre service and post service time when a procedure is billed with an E/M visit, we believe such a reduction is not appropriate here as 2 minutes is necessary to counsel the patient regarding what they should do in the event their ear becomes impacted, and how to prevent future wax impaction. Thus, our expert panel believes 2 minutes of post service work is necessary for this procedure and is not duplicative of the work performed during the E/M visit.

### **Physician Work**

Our expert panel reviewed the results of the survey for CPT 69210 and felt the survey’s 25<sup>th</sup> percentile, 0.60 RVUs, for physician work was the most appropriate value for this service. While the survey respondents provided a median RVW of 0.85, our expert panel did not believe there was compelling evidence to justify an increase in physician work RVUs for this service. The 0.60 RVU value is also justified by the fact that this service was surveyed in 2005 by Otolaryngology using virtually the same vignette. In fact, the 2005 survey produced a nearly identical median physician work RVU and the exact same physician time as the 2012 survey. This reinforces the validity of the existing value and confirms that 0.60 is an appropriate value for this service. **We therefore, recommend a work RVU of 0.60 for CPT 69210 which is consistent with the survey’s 25<sup>th</sup> percentile.**

Our recommendation is supported by the key reference code CPT 11100 which survey respondents said required more mental effort and judgment than CPT 69210. In addition, the key reference service includes more intra and post time, and

therefore, has a slightly higher RVW of 0.81. We are also providing the following reference tables which include recently reviewed services that support our requested values for physician time and work for CPT 69210.

#### Comparison to key reference code

<u>CPT Code</u>	<u>RVW</u>	<u>IWPUT</u>	<u>Total Time</u>	<u>Eval</u>	<u>Posit</u>	<u>SDW</u>	<u>INTRA</u>	<u>Post</u>
<b>11100</b>	0.81	0.0488	22	5	0	0	12	5
<b>69210</b>	0.60	0.0443	17	3	2	0	10	2

#### Comparison to MPC codes

<u>CPT Code</u>	<u>Descriptor</u>	<u>RVW</u>	<u>IWPUT</u>	<u>Total Time</u>	<u>Eval</u>	<u>Posit</u>	<u>SDW</u>	<u>INTRA</u>	<u>Post</u>
<b>46600</b>	Anoscopy; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	0.55	0.0338	22	2	5	0	5	10
<b>69210</b>	Removal impacted cerumen requiring instrumentation, unilateral	0.60	0.0443	17	3	2	0	10	2
<b>20553</b>	Injection(s); single or multiple trigger point(s), 3 or more muscle(s)	0.75	0.0481	22	7	0	0	10	5

The table below compares the surveyed code to other RUC reviewed codes of similar time and work, providing further support that the recommended value for 69210 is appropriate.

<u>RUC Reviewed</u>	<u>CPT Code</u>	<u>Descriptor</u>	<u>RVW</u>	<u>IWPUT</u>	<u>Total Time</u>	<u>Eval</u>	<u>Posit</u>	<u>SDW</u>	<u>INTRA</u>	<u>Post</u>
2011	<b>98925</b>	Osteopathic manipulative treatment (OMT); 1-2 body regions involved	0.46	0.0370	14	5	1	1	10	2
2010	<b>11900</b>	Injection, intralesional; up to and including 7 lesions	0.52	0.0454	15	5	0	0	8	2
1995	<b>11305</b>	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less	0.67	0.0372	22	5	0	0	12	5
2010	<b>69220</b>	Debridement, mastoidectomy cavity, simple (eg, routine cleaning)	0.83	0.0651	18	5	1	0	10	2
2010	<b>30901</b>	Control of nasal hemorrhage	1.10	0.0813	26	6	0	5	10	5

---

### SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.

☒ Other reason (please explain) This service is typically billed with an E/M code (70% of the time based on 2011 data). The patient is typically seen for evaluation of otolaryngologic symptoms which may include decreased hearing or is found to have cerumen impaction obscuring the view of the tympanic membrane during routine physical examination. The physician will typically provide an E/M visit to fully evaluate the patient and upon diagnosis of the problem as impacted cerumen, proceeds with removal of cerumen constituting a separately reportable service.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Typically billed with one of the following E/M codes 99201-99205 or 99212-99215.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 69210

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otolaryngology                      How often? Commonly

Specialty Family Medicine                      How often? Commonly

Specialty Internal Medicine                      How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 5974908

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Given that this service is not age specific, we estimate that the national volume for a one year period will be approximately four times greater than the Medicare volume.

Specialty Otolaryngology	Frequency 2748458	Percentage 46.00 %
--------------------------	-------------------	--------------------

Specialty Family Medicine	Frequency 1254731	Percentage 21.00 %
---------------------------	-------------------	--------------------

Specialty Internal Medicine	Frequency 1135233	Percentage 19.00 %
-----------------------------	-------------------	--------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

1,620,808 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is based on the 2011 volume from the RUC database plus the additional 10% that will now be billed as bilateral.

Specialty Otolaryngology	Frequency 687114	Percentage 45.99 %
--------------------------	------------------	--------------------

Specialty Family Medicine	Frequency 313682	Percentage 20.99 %
---------------------------	------------------	--------------------

Specialty Internal Medicine	Frequency 283808	Percentage 18.99 %
-----------------------------	------------------	--------------------

Do many physicians perform this service across the United States? Yes

## Professional Liability Insurance Information (PLI)



If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 69210

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
12	ISSUE: 69210 Removal impacted cerumen requiring instrumentation, unilateral																			
13	TAB: 13																			
14						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
15	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
16	REF	11100	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure) unless otherwise	68	0.0488			0.81			22	5	0	0			12			5
17	CURRENT	69210	Removal impacted cerumen (separate procedure), 1 or both ears		0.0408			0.61			19	5	2	0			10			2
18	SVY	69210	Removal impacted cerumen requiring instrumentation, unilateral	312	0.0648	0.18	0.60	0.85	1.00	3.00	19	5	2	0	0	6	10	15	30	2
19	REC	69210	Removal impacted cerumen requiring instrumentation, unilateral		0.0423	0.58					17	3	2				10			2
20	Preservice package 5																			
21																				
22																				
23																				
24																				
25																				

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor:

Global Period: 000 Meeting Date: January 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Our societies convened an expert panel comprised of our RUC Advisors and Alternate Advisors, all of which are familiar with this service, to derive recommendations for the direct practice expense inputs and clinical staff time for CPT 69210 removal impacted cerumen.

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

We selected 69210 as our reference code when determining our recommendations for practice expense for the revised 69210, and used the existing inputs as for comparison.

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:

We are requesting the addition of 4 intra service minutes of clinical staff time above the PEAC's previously approved 2001 clinical staff time for CPT 69210. Despite the fact that we are backing out 11 minutes of intraservice staff time, we are adding minutes for several clinical activities that typically take place when providing this service which were not previously reflected in the practice expense for this code. Specifically, we are requesting new staff minutes for staff to provide pre-service education and obtain consent for the procedure (requesting the PEAC 000 global standard 3 minutes for this activity), we are requesting 2 minutes for staff to prepare and position the patient for the procedure (standard 2 minutes for 000 globals), and we are requesting 10 minutes for cleaning the basic surgical instrument package necessary to perform this procedure (PEAC standard cleaning time for the basic instrument pack).

As is noted in the SOR, this service is performed with an E/M service 70% of the time. Therefore, the staff must educate the patient regarding this separate procedure once the decision has been made, during the E/M, to perform the removal of cerumen procedure. Consent must also be obtained for this separate procedure. Likewise, the patient must be positioned for the removal of cerumen procedure and moved from their position during the E/M (i.e. sitting upright) into the proper position for the cerumen procedure. Finally, the cleaning time is necessary because the code descriptor was changed by CPT to include the language "requiring instrumentation" which has led to our request to add surgical instruments, such as specula and forceps to the list of equipment for this CPT code. These are non-disposable pieces of equipment which must be cleaned prior to reuse by the physician office, and therefore, we have incorporated time for that cleaning in our non-facility PE recommendations for this code.

4. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

There are no pre-service clinical labor activities in the office setting for CPT 69210.

Intra-Service Clinical Labor Activities:

During the intra-service period, the clinical labor performed includes: providing pre-service education and obtaining consent, preparing the room equipment, and supplies, positioning the patient for the procedure, assisting the physician in performing the procedure, cleaning the room and equipment, and cleaning the basic surgical instrument package.

Post-Service Clinical Labor Activities:

There is no post-service clinical labor time in the office setting for CPT 69210.

	A	B	C	D	E	F	G
1				<b>REFERENCE CODE</b>		<b>AAO-HNS / AAFP Recommendations</b>	
2				<b>PEAC 2001 CPT Code 69210</b>		<b>CPT Code 69210</b>	
3	<b>REVISED 1/25/2013</b> <b>Meeting Date: January 2013</b> <b>Tab: 13 Removal Impacted Cerumen</b> <b>Specialty: AAO-HNS / AAFP</b>	<b>CMS Code</b>	<b>Staff Type</b>	Removal impacted cerumen (separate procedure), 1 or both ears		Removal impacted cerumen requiring instrumentation, unilateral	
4	<b>LOCATION</b>			<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>
5	<b>GLOBAL PERIOD</b>			<b>000</b>	<b>000</b>	<b>000</b>	<b>000</b>
6	<b>TOTAL CLINICAL LABOR TIME</b>	L037D	RN/LPN/MTA	<b>26.0</b>	<b>0.0</b>	<b>23.0</b>	<b>0.0</b>
7	<b>TOTAL PRE-SERV CLINICAL LABOR TIME</b>	L037D	RN/LPN/MTA	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>
8	<b>TOTAL SERVICE PERIOD CLINICAL LABOR TIME</b>	L037D	RN/LPN/MTA	<b>26.0</b>	<b>0.0</b>	<b>23.0</b>	<b>0.0</b>
9	<b>TOTAL POST-SERV CLINICAL LABOR TIME</b>	L037D	RN/LPN/MTA	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>
10	<b>PRE-SERVICE</b>						
11	<b>Start: Following visit when decision for surgery or procedure made</b>						
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
17	Other Clinical Activity - <i>specify:</i>	L037D	RN/LPN/MTA	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
18	<b>End: When patient enters office/facility for surgery/procedure</b>						
19	<b>SERVICE PERIOD</b>						
20	<b>Start: When patient enters office/facility for surgery/procedure:</b>						
21	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
22	Obtain vital signs	L037D	RN/LPN/MTA	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
23	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	<b>0</b>	<b>0</b>	<b>3</b>	<b>0</b>
24	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	<b>4</b>	<b>0</b>	<b>2</b>	<b>0</b>
25	Setup scope (non facility setting only)	L037D	RN/LPN/MTA	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
26	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	<b>0</b>	<b>0</b>	<b>2</b>	<b>0</b>
27	Sedate/apply anesthesia	L037D	RN/LPN/MTA	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
28	<b>Intra-service</b>						
29	Assist physician in performing procedure	L037D	RN/LPN/MTA	<b>18</b>	<b>0</b>	<b>10</b>	<b>0</b>
30	<b>Post-Service</b>						
31	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MTA	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
32	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	<b>4</b>	<b>0</b>	<b>3</b>	<b>0</b>
33	Clean Scope	L037D	RN/LPN/MTA	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
34	Clean Surgical Instrument Package	L037D	RN/LPN/MTA	<b>0</b>	<b>0</b>	<b>3</b>	<b>0</b>
35	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
36	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
38	Other Clinical Activity - <i>specify:</i>	L037D	RN/LPN/MTA	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
39	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			<b>n/a</b>		<b>n/a</b>	
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)			<b>n/a</b>		<b>n/a</b>	
41	Dischrg mgmt (1.0 x 99239) (enter 15 min)			<b>n/a</b>		<b>n/a</b>	
42	<b>End: Patient leaves office</b>						
43	<b>POST-SERVICE Period</b>						
44	<b>Start: Patient leaves office/facility</b>						
45	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
46	<b>Office visits: List Number and Level of Office Visits</b>			<b># visits</b>	<b># visits</b>	<b># visits</b>	<b># visits</b>
47	99211 16 minutes		16				
48	99212 27 minutes		27				
49	99213 36 minutes		36				
50	99214 53 minutes		53				
51	99215 63 minutes		63				
52	<b>Total Office Visit Time</b>			<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>
53	Other Clinical Activity - <i>specify:</i>						
54	<b>End: with last office visit before end of global period</b>						

	A	B	C	D	E	F	G
1				<b>REFERENCE CODE</b>		<b>AAO-HNS / AAFP Recommendations</b>	
2				<b>PEAC 2001 CPT Code 69210</b>		<b>CPT Code 69210</b>	
3	<b>REVISED 1/25/2013</b> <b>Meeting Date: January 2013</b> <b>Tab: 13 Removal Impacted Cerumen</b> <b>Specialty: AAO-HNS / AAFP</b>	<b>CMS Code</b>	<b>Staff Type</b>	Removal impacted cerumen (separate procedure), 1 or both ears		Removal impacted cerumen requiring instrumentation, unilateral	
4	<b>LOCATION</b>			<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>
5	<b>GLOBAL PERIOD</b>			<b>000</b>	<b>000</b>	<b>000</b>	<b>000</b>
55	<b>MEDICAL SUPPLIES</b>	<b>CODE</b>	<b>UNIT</b>				
56	pack, minimum multi-specialty visit	SA048	pack	1	0	1	0
57	basin, emesis	SJ010	item	1	0	1	0
58	curette for ear cerumen	SF023	item	2	0	2	0
59	applicator, cotton-tipped, non-sterile 6in	SG008	item	2	0	2	0
60	underpad 2ft x 3ft (Chux)	SB044	item	2	0	-	-
61	syringe 20 ml	SG053	item	1	0	-	-
62	specula tips, otoscope	SM025	item	2	0	1	0
63	gauze, non-sterile 4in x 4in	SG051	item	NEW	NEW	1	0
64	tubing, suction, non-latex (6ft) with Poole tip (1)	SD133	item	NEW	NEW	1	0
65	pack, cleaning, surgical instruments	SA043	pack	NEW	NEW	1	0
66	canister, suction	SD009	item	NEW	NEW	1	0
67	<b>EQUIPMENT</b>	<b>CODE</b>		Minutes in use	Minutes in use	Minutes in use	Minutes in use
68	table, exam	EF023		26	0	20	0
69	light, exam	EQ168		26	0	20	0
70	microscope, binocular - dissecting	EP023		NEW	NEW	20	0
71	instrument pack, basic (\$500-\$1499)	EQ137		NEW	NEW	30	0
72	suction and pressure cabinet, ENT (SMR)	EQ234		NEW	NEW	20	0
73	otoscope-ophthalmoscope (wall unit)	EQ189		NEW	NEW	10	0

	A	B	C	J
1				
2				
3	<b>REVISED 1/25/2013</b> <b>Meeting Date: January 2013</b> <b>Tab: 13 Removal Impacted Cerumen</b> <b>Specialty: AAO-HNS / AAFP</b>	<b>CMS Code</b>	<b>Staff Type</b>	
4	<b>LOCATION</b>			
5	<b>GLOBAL PERIOD</b>			
6	<b>TOTAL CLINICAL LABOR TIME</b>	L037D	RN/LPN/MTA	
7	<b>TOTAL PRE-SERV CLINICAL LABOR TIME</b>	L037D	RN/LPN/MTA	
8	<b>TOTAL SERVICE PERIOD CLINICAL LABOR TIME</b>	L037D	RN/LPN/MTA	
9	<b>TOTAL POST-SERV CLINICAL LABOR TIME</b>	L037D	RN/LPN/MTA	
10	<b>PRE-SERVICE</b>			
11	<b>Start: Following visit when decision for surgery or procedure made</b>			
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA	
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA	
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	
17	Other Clinical Activity - <i>specify:</i>	L037D	RN/LPN/MTA	
18	<b>End: When patient enters office/facility for surgery/procedure</b>			
19	<b>SERVICE PERIOD</b>			
20	<b>Start: When patient enters office/facility for surgery/procedure:</b>			
21	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	
22	Obtain vital signs	L037D	RN/LPN/MTA	
23	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	
24	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	
25	Setup scope (non facility setting only)	L037D	RN/LPN/MTA	
26	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	
27	Sedate/apply anesthesia	L037D	RN/LPN/MTA	
28	<b>Intra-service</b>			
29	Assist physician in performing procedure	L037D	RN/LPN/MTA	
30	<b>Post-Service</b>			
31	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MTA	
32	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	
33	Clean Scope	L037D	RN/LPN/MTA	
34	Clean Surgical Instrument Package	L037D	RN/LPN/MTA	
35	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA	
36	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA	
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	
38	Other Clinical Activity - <i>specify:</i>	L037D	RN/LPN/MTA	
39	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)			
41	Dischrg mgmt (1.0 x 99239) (enter 15 min)			
42	<b>End: Patient leaves office</b>			
43	<b>POST-SERVICE Period</b>			
44	<b>Start: Patient leaves office/facility</b>			
45	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	
46	<b>Office visits: List Number and Level of Office Visits</b>			
47	99211 16 minutes		16	
48	99212 27 minutes		27	
49	99213 36 minutes		36	
50	99214 53 minutes		53	
51	99215 63 minutes		63	
52	<b>Total Office Visit Time</b>			
53	Other Clinical Activity - <i>specify:</i>			
54	<b>End: with last office visit before end of global period</b>			

	A	B	C	J
1				
2				
3	<b>REVISED 1/25/2013</b> <b>Meeting Date: January 2013</b> <b>Tab: 13 Removal Impacted Cerumen</b> <b>Specialty: AAO-HNS / AAFP</b>	<b>CMS Code</b>	<b>Staff Type</b>	
4	<b>LOCATION</b>			
5	<b>GLOBAL PERIOD</b>			
55	<b>MEDICAL SUPPLIES</b>	<b>CODE</b>	<b>UNIT</b>	
56	pack, minimum multi-specialty visit	SA048	pack	
57	basin, emesis	SJ010	item	
58	curette for ear cerumen	SF023	item	
59	applicator, cotton-tipped, non-sterile 6in	SG008	item	
60	underpad 2ft x 3ft (Chux)	SB044	item	
61	syringe 20 ml	SC053	item	
62	specula tips, otoscope	SM025	item	
63	gauze, non-sterile 4in x 4in	SG051	item	
64	tubing, suction, non-latex (6ft) with Poole tip (1)	SD133	item	
65	pack, cleaning, surgical instruments	SA043	pack	
66	canister, suction	SD009	item	
67	<b>EQUIPMENT</b>	<b>CODE</b>		
68	table, exam	EF023		
69	light, exam	EQ168		
70	microscope, binocular--dissecting	EP023		
71	instrument pack, basic (\$500-\$1499)	EQ137		
72	suction and pressure cabinet, ENT (SMR)	EQ234		
73	otoscope-ophthalmoscope (wall unit)	EQ189		



	A	B	C	K	L	M
1						
2						
3	<b>REVISED 1/25/2013</b> <b>Meeting Date: January 2013</b> <b>Tab: 13 Removal Impacted Cerumen</b> <b>Specialty: AAO-HNS / AAFP</b>	CMS Code	Staff Type			
4	LOCATION					
5	GLOBAL PERIOD					
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA			
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA			
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA			
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA			
10	<b>PRE-SERVICE</b>					
11	Start: Following visit when decision for surgery or procedure made					
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA			
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA			
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA			
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA			
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA			
17	Other Clinical Activity - <i>specify:</i>	L037D	RN/LPN/MTA			
18	End: When patient enters office/facility for surgery/procedure					
19	<b>SERVICE PERIOD</b>					
20	Start: When patient enters office/facility for surgery/procedure:					
21	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA			
22	Obtain vital signs	L037D	RN/LPN/MTA			
23	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA			
24	Prepare room, equipment, supplies	L037D	RN/LPN/MTA			
25	Setup scope (non facility setting only)	L037D	RN/LPN/MTA			
26	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA			
27	Sedate/apply anesthesia	L037D	RN/LPN/MTA			
28	<b>Intra-service</b>					
29	Assist physician in performing procedure	L037D	RN/LPN/MTA			
30	<b>Post-Service</b>					
31	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MTA			
32	Clean room/equipment by physician staff	L037D	RN/LPN/MTA			
33	Clean Scope	L037D	RN/LPN/MTA			
34	Clean Surgical Instrument Package	L037D	RN/LPN/MTA			
35	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA			
36	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA			
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA			
38	Other Clinical Activity - <i>specify:</i>	L037D	RN/LPN/MTA			
39	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)					
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)					
41	Dischrg mgmt (1.0 x 99239) (enter 15 min)					
42	End: Patient leaves office					
43	<b>POST-SERVICE Period</b>					
44	Start: Patient leaves office/facility					
45	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA			
46	<b>Office visits: List Number and Level of Office Visits</b>					
47	99211 16 minutes		16			
48	99212 27 minutes		27			
49	99213 36 minutes		36			
50	99214 53 minutes		53			
51	99215 63 minutes		63			
52	<b>Total Office Visit Time</b>					
53	Other Clinical Activity - <i>specify:</i>					
54	End: with last office visit before end of global period					

	A	B	C	K	L	M
1						
2						
3	<b>REVISED 1/25/2013</b> <b>Meeting Date: January 2013</b> <b>Tab: 13 Removal Impacted Cerumen</b> <b>Specialty: AAO-HNS / AAFP</b>	<b>CMS Code</b>	<b>Staff Type</b>			
4	<b>LOCATION</b>					
5	<b>GLOBAL PERIOD</b>					
55	<b>MEDICAL SUPPLIES</b>	<b>CODE</b>	<b>UNIT</b>			
56	pack, minimum multi-specialty visit	SA048	pack			
57	basin, emesis	SJ010	item			
58	curette for ear cerumen	SF023	item			
59	applicator, cotton-tipped, non-sterile 6in	SG008	item			
60	underpad 2ft x 3ft (Chux)	SB044	item			
61	syringe 20 ml	SG053	item			
62	specula tips, otoscope	SM025	item			
63	gauze, non-sterile 4in x 4in	SG054	item			
64	tubing, suction, non-latex (6ft) with Poole tip (1)	SD133	item			
65	pack, cleaning, surgical instruments	SA043	pack			
66	canister, suction	SD009	item			
67	<b>EQUIPMENT</b>	<b>CODE</b>				
68	table, exam	EF023				
69	light, exam	EQ168				
70	microscope, binocular - dissecting	EP023				
71	instrument pack, basic (\$500-\$1499)	EQ137				
72	suction and pressure cabinet, ENT (SMR)	EQ234				
73	otoscope-ophthalmoscope (wall unit)	EQ189				

AMA/Specialty Society RVS Update Committee Summary of Recommendations  
*Harvard Valued - Utilization over 30,000 / PE Services with Stand-Alone Procedure Time Screens*

January 2013

**Respiratory Motion Management Simulation**

These services were identified as part of two CMS screens, the Harvard Valued - Utilization over 30,000 CMS screen as well as the Services with Stand-Alone PE Procedure Time screen. In September 2011, the RUC recommended that the specialty societies survey work and review PE for January 2012. In January 2012 the specialties requested referral to the CPT Editorial Panel and in October 2012 the panel revised CPT codes 77280, 77285, 77290 and 77295 to more accurately describe radiotherapy simulation and established an add-on code to describe respiratory motion management simulation.

***77280 Therapeutic radiology simulation-aided field setting; simple***

The RUC reviewed the survey results from 74 radiation oncologists for CPT code 77280 and recognized that there is a technical component performed by a radiation therapist concurrently with the physician work. The RUC determined that the specialty recommended current work RVU of 0.70 is appropriate for this service. The RUC recommends 7 minutes pre-service, 25 minutes intra-service and 5 minutes post-service. The RUC compared 77280 to similar service 77300 *Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician* (work RVU=0.62, 15 minutes intra-service) and noted that 77280 requires more time to perform, accounting for the higher work value. For additional support, the RUC compared 77280 to CPT code 92579 *Visual reinforcement audiometry (VRA)* (work RVU=0.70, 4 minutes pre-service, 25 minutes intra-service and 5 minutes post-service), and noted that both codes have the same work value and the same intra-service time. **The RUC recommends a work RVU of 0.70 for CPT code 77280.**

***77285 Therapeutic radiology simulation-aided field setting; intermediate***

The RUC reviewed the survey results from 57 radiation oncologists for CPT code 77285 and recognized that there is a technical component performed by a radiation therapist concurrently with the physician work. The RUC determined that the specialty recommended current work RVU of 1.05 is appropriate for this service. The RUC recommends 7 minutes pre-service, 40 minutes intra-service and 5 minutes post-service. The RUC compared 77285 to similar service 77331 *Special dosimetry (eg, TLD, microdosimetry) (specify), only when prescribed by the treating physician* (work RVU=0.87, 30 minutes intra-service) and noted that 77285 requires more time to perform, accounting for the higher work value. For additional support, the RUC compared 77285 to CPT code 88361 *Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; using computer-assisted technology* (work RVU=1.18, 40 minutes intra-service), and noted that the codes have the same intra-service time, but 88361 is more intense to perform, accounting for the higher work value. **The RUC recommends a work RVU of 1.05 for CPT code 77285.**

#### **77290 Therapeutic radiology simulation-aided field setting; complex**

The RUC reviewed the survey results from 66 radiation oncologists for CPT code 77290 and discussed that there is a technical component performed by a radiation therapist concurrently with the physician work. The RUC determined that the specialty recommended current work RVU of 1.56 is appropriate for this service. The RUC recommends 7 minutes pre-service, 60 minutes intra-service and 10 minutes post-service. The RUC questioned the additional 5 minutes of post-service in relation to 77285, when the work appears to be identical. The specialty clarified that there are 4 separate fields for the complex service, which all have to be recorded, requiring more time than the intermediate code. The RUC compared 77280 to similar service 77315 *Teletherapy, isodose plan (whether hand or computer calculated); complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex blocking, rotational beam, or special beam considerations)* (work RVU=1.56, 45 minutes intra-service), with identical work values. For additional support, the RUC compared 77290 to CPT code 88321 *Consultation and report on referred slides prepared elsewhere* (work RVU=1.63, 50 minutes intra-service), and noted that 88321 requires less time, but is more intense to perform, accounting for the higher work value. **The RUC recommends a work RVU of 1.56 for CPT code 77290.**

#### **77293 Respiratory motion management simulation**

The RUC reviewed the survey results from 49 radiation oncologists for CPT code new add-on CPT code 77293 and discussed the division of work between the medical physicist and the physicians. The specialty clarified that there is a large amount of patient training that the physician must perform for this service. The medical physicist will not be able to provide this training as it is the physician who will determine the physical limitations of the patient. The RUC determined that the survey 25th percentile work RVU of 2.00 and 45 minutes intra-service time are appropriate for this service. The RUC compared 77293 to similar service 77470 *Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral or endocavitary irradiation)* (work RVU=2.09, 55 minutes intra-service) and noted that 77470 requires more time to perform accounting for the higher work value. For additional support, the RUC compared 77293 to CPT code 48400 *Injection procedure for intraoperative pancreatography (List separately in addition to code for primary procedure)* (work RVU=1.95, 45 minutes intra-service), and noted that both services have identical intra-service time and 77293 is slightly more intense to perform, accounting for the higher work value. **The RUC recommends a work RVU of 2.00 for CPT code 77293.**

#### **77295 Therapeutic radiology simulation-aided field setting; 3-dimensional**

The RUC reviewed the survey results from 67 radiation oncologists for CPT code 77295 and determined that the specialty recommended current work RVU of 4.56 was not appropriate for this service. The RUC recommends 7 minutes pre-service, 90 minutes intra-service and 15 minutes post-service. The RUC compared 77295 to 77338 *Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan* (work RVU = 4.29, 0 minutes pre-service, 115 minutes intra-service and 0 minutes post-service), which requires the same physician work to perform. The code is also in a similar family of codes and both are radiation treatment dosimetry. The RUC determined that 77338 is an appropriate crosswalk and determined that a work RVU of 4.29 appropriately accounts the physician work required to perform 77295. For additional support, the RUC compared 77295 to similar services 77787 *Remote after loading high dose rate radionuclide brachytherapy; over 12 channels* (work RVU = 4.89, 20 minutes pre-service, 90 minutes intra-service, 20 minutes post-service) and MPC code

90966 *End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older* (work RVU = 4.26, 75 minutes intra-service). **The RUC recommends a work RVU of 4.29 for CPT code 77295.**

**Practice Expense:**

The PE Subcommittee discussed this code in great detail and requested that the specialty revise the spreadsheet and represent to the Subcommittee. The updated spreadsheet addressed the Subcommittee's concerns. The RUC accepted the direct practice expense inputs with minor modifications as approved by the Practice Expense Subcommittee.

**New Technology:**

CPT code 77293 will be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

**Work Neutrality:**

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

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<b>Category I</b> <b>Radiology</b> <b>Radiation Oncology</b> <b>Clinical Treatment Planning</b> <b>(External and Internal Sources)</b>				
77261		Therapeutic radiology treatment planning; simple		
77262		intermediate		
77263		complex		
<u>Simulation is the process of defining relevant normal and abnormal target anatomy, and acquiring the images and data necessary to develop the optimal radiation treatment process for the patient. A simulation is defined as complex if any of these criteria are met: particle, rotation or arc therapy, complex or custom blocking, brachytherapy simulation, hyperthermia probe verification, or any use of contrast material. If a simulation does not meet any of these criteria, the complexity is defined by the number of treatment areas: one treatment area is simple, two treatment areas are intermediate and three or more treatment areas are complex.</u>				

**Definitions**

**Simple** simulation of a single treatment area. ~~with either a single port or parallel opposed ports. Simple or no blocking.~~

**Intermediate** ~~simulation of three or more converging ports, two separate treatment areas. multiple blocks.~~

**Complex** ~~simulation of tangential portals, three or more treatment areas, or any number of treatment areas if any of the following are involved: particle, rotation or arc therapy, complex blocking, custom shielding blocks, brachytherapy simulation source verification, hyperthermia probe verification, any use of contrast materials.~~

**Three-dimensional (3D)** ~~computer-generated 3D reconstruction of tumor volume and surrounding critical normal tissue structures from direct CT scans and/or MRI data in preparation for non-coplanar or coplanar therapy. The simulation uses documented 3D beam's eye view volume dose displays of multiple or moving beams. Documentation with 3D volume reconstruction and dose distribution is required.~~

~~Simulation may be carried out on a dedicated simulator, a radiation therapy treatment unit, or diagnostic X ray machine.~~

77280	T1	Therapeutic radiology simulation-aided field setting; simple	XXX	0.70 (No Change)
77285	T2	intermediate	XXX	1.05 (No Change)
77290	T3	complex	XXX	1.56 (No Change)
●+77293	T4	Respiratory motion management simulation (List separately in addition to code for primary procedure) <u>(Use 77293 in conjunction with 77295, 77301)</u>	ZZZ	2.00

**Medical Radiation Physics,  
Dosimetry, Treatment Devices, and  
Special Services**

▲#77295	T5	3-dimensional <u>radiotherapy plan, including dose-volume histograms</u>	XXX	4.29
---------	----	--	-----	------



**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 77280	Tracking Number T1	Original Specialty Recommended RVU: <b>0.70</b>
		Presented Recommended RVU: <b>0.70</b>
Global Period: XXX		RUC Recommended RVU: <b>0.70</b>

CPT Descriptor: Therapeutic radiology simulation-aided field setting; simple

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 65-year-old man presents with metastatic prostate cancer. He complains of severe pain in the lumbar spine. Bone scan shows multiple metastases, and MRI of the spine shows marrow replacement in several lumbar vertebral bodies. Simulation for radiation therapy to the lumbar spine is scheduled.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Review of Bone Scan and MRI scan to confirm disease location and extent of disease. The patient is asked about areas of pain, intensity of pain and pain medications are administered as needed. The simulation process is explained to the patient.

Description of Intra-Service Work: Patient is positioned prone on the CT table/simulation table using a special immobilization prone pillow and aligned using room lasers. The radiation oncologist examines the patient clinically to determine the area of pain and clinically confirms the findings of the bone scan and MRI. Radio-opaque markers are placed on the skin to identify symptomatic areas, as well as sites of prior radiotherapy and any relevant surgical scars or avoidance structures. The radiation oncologist views the area of interest on CT PA view scout image in the simulation room directing the simulation therapist to open scan field borders to include the lower thoracic, lumbar and upper sacral vertebrae in the superoinferior directions. Field of view is set laterally. The radiation oncologist reviews the scout image(s) to confirm that the patient is well aligned. If the patient cannot tolerate the prone position and/or it is felt that the prone position may bring in other organs (e.g. kidneys, bowel) closer to the metastatic site; or cannot maintain good alignment, he is repositioned in the supine position and the process repeated. The radiation oncologist and therapist ensure the proper treatment position and that the patient will pass safely through the CT bore without collision or the loss of any soft tissues on images. The radiation oncologist directs the choice of CT slice thickness, based on the anticipated planning needs and a therapeutic planning CT scan is obtained. After reconstruction, the therapeutic planning CT images are reviewed for completeness and inclusion of all relevant targets, organs at risk, and markers.

The planning CT data set is then transferred to a work station where virtual fields are applied to the selected vertebral bodies and reviewed on digitally reconstructed radiographs (DRR). Upper and lower field borders are set to cover the selected levels. Vertebral levels are counted and reviewed on scout images, axial images, and any DRR. The field borders

are reviewed to insure that there is no overlap with prior radiation portals, especially at the spinal cord. Lateral field edges are similarly reviewed and modified. Virtual simulation shows the beam lateral borders in relation to the kidneys for a lumbar spine field and this is adjusted to minimize exit through these organs. The field center is finalized by the physician and an opposed field applied and the above process is repeated. The field center and alignment marks are placed by tattoo by the therapist on the patient and the field borders are outlined by marking pen and approved by the physician. The patient is then taken off the table.

Description of Post-Service Work: The set up parameters are documented by the therapist and reviewed by the physician for accuracy and reproducibility. The physician documents and signs the simulation process and approved images. The images are reviewed with the patient (and also family if present).

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	01/2013				
<b>Presenter(s):</b>	Najeeb Mohideen, MD, Micheal Kuettel, MD, PhD, Dwight Heron, MD, Gerald White, MS				
<b>Specialty(s):</b>	Radiation Oncology				
<b>CPT Code:</b>	77280				
<b>Sample Size:</b>	1180	<b>Resp N:</b>	74	<b>Response:</b>	6.2 %
<b>Description of Sample:</b>	Random Sample from the full ASTRO MD Membership				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	2.00	44.00	100.00	266.00	772.00
<b>Survey RVW:</b>	0.50	0.75	0.79	1.08	5.50
<b>Pre-Service Evaluation Time:</b>			10.00		
<b>Pre-Service Positioning Time:</b>			0.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.00		
<b>Intra-Service Time:</b>	5.00	23.00	25.00	30.00	60.00
<b>Immediate Post Service-Time:</b>	<u>5.00</u>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

5 - NF Procedure without sedation/anesthesia care

<b>CPT Code:</b>	77280	<b>Recommended Physician Work RVU: 0.70</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		7.00	7.00	0.00
<b>Pre-Service Positioning Time:</b>		0.00	0.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	0.00	0.00
<b>Intra-Service Time:</b>		25.00		
<b>Immediate Post Service-Time:</b>	<u>5.00</u>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
77300	XXX	0.62	RUC Time

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

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
93224	XXX	0.52	RUC Time	531,802

CPT Descriptor 1 External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, physician review and interpretation

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
95991	XXX	0.77	RUC Time	91,772

CPT Descriptor 2 Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed; requiring physician's skill

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 43      % of respondents: 58.1 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 77280</b>	<b>Key Reference CPT Code: 77300</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	7.00	0.00	
Median Intra-Service Time	25.00	15.00	
Median Immediate Post-service Time	5.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>37.00</b>	<b>15.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.95	2.09
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.72	2.21
--	------	------

Urgency of medical decision making	3.70	2.12
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.91	2.93
--------------------------	------	------

Physical effort required	2.21	1.98
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.19	3.00
---	------	------

Outcome depends on the skill and judgment of physician	3.14	3.00
--	------	------

Estimated risk of malpractice suit with poor outcome	2.91	2.81
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.49	2.60
----------------------------------	------	------

Intra-Service intensity/complexity	3.07	2.28
------------------------------------	------	------

Post-Service intensity/complexity	2.70	1.95
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

CPT code 77280 Therapeutic radiology simulation – aided field setting; simple, is a therapeutic radiation simulation code, which has PC and TC. The PC describes the physician work associated with the simulation process – transferring what exists in the radiation oncologist’s prescription into something that will allow the daily treatment to be delivered. This is not a treatment, but by simulating the treatment, all the decisions are made to allow a therapist to comfortably, safely and accurately position the patient for treatment. The level of simulation is dependent on the number of treatment areas, contrast material, complex or custom blocking, etc., and is coded with CPT codes 77280-77290. In this family of simulation codes, 77280 is classified as a “simple simulation”.

ASTRO conducted a survey, with a 1180 sample size, and collected 74 random surveys (6.2% response rate). ASTRO convened a panel that included a number of experts familiar with this service to evaluate the RUC survey data. ASTRO recommends maintaining a current RVU of 0.70 for CPT code 77280.

Our rationale for that recommendation is based on multiple factors and is described below.

#### Vignette

Currently the most reported diagnosis for this code is metastatic prostate cancer. Therefore, we used the vignette of a patient with prostate cancer with metastases to the lumbar spine in this survey and 96 % of our survey respondents felt the vignette was typical.

#### Codes Reported on the Same Day

The data in the “Same Day Billings from CMS” file shows that no codes are billed frequently with 77280.

#### Time

Our current surveyed total time is 40 minutes (10, 25, 5). ASTRO is recommending the median survey times for intra and post, and Preservice package 5 (7 minutes), for a total recommended time of 37 minutes (7, 25, 5). The surveyed time clearly supports the recommended 25 minutes of intraservice time.

#### IWPUT

The surveyed code 77280 will have an IWPUT of 0.017, when using the median times and RVU. While this is an inappropriately low IWPUT, the relationship within the family of codes maintains rank order.

CPT	IWPUT
77280	0.017
77285	0.020
77290	0.020

#### Comparison to the Key Reference Services

The key reference service code was CPT code 77300, Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician. This key reference code was most often selected by the survey respondents. It has a total intra-service time of 15 minutes, an IWPUT of 0.041 and a wRVU of 0.62. The surveyed code has more time and RVUs than the reference code, both codes have clinical and technical similarities and the work is well understood by our members. We believe that this was an appropriate selection by our survey respondents and fits nicely with our survey data.

#### Relativity

Our recommendation maintains relativity compared to the reference code, the other simulation codes, and codes within the radiation family. Simple simulation (77280) is the typical code used when simulating a metastatic lesion. When two lesions are simulated, 77285 is used. Our survey data nicely correlates with a 50% adjustment in RVW when two separate lesions are simulated (0.70 and 1.05 respectively).

#### Recommendations:

We are recommending the current RVU of 0.70, with pre-service: 7 minutes, median intra time of 25 minutes and post service times of 5 minutes, for a total time of 37 minutes. The expert panel believes that our survey supports our recommendations.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 77280

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty                      How often?

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. A national estimate is not available.

Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency	Percentage %
Specialty	Frequency	Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

283,421 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Radiation Oncology	Frequency 266416	Percentage 94.00 %
Specialty	Frequency	Percentage %
Specialty	Frequency	Percentage %

Do many physicians perform this service across the United States? Yes

## Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 77280

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.



**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 77285	Tracking Number T2	Original Specialty Recommended RVU: <b>1.05</b>
		Presented Recommended RVU: <b>1.05</b>
Global Period: XXX		RUC Recommended RVU: <b>1.05</b>

CPT Descriptor: Therapeutic radiology simulation-aided field setting; intermediate

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 68 year-old woman with a history of breast cancer has been treated with systemic chemotherapy and presents with neck and right hip pain. Imaging demonstrates metastatic disease in the cervical spine and right femoral neck. Simulation for radiation therapy of both sites is scheduled.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Review of diagnostic imaging to confirm disease location and extent of disease to ensure that this corresponds to area of patient's symptoms. The patient is asked about areas of pain, intensity of pain and pain medications are administered as needed. The simulation process is explained to the patient.

Description of Intra-Service Work: If there is no contraindication such as vertebral body stability issues, the patient is positioned prone on the CT simulation table using a special immobilization prone pillow and aligned using a laser targeting system. The radiation oncologist examines the patient clinically to confirm the clinical areas of pain correspond to the bone scan and MRI findings. The radiation oncologist places radio-opaque markers on the skin to identify symptomatic areas, as well as sites of prior radiotherapy and any relevant surgical scars or avoidance structures. If the patient cannot tolerate the prone position and maintain good alignment, she is repositioned in the supine position and the process repeated. The radiation oncologist and therapist ensure that in the correct position, the patient will pass safely through the CT bore without collision or loss of any soft tissues images. The radiation oncologist views the area of interest on CT PA scout images in the simulation room directing the simulation therapist to open field borders to include the cervical vertebral bodies and another field border to include the right hip region in the superoinferior directions. Field of view is set laterally for each region. The radiation oncologist reviews the scout images to confirm that the patient is well aligned. The radiation oncologist now determines the appropriate CT slice thickness so as to minimize artifacts based on analysis of the scout image and ensures that the field of view will encompass all normal organs at risk. The CT data set is acquired for the first treatment region using the specifications given by the radiation oncologist, which are based on spatial resolution and image parameters needed to visualize the tumor location and target volumes unique to the patient's habitus.

The therapeutic planning CT data set is then transferred to a work station. After reconstruction, the therapeutic planning CT images are reviewed by the radiation oncologist for completeness and inclusion of all relevant targets, organs at risk

and markers. Virtual fields are applied to the cervical spine region. The cervical vertebral bodies are counted and reviewed on scout images, axial images, and any DRR. Field borders are set by the radiation oncologist; including lateral field edges. For each field targeting this treatment site, the projection of the field edges are reviewed on the virtual reconstruction of the patient's skin. Inclusion (or exclusion) of all relevant skin markers is ensured. Any possible flash is reviewed. The radiation oncologist sets the cervical spine field isocenter.

The final measurements are relayed to the therapist who discusses with the radiation oncologist where the tattoos and other temporary skin marks (identifying field centers and field borders) should be placed so as to align the four directional alignment lasers for reproducibility on a daily basis and the patient is tattooed by the therapist. The measurement numbers from the CT simulator treatment couch indexing system are carefully recorded with the image dataset and other patient positioning parameters.

Simulation of the second site is then performed. The patient is repositioned supine on the scanner in feet-first orientation to scan the hip. The entire process of scanning, virtual simulation, and skin marking described above is repeated.

The patient is then taken off the table.

Description of Post-Service Work: The set up parameters are documented by the therapist and reviewed by the physician for accuracy and reproducibility. The physician documents and signs the simulation process for both areas of interest and approves the images. The images are reviewed with the patient (and also family if present).

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	01/2013				
<b>Presenter(s):</b>	Najeeb Mohideen, MD, Micheal Kuettel, MD, PhD, Dwight Heron, MD, Gerald White, MS				
<b>Specialty(s):</b>	Radiation Oncology				
<b>CPT Code:</b>	77285				
<b>Sample Size:</b>	1180	<b>Resp N:</b>	57	<b>Response:</b>	4.8 %
<b>Description of Sample:</b>	Random Sample from the full ASTRO MD Membership				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	1.00	12.00	<b>24.00</b>	50.00	326.00
<b>Survey RVW:</b>	0.55	1.00	<b>1.20</b>	1.69	6.00
<b>Pre-Service Evaluation Time:</b>			<b>10.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>0.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>0.00</b>		
<b>Intra-Service Time:</b>	5.00	30.00	<b>40.00</b>	45.00	75.00
<b>Immediate Post Service-Time:</b>	<b>5.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

5 - NF Procedure without sedation/anesthesia care

<b>CPT Code:</b>	77285	<b>Recommended Physician Work RVU: 1.05</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>7.00</b>	<b>7.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>40.00</b>		
<b>Immediate Post Service-Time:</b>	<b>5.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
77331	XXX	0.87	RUC Time

CPT Descriptor Special dosimetry (eg, TLD, microdosimetry) (specify), only when prescribed by the treating physician**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
95991	XXX	0.77	RUC Time	91,772

CPT Descriptor 1 Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed; requiring physician's skill

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
88361	XXX	1.18	RUC Time	152,340

CPT Descriptor 2 Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; using computer-assisted technology

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 30      % of respondents: 52.6 %

**TIME ESTIMATES (Median)**

	CPT Code: 77285	Key Reference CPT Code: 77331	Source of Time RUC Time
Median Pre-Service Time	7.00	0.00	
Median Intra-Service Time	40.00	30.00	
Median Immediate Post-service Time	5.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>52.00</b>	<b>30.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.03	2.07
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.80	2.30
--	------	------

Urgency of medical decision making	3.07	2.20
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.63	2.63
--------------------------	------	------

Physical effort required	2.87	2.07
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.30	2.90
---	------	------

Outcome depends on the skill and judgment of physician	3.37	2.40
--	------	------

Estimated risk of malpractice suit with poor outcome	3.03	2.83
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.90	2.43
----------------------------------	------	------

Intra-Service intensity/complexity	3.27	2.49
------------------------------------	------	------

Post-Service intensity/complexity	2.73	2.60
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUR analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

CPT code 77285, Therapeutic radiology simulation-aided field setting; intermediate, is a therapeutic radiation simulation code, which has PC and TC. The PC describes the physician work associated with the simulation process – transferring what exists in the radiation oncologist’s prescription into something that will allow the daily treatment to be delivered. This is not a treatment, but by simulating the treatment, all the decisions are made to allow a therapist to comfortably, safely and accurately position the patient for treatment. The level of simulation is dependent on the number of treatment areas, contrast material, complex or custom blocking, etc., and is coded with CPT codes 77280-77290. In this family of simulation codes, 77285 is classified as an “intermediate simulation”, given that two separate areas of the body require treatment.

ASTRO conducted a survey, with a 1180 sample size, and collected 57 random surveys (4.8% response rate). ASTRO convened a panel that included a number of experts familiar with this service to evaluate the RUC survey data. ASTRO recommends maintaining a current RVU of 1.05 for CPT code 77285

Our rationale for that recommendation is based on multiple factors and is described below.

#### Vignette

We used the vignette of a patient with metastatic breast cancer to two separate sites (cervical spine and right femoral neck) in this survey. 98 % of our survey respondents felt the vignette was typical.

#### Codes Reported on the Same Day

The data in the “Same Day Billings from CMS” file shows that no codes are billed frequently with 77285.

#### Time

Our current surveyed total time is 55 minutes (10, 40, 5). ASTRO is recommending the median survey times for intra and post, and Preservice package 5 (7 minutes) for a total recommended time of 52 minutes (7, 40, 5). The surveyed intra time is slightly less than the current intra-service time of 46 minutes. The surveyed time clearly supports the recommended 40 minutes of intraservice time.

#### IWPUT

The surveyed code 77285 will have an IWPUT of 0.02, when using the median times and RVU. While this is an inappropriately low IWPUT, the relationship within the family of codes maintains rank order.

CPT	IWPUT
77280	0.017
77285	0.020
77290	0.020

#### Comparison to the Key Reference Services

CPT code 77331, Special dosimetry (eg. TLD, microdosimetry), only when prescribed by the treating physician, was the key reference code and was most often selected by the survey respondents. The key reference service code has a total intra-service time of 30 minutes, an IWPUT of 0.029 and wRVU of 0.87. The surveyed code has slightly higher time and RVUs than the reference code. There is similarity in the work of the two codes in the degree of clinical correlation, and technical skill needed. We believe that this was an appropriate selection by our survey respondents and fits nicely with our survey data.

#### Relativity

Our recommendation will maintain relativity compared to the reference code, the other simulation codes, and codes within the radiation family, Simple simulation - 77280 (by definition, includes one lesion) has an w RVU of 0.70. Intermediate simulation - 77285 (by definition includes 2 separate lesions), has a wRVU of 1.05, that correlates nicely with the added effort and time.

#### Recommendations

We are recommending the current RVUw of 1.05, with pre-service: 7 minutes, median intra time of 40 minutes and post service times of 5 minutes, for a total time of 52 minutes. The expert panel believes our survey supports our recommendations

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.

- ☐ Multiple codes are used to maintain consistency with similar codes.  
☐ Historical precedents.  
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 77285

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Radiation Oncology                      How often? Commonly

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? A national estimate is not available.

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 4,336

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Radiation Oncology	Frequency 4163	Percentage 96.01 %
------------------------------	----------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States? Yes

## Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 77285

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.





**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 77290	Tracking Number T3	Original Specialty Recommended RVU: <b>1.56</b>
		Presented Recommended RVU: <b>1.56</b>
Global Period: XXX		RUC Recommended RVU: <b>1.56</b>

CPT Descriptor: Therapeutic radiology simulation-aided field setting; complex

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 70-year-old woman with a BMI of 35 presents with a breast mass. Lumpectomy and nodal dissection show a 3cm infiltrating ductal carcinoma (with negative margins), and 6 of 14 axillary nodes showing cancer. Simulation for breast and nodal irradiation is scheduled.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Review patient chart, surgical notes, pathology report, mammogram and other imaging studies. Discuss procedure with patient.

Description of Intra-Service Work: The radiation oncologist chooses the patient position for simulation, based on knowledge of the physical capabilities of the treatment machine and the technical limitations on delivering radiation to the patient's unique body shape, tumor location , patient limitations, patient comfort to achieve reproducibility. The patient is positioned after selecting the appropriate breast board and arm position both ipsilateral and contralateral. The radiation oncologist palpates and outlines the breast tissue to determine the upper, lower, medial and lateral field edges as defined by the clinical findings correlating to the mammogram and/or MRI imaging. The entire position is then checked again and adjustments made by the radiation oncologist to determine if there are any patient and tumor anatomical issues that would be necessary to incorporate into simulation (e.g. bolus, different angle, skin folds, steps to avoid the exit beam etc.).

Once this is satisfactorily set, the radiation oncologist marks the breast contour, corners of the field and surgical scars with radio-opaque wires and markers. The radiation oncologist will then check to ensure that palpable/ imaged abnormalities in the tumor bed and scars are encompassed within the borders. He will make sure that the patient in the simulation position passes through the CT bore without collision or loss of soft tissue images. This typically involves adjustments including the ipsilateral and contralateral positions while taking care to ensure reproducibility of the radiation fields. The patient is brought out of the CT bore and the four directional laser targeting system is utilized based on the radio-opaque marks placed by the physician. The initial simulation isocenter is determined by the physician based on the patient's anatomy, contour of the anterior chest wall, breast tissue and lateral chest wall along with reproducibility issues. CT scout images are obtained which are reviewed by the radiation oncologist to ensure that the area of interest is covered and that there is no clip, staple or soft tissue image artifacts and that the Hounsfield units are appropriate. The radiation oncologist now

determines the appropriate CT slice thickness so as to minimize artifacts based on analysis of the scout image and ensures that the field of view will encompass all normal organs at risk. The CT data set is acquired based on the parameters given by the radiation oncologist based on spatial resolution and image parameters needed to visualize the tumor bed and target volumes unique to the patient's habitus.

The therapeutic planning CT data set is analyzed by the radiation oncologist using a virtual simulation system. The radiation oncologist applies virtual fields to the target areas and adjusts the treatment isocenter. Typically a single isocentric setup is selected for the breast and the regional nodal stations. The process involves setting virtual field borders for the chestwall and similarly setting this up for the supraclavicular nodal regions. A junctional plane is selected for the single isocenter using a virtual half beam technique and the true isocenter is selected. The depth of this isocenter from the skin and reference to fixed bony points such as the sternum is measured and recorded by the physician.

Once the isocenter is established, each of the individual portals are projected on the patient's skin (virtually) and checked against the skin markers to ensure coverage. The path of each field through the patient is reviewed to assess the amount of lung, heart or other normal structures included in the field and adjustments made by the physician. This process is repeated for each of the individual fields simulated (two chest tangents, internal mammary, supraclavicular, and posterior axillary fields). The isocenter is adjusted as necessary during the creation of each field.

The final measurements are relayed to the therapist who discusses with the radiation oncologist where the tattoos and other temporary skin marks should be placed so as to align the four directional alignment lasers for reproducibility on a daily basis and the patient is tattooed by the therapist. The numbers from the CT simulator treatment couch indexing system are carefully recorded with the image dataset and other patient positioning parameters and the patient is then taken off the table.

Description of Post-Service Work: The radiation oncologist verifies that all the appropriate data has been acquired, all the parameters are documented accurately. The physician documents and signs the simulation process and approved images and dictates the simulation note.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	01/2013				
<b>Presenter(s):</b>	Najeeb Mohideen, MD, Micheal Kuettel, MD, PhD, Dwight Heron, MD, Gerald White, MS				
<b>Specialty(s):</b>	Radiation Oncology				
<b>CPT Code:</b>	77290				
<b>Sample Size:</b>	1180	<b>Resp N:</b>	66	<b>Response:</b>	5.5 %
<b>Description of Sample:</b>	Random Sample from the full ASTRO MD Membership				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	5.00	50.00	<b>85.00</b>	164.00	500.00
<b>Survey RVW:</b>	0.72	1.60	<b>1.69</b>	2.19	9.00
<b>Pre-Service Evaluation Time:</b>			<b>10.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>0.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>0.00</b>		
<b>Intra-Service Time:</b>	10.00	45.00	<b>60.00</b>	60.00	120.00
<b>Immediate Post Service-Time:</b>	<b>10.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

5 - NF Procedure without sedation/anesthesia care

<b>CPT Code:</b>	77290	<b>Recommended Physician Work RVU: 1.56</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>7.00</b>	<b>7.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>60.00</b>		
<b>Immediate Post Service-Time:</b>	<b>10.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
77315	XXX	1.56	RUC Time

CPT Descriptor Teletherapy, isodose plan (whether hand or computer calculated); complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex blocking, rotational beam, or special beam considerations)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
95991	XXX	0.77	RUC Time	91,772

CPT Descriptor 1 Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed; requiring physician's skill

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
88321	XXX	1.63	RUC Time	191,180

CPT Descriptor 2 Consultation and report on referred slides prepared elsewhere

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code:** 43      **% of respondents:** 65.1 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 77290</b>	<b>Key Reference CPT Code: 77315</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	7.00	0.00	
Median Intra-Service Time	60.00	45.00	
Median Immediate Post-service Time	10.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>77.00</b>	<b>45.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.05	2.84
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.07	2.79
Urgency of medical decision making	3.84	3.14

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.19	2.95
Physical effort required	3.72	2.58

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.12	3.05
Outcome depends on the skill and judgment of physician	4.16	3.51
Estimated risk of malpractice suit with poor outcome	4.09	2.95

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.26	3.12
Intra-Service intensity/complexity	3.58	3.40
Post-Service intensity/complexity	3.12	3.09

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUR analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

CPT code 77290, Therapeutic radiology simulation – aided field setting; complex, is a therapeutic radiation simulation code, which has PC and TC. The PC describes the physician work associated with the simulation process – transferring what exists in the radiation oncologist’s prescription into something that will allow the daily treatment to be delivered. This is not a treatment, but by simulating the treatment, all the decisions are made to allow a therapist to comfortably, safely and accurately position the patient for treatment. The level of simulation is dependent on the number of treatment areas, contrast material, complex or custom blocking, etc., and is coded with CPT codes 77280-77290. In this family of simulation codes, 77295 is classified as a “complex simulation”.

ASTRO conducted a survey, with a 1180 sample size, and collected 66 random surveys (5.5% response rate). ASTRO convened a panel that included a number of experts familiar with this service to evaluate the RUC survey data. ASTRO recommends maintaining a current RVU of 1.56 for CPT code 77290.

Our rationale for that recommendation is based on multiple factors and is described below.

#### Vignette

The vignette is of a patient with breast cancer, requiring simulation for breast and nodal irradiation. Breast cancer is in the top two diagnosis for the use of this code in both the facility and non facility. 98 % of our survey respondents felt the vignette was typical.

#### Time

Our current surveyed total time is 80 minutes (10, 60, 10). ASTRO is recommending the median survey times for intra and post, and Preservice package 5 (7 minutes) for a total recommended time of 77 minutes (7, 60, 10). The survey time clearly supports the recommended 60 minutes of intraservice time.

#### IWPUT

The surveyed code 77290 will have an IWPUT of 0.020. While this is an inappropriately low IWPUT, the relationship within the family of codes maintains rank order.

CPT	IWPUT
77280	0.017
77285	0.020
77290	0.020

#### Comparison to the Key Reference Services

The key reference service code was CPT code 77315, Teletherapy, isodose plan; complex. This key reference code was most often selected (65.1%) by the survey respondents. It has a total intra service time of 45 minutes, an IWPUT of 0.035 and a wRVU of 1.56. The surveyed code has more time than the reference code. Both codes have similarities well understood by the membership, high degree of complex planning, image evaluation and clinical correlation, and technical skill. We believe that this was an appropriate selection by our survey respondents and fits nicely with our survey data.

#### Relativity

Our recommendation will maintain relativity compared to the reference code, the other simulation codes, and codes within the radiation family. Simple simulation (by definition, includes one lesion) has an RVU of 0.70. Intermediate simulation - 77285 (by definition includes 2 separate lesions), has a wRVU of 1.05, that correlates nicely with the added effort and time. Complex simulation (with a wRVU of 1.56), which has multiple field simulations, takes into account the added complexity, time and effort, and correlates nicely with the other two simulation codes.

#### Recommendations

We are recommending the current RVUw of 1.56, pre-service: 7 minutes, median intra time of 60 minutes and post service times of 10 minutes, for a total time of 77 minutes. The expert panel believes that our survey supports our recommendations.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.

☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. A treatment device code (i.e. 77334) is sometimes billed on the same day as this complex simulation code (approximately 62% of the time). CPT code 77334 has an XXX global period, 1.24 work RVUs and 35 minutes of intra time (total time).

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 77290

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Radiation Oncology                      How often? Commonly

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? A national estimate is not available.

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 340,157 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Radiation Oncology	Frequency 326551	Percentage 96.00 %
------------------------------	------------------	--------------------

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States? Yes

## Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 77290

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.





**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 77293	Tracking Number T4	Original Specialty Recommended RVU: <b>2.00</b>
		Presented Recommended RVU: <b>2.00</b>
Global Period: ZZZ		RUC Recommended RVU: <b>2.00</b>

CPT Descriptor: Respiratory motion management simulation  
 (List separately in addition to code for primary procedure)  
 (Use +77293 in conjunction with 77295, 77301)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 65-year-old man with a history of heavy smoking and mild chronic obstructive pulmonary disease is found to have a squamous cancer of the left lower lung with nodal involvement shown on positron emission tomography scanning. Radiation therapy is recommended. Following simulation (reported separately) the patient undergoes motion management simulation.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

**Description of Pre-Service Work:**

Description of Intra-Service Work: After the initial process of patient setup on the simulator table and immobilization, the radiation oncologist provides detailed instruction for the patient concerning the 4D CT simulation process and coaches the patient on the proper breathing technique (smooth, relaxed, continuous inhalation-exhalation) during image acquisition. The radiation oncologist observes the patient as a reproducible but comfortable breathing pattern is established over several breathing cycles. An external fiducial marker that provides optical and/or other radiofrequency feedback tracing the depth and frequency of breathing is placed near the lower ribcage, and the radiation oncologist then verifies that this motion recognition device (breath cycle sensor) accurately records the patient's breathing cycle, adjusting the sensor's position as needed to achieve an unobstructed and reliable signal transmission from the patient to the ceiling-mounted receiver.

A breathing motion management device (typically a flat plate abdominal compression device or polymer sheet vacuum restraint) is positioned on the patient to minimize diaphragmatic excursion and facilitate breathing pattern regularity. The radiation oncologist verifies proper, reproducible, and comfortable placement of the breathing motion management device. The radiation oncologist then observes the breathing pattern again using the previously placed external respiratory monitoring system to ensure that the motion management device did not disrupt the regularity of the patient's breathing. The radiation oncologist then adjusts the placement of either the motion management device or breathing cycle sensor as needed to achieve a proper signal that indicates a consistent shallow breathing pattern synchronized with the anticipated

tumor motion. Internal fiducial markers may have been previously placed by the thoracic surgeon or pulmonologist but are not considered a necessary part of the process.

Four-dimensional CT images are then obtained. This process involves recording the real-time breathing cycle signal simultaneously while multiple overlapping CT slice images are acquired at high speed as the simulator table moves longitudinally through the scanner. This multi-image technique is known as over-sampling. Because multiple images are obtained for each axial level in the patient, the appearance of each given axial level can be known for any point within the breathing cycle as images are sorted (or “binned”) and assembled into sets that represent the anatomic appearance at discrete phases of the breathing cycle (typically representing 0% -100% inhalation, at 10% increments). Once the image sets are assembled, the radiation oncologist reviews the “cine” (movie-like) playback sequence of image sets in three planes (axial, coronal, sagittal) to verify that the sets faithfully represent the smooth and continuous tumor motion throughout the breathing cycles without unacceptable artifact, for example the so-called “mushrooming” distortion caused by breathing cycle irregularity during image acquisition that yields discontinuities in the diaphragm contour. If the images are unsatisfactory, either because of artifact or excess diaphragmatic excursion, the radiation oncologist adjusts the motion management device if needed and instructs the CT technician to repeat the 4D image acquisition process until a clean representation of tumor motion is obtained and approved by the radiation oncologist.

Once a satisfactory set of 4D images is obtained, the radiation oncologist uses the complete set of 4D images to determine whether it is acceptable to represent the gross tumor volume (GTV) as a static structure or whether (more likely) the net vector motion of the tumor (incorporating magnitude and direction of motion) necessitates the creation of a composite structure known as the internal target volume (ITV) to account for its location throughout the breathing cycle. Typically, this determination is made after the radiation oncologist contours the GTV on several binned image sets (eg full exhalation, mid-cycle, full inhalation), which are then fused to assess total motion-related displacement during the breath cycle. Alternatively, the 4D image sets may be processed into a maximum intensity projection (MIP) image set, which also can be fused with sets representing various phases of the breathing cycle to allow a determination of the extent and direction of tumor motion. This final decision about how best to represent tumor motion allows for the commencement of the treatment planning process.

Description of Post-Service Work:

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	01/2013				
<b>Presenter(s):</b>	Najeeb Mohideen, MD, Micheal Kuettel, MD, PhD, Dwight Heron, MD, Gerald White, MS				
<b>Specialty(s):</b>	Radiation Oncology				
<b>CPT Code:</b>	77293				
<b>Sample Size:</b>	1180	<b>Resp N:</b>	49	<b>Response:</b>	4.1 %
<b>Description of Sample:</b>	Random Sample from the full ASTRO MD Membership				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	5.00	12.00	25.00	53.00
<b>Survey RVW:</b>	1.00	2.00	2.20	3.30	8.00
<b>Pre-Service Evaluation Time:</b>			0.00		
<b>Pre-Service Positioning Time:</b>			0.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.00		
<b>Intra-Service Time:</b>	10.00	30.00	45.00	55.00	120.00
<b>Immediate Post Service-Time:</b>	0.00				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	0.00	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: ZZZ Global Code

<b>CPT Code:</b>	77293	<b>Recommended Physician Work RVU: 2.00</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		0.00	0.00	0.00
<b>Pre-Service Positioning Time:</b>		0.00	0.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	0.00	0.00
<b>Intra-Service Time:</b>		45.00		
<b>Immediate Post Service-Time:</b>	0.00			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	0.00	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	0.00	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	0.00	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		
<b>Sub Obs Care:</b>	0.00	99224x 0.00 99225x 0.00 99226x 0.00		

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? Yes

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
77470	XXX	2.09	Other

CPT Descriptor Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral or endocavitary irradiation)**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
31633	ZZZ	1.32	RUC Time	6,361

CPT Descriptor 1 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), each additional lobe (List separately in addition to code for primary procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 32      % of respondents: 65.3 %

**TIME ESTIMATES (Median)**

	CPT Code: 77293	Key Reference CPT Code: 77470	Source of Time Other
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	45.00	55.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>45.00</b>	<b>55.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.84	3.63
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.91
Urgency of medical decision making	3.53	3.47

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.28	3.84
Physical effort required	3.59	3.78

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.03	4.09
Outcome depends on the skill and judgment of physician	4.31	3.94
Estimated risk of malpractice suit with poor outcome	3.81	3.84

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity		
Intra-Service intensity/complexity	4.16	3.97
Post-Service intensity/complexity		

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUR analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

CPT code 77293, *Respiratory motion management simulation (List separately in addition to code for primary procedure)*, was approved at the October 2012 CPT Editorial Panel meeting. This is an add-on code and describes the physician work involved in simulating a patient using motion (respiratory) tracking of a mobile target volume. It has been assigned a ZZZ global period and is typically performed in the facility setting but may be performed in the non-facility setting, as well.

ASTRO conducted a survey and collected 49 surveys for a response rate of 4.1%. ASTRO convened a panel that included experts familiar with this service to evaluate the RUC survey data. The median physician work RVUs was 2.20. ASTRO recommends the 25<sup>th</sup> percentile of 2.00 physician work RVUs for this procedure. Our rationale for that recommendation is based on multiple factors and is described below.

Respiratory motion management simulation represents the separate and distinct work performed in addition to a conventional simulation when there is a need to account for the breathing-related motion of pulmonary or abdominal tumors that will be targeted with radiation therapy. The work involves acquisition and review of multiple additional CT images (frequently >500) that allow for a full accounting of breathing-related tumor motion. The code is, therefore, performed in addition to the base static simulation code. The work represented by respiratory motion management simulation is also distinct from the work of the treatment planning process, which can be either a 3D or IMRT planning process.

The expert panel concluded that while the vast majority of facilities have the technical capability of performing CT simulation, they do not all have the equipment or the technical capability for motion management, and therefore its implementation is limited to a much smaller number of practitioners with a projected penetration of ~12,000 the first year.

#### Vignette

The percentage of survey respondents who found the vignette to be typical was 96%.

#### Survey Time

There is no pre or post survey time for 77293. The median intra time was 45 minutes. ASTRO is recommending this median survey time of 45 minutes.

#### Comparison to Key Reference Services

We have included CPT code 77470, *Special treatment procedure (e.g., total body irradiation, hemibody radiation, per oral or endocavitary irradiation)* as our reference code on the Summary of Recommendation form, because it was most often selected by the survey respondents. 65% of respondents selected 77470 as the Key Reference Service with a work RVU of 2.09 and an XXX global period, very similar to the surveyed code. The members who perform motion management simulation are very familiar with the work of the key reference service code and correctly judged that this captures the extra facility and physician work of motion management.

#### Conclusion

After reviewing the survey data, and other codes in the physician fee schedule, the expert panel recommends a physician work value of 2.00 RVUs and a total time of 45 minutes.

## **SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. This add on code will be billed with 77301 or 77302

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 77299 or 77470

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Radiation Oncology                      How often? Commonly

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. A national estimate is not available.

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?  
12,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.  
Please explain the rationale for this estimate. We estimate that that 50% of the SBRT treatments and 50% of the plans for lung might use motion management

Specialty Radiation Oncology	Frequency 12000	Percentage 100.00 %
------------------------------	-----------------	---------------------

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States? Yes

**Professional Liability Insurance Information (PLI)**

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 77470

## AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 77295	Tracking Number T5	Original Specialty Recommended RVU: <b>4.56</b>
		Presented Recommended RVU: <b>4.29</b>
Global Period: XXX		RUC Recommended RVU: <b>4.29</b>

CPT Descriptor: 3-dimensional radiotherapy plan, including dose volume histograms

### CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old woman presents with a stage 3 lung cancer of the right upper lobe. Three dimensional conformal radiation therapy is prescribed to deliver a therapeutic dose while limiting dose constraints to organs at risk.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

### Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

### Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The planning CT scans are uploaded into the treatment planning software. The radiation oncologist first reviews the external anatomy to be sure that all of the tissue is included in the field of view, and evaluates any irregularities in the external contour. The radiation oncologist then reviews the patient's internal anatomy with special attention to the tumor-bearing regions seen on relevant prior diagnostic imaging studies, including the CT /PET scan. The image set is manually adjusted by the physician to ensure accurate matching of fiducial markers (if placed), internal anatomy, and any previously fused imaging studies. This may require the use of more than one fusion set or imaging sequence if there are significant difference in patient position between the diagnostic imaging and the planning CT scan.

Description of Intra-Service Work: The radiation oncologist outlines target volumes on each of the 1.5-3mm thickness axial images of the fused dataset. The gross tumor volume (GTV), representing radiographically evident cancer-containing volume, is expanded into the clinical target volume (CTV), which includes the zone of potential microscopic disease extension. The GTV is the visible tumor seen on CT scan, abnormal nodes and PET active disease. The CTV includes a margin for microscopic extension around the primary lung tumor and mediastinal nodal stations, with special attention to specific anatomic boundaries which may change the extent of the margin. These contours are made slice by slice on the fused scans. These images are initially performed on the axial images, and then reviewed and adjusted on the sagittal and coronal images. The contours are adjusted alternating between lung and mediastinal windows. The initial and boost target volumes (gross and clinical ) are defined. Planning target volumes (PTV) are added to the initial and boost CTV's which accounts for systematic and minor daily set-up variations. The creation of several PTV (eg. PTV1, PTV2, PTV3, etc) is frequently necessary to ensure the maximal dose to tumor while protecting OARs. In a similar fashion to the creation of the GTV, CTV & PTV, important organs at risk eg. heart, esophagus, trachea, spinal cord, contralateral lung, and brachial plexus etc, are also contoured on each 1.5-3 mm planning scan slice and labeled accordingly. A careful review of the target



volumes and normal tissues is then performed in the axial, coronal and sagittal planes to ensure the appropriate delineation for treatment planning.

The intended dose to the initial and final PTVs is then prescribed. Partial dose/volume tolerances for each OARs are also specified. The first version of three-dimensional computer dosimetry is calculated by the dosimetrist and physicist. The physician then evaluates the initial plan to determine whether the intended goal dose to PTVs and dose constraints to OARs have been achieved. The physician then works with the dosimetrist and physicist in an iterative manner to modify the plan to achieve an acceptable dose to the target volumes while respecting the normal tissue tolerance doses. During this process, multiple plans are generated and compared with reference to adequacy of tumor coverage, location of dose “hot spots” and “cold spots”, and risk of normal tissue injury based on the graphical and tabular summaries of dose volume histograms for tumor and critical normal tissues until a properly optimized plan is selected.

Description of Post-Service Work: The radiation oncologist dictates, reviews and signs the report. The radiation oncologist reviews and confirms set-up data has been accurately transferred into record and verify computer. He/she communicates with physicist, dosimetrist, radiation therapist/technician, and referring physician regarding the plan development and coordinates the initiation of treatment.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	01/2013				
<b>Presenter(s):</b>	Najeeb Mohideen, MD, Micheal Kuettel, MD, PhD, Dwight Heron, MD, Gerald White, MS				
<b>Specialty(s):</b>	Radiation Oncology				
<b>CPT Code:</b>	77295				
<b>Sample Size:</b>	1180	<b>Resp N:</b>	67	<b>Response:</b>	5.6 %
<b>Description of Sample:</b>	Random Sample from the full ASTRO MD Membership				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	4.00	40.00	<b>75.00</b>	150.00	670.00
<b>Survey RVW:</b>	1.88	4.60	<b>4.60</b>	5.00	11.00
<b>Pre-Service Evaluation Time:</b>			<b>15.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>0.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>0.00</b>		
<b>Intra-Service Time:</b>	40.00	78.00	<b>90.00</b>	95.00	125.00
<b>Immediate Post Service-Time:</b>	<b>15.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

5 - NF Procedure without sedation/anesthesia care

<b>CPT Code:</b>	77295	<b>Recommended Physician Work RVU: 4.29</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>7.00</b>	<b>7.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>90.00</b>		
<b>Immediate Post Service-Time:</b>	<b>15.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
77301	XXX	7.99	RUC Time

CPT Descriptor Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
90962	XXX	3.15	RUC Time	183,613

CPT Descriptor 1 End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face physician visit per month

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
90960	XXX	5.18	RUC Time	2,160,993

CPT Descriptor 2 End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face physician visits per month

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 45      % of respondents: 67.1 %

**TIME ESTIMATES (Median)**

	CPT Code: 77295	Key Reference CPT Code: 77301	Source of Time RUC Time
Median Pre-Service Time	7.00	30.00	
Median Intra-Service Time	90.00	131.00	
Median Immediate Post-service Time	15.00	35.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>112.00</b>	<b>196.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.33	3.76
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.82	3.91
--	------	------

Urgency of medical decision making	3.62	4.07
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.82	4.38
--------------------------	------	------

Physical effort required	3.09	3.60
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.89	4.44
---	------	------

Outcome depends on the skill and judgment of physician	3.96	4.47
--	------	------

Estimated risk of malpractice suit with poor outcome	4.24	4.33
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.91	3.98
----------------------------------	------	------

Intra-Service intensity/complexity	4.18	4.36
------------------------------------	------	------

Post-Service intensity/complexity	3.51	3.44
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**CPT code 773X2, 3-dimensional radiotherapy plan, including dose volume histograms,** is a therapeutic radiation planning code, which has PC and TC. This code is replacing CPT 77295, as it fits better within the planning family of codes instead of within the simulation family. The PC describes the physician work associated with the planning process that establishes the correct technical details to properly deliver the desired radiation dose to the target. This code accounts for 3 dimensional planning for dose delivery, with the generation of a dose volume histogram, that is more conformal than 2D plans. This code is not a treatment code. Rather, this planning code allows for 3 dimensional calculations on a specific treatment volume. This code fits within the family of treatment planning codes (2D - simple, intermediate, complex; 3D, and IMRT) and is used once per course of treatment.

ASTRO conducted a survey, with a 1180 sample size, and collected 67 random surveys (5.6% response rate). ASTRO convened a panel that included a number of experts familiar with this service to evaluate the RUC survey data. ASTRO recommends a wRVU of 4.56 for 773X2.

Our rationale for that recommendation is based on multiple factors and is described below.

#### Vignette

The vignette used is of a patient with locally advanced lung cancer, requiring 3D-conformal irradiation. 100 % of our survey respondents felt the vignette was typical.

#### Time

Our current surveyed total time is 120 minutes (15, 90, 15). ASTRO is recommending the median survey times for intra and post, and Preservice package 5 (7 minutes), for a total recommended time of 112 minutes (7, 90, 15). The surveyed time clearly supports the recommended 90 minutes of intraservice time.

#### IWPUT

The current IWPUT for CPT code 77295 is 0.047, and the IWPUT for 773X2 based on the recommended times and RVU is 0.045. This relationship within the family of dosimetric planning codes also maintains rank order with 3 D planning being higher than Complex Isodose Plan, CPT 77315 and lower than IMRT Planning CPT 77301 both in IWPUT and RVU.

CPT	IWPUT	RVU
77315	0.035	1.56
773X2	0.045	4.56
77301	0.050	7.99

#### Comparison to the Key Reference Services

The survey responders chose CPT 77301 (intensity modulated radiotherapy plan including dose volume histograms for target and critical structure partial tolerance specifications) as the reference service code. The key reference service code was most often selected by the survey respondents (67.1%). 773X2 was scored as less intense and complex than the reference service code. We believe our current recommendations supports and maintains the relationship between the surveyed code and the reference service code and stays in line with other radiation oncology IWPUTs.

The key reference service code, 77301, has a total time of 196 minutes, an IWPUT of 0.0499 and a wRVU of 7.99. The surveyed code has a shorter time than the reference code, and less intensity Recommended IWPUT and wRVU are similar to existing code – 77295 that it is replacing. Total time, however has been modified to account for pre and post times. We believe that this reference code was an appropriate selection by our survey respondents and fits nicely with our survey data.

#### Relativity

Our recommendation maintain relativity compared to the reference code, the other simulation codes, and treatment planning codes within the radiation family, summarized in the table below.

CPT	RVU	Time
77300	0.62	15
77280	0.70	37 (7, 25, 5)
77331	0.87	30
77285	1.05	52 (7, 40, 5)
77290	1.56	77 (7, 60, 10)

77315	1.56	45
772X1X	2.00	45 (0, 45, 0)
77470	2.09	55
773X2	4.56	112 (7, 90, 15)
77301	7.99	196

#### Recommendations

We are recommending the current RVUw of 4.56 for existing code 77295, pre-service: 7 minutes, median intra time of 90 minutes and post service times of 15 minutes, for a total time of 112 minutes. The expert panel believes our survey supports our recommendations.

### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. A treatment device code (i.e. 77334) is sometimes billed on the same day as this complex simulation code (approximately 62% of the time). CPT code 77334 has an XXX global period, 1.24 work RVUs and 35 minutes of intra time (total time). A basic dosimetry calculation (77300) is typically billed with this planning code. CPT code 77300 has an XXX global period, 0.62 work RVUs and 15 minutes of intra/total time.

### FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 77295

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Radiation Oncology                      How often? Commonly

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. A national estimate is not available.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?  
 138,610 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.  
 Please explain the rationale for this estimate.

Specialty Radiation Oncology	Frequency 131680	Percentage 95.00 %
------------------------------	------------------	--------------------

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 77295

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	AO	AP	AQ	AR	AS
12	ISSUE: Respiratory Motion Management Simulation																								
13	TAB: 14																								
14						RVW					Total Time	PRE-TIME			INTRA-TIME					IMMD POST	SURVEY EXPERIENCE				
15	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX		EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX		MIN	25th	MED	75th	MAX
16	REF	77300	Basic radiatio	43	0.041			0.62			15						15								
17	CURRENT	77280	Therapeutic radiolog		0.030			0.70			23						23								
18	SVY	77280	Therapeutic ra	74	0.018	0.50	0.75	0.79	1.08	5.50	40	10			5	23	25	30	60	5	2	44	100	266	772
19	REC				0.017	0.70					37	7					25			5					
20																									
21						RVW					Total Time	PRE-TIME			INTRA-TIME					IMMD POST	SURVEY EXPERIENCE				
22	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX		EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX		MIN	25th	MED	75th	MAX
23	REF	77331	Special dosim	30	0.029			0.87			30						30								
24	CURRENT	77285	Therapeutic radiolog		0.023			1.05			46						46								
25	SVY	77285	Therapeutic ra	57	0.022	0.55	1.00	1.20	1.69	6.00	55	10			5	30	40	45	75	5	1	12	24	50	326
26	REC				0.020	1.05					52	7					40			5					
27																									
28						RVW					Total Time	PRE-TIME			INTRA-TIME					IMMD POST	SURVEY EXPERIENCE				
29	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX		EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX		MIN	25th	MED	75th	MAX
30	REF	77315	Teletherapy, is	43	0.035			1.56			45						45								
31	CURRENT	77290	Therapeutic radiolog		0.022			1.56			70						70								
32	SVY	77290	Therapeutic ra	66	0.021	0.72	1.60	1.69	2.19	9.00	80	10			10	45	60	60	120	10	5	50	85	164	500
33	REC				0.020	1.56					77	7					60			10					
34																									
35						RVW					Total Time	PRE-TIME			INTRA-TIME					IMMD POST	SURVEY EXPERIENCE				
36	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX		EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX		MIN	25th	MED	75th	MAX
37	REF	77301	Intensity mod	45	0.045			7.99			196						161			35					
38	CURRENT	77295	Therapeutic radiolog		0.047			4.56			98						98								
39	SVY	77295	3-dimensional	67	0.044	1.88	4.60	4.60	5.00	11.00	120	15			40	78	90	95	125	15	4	40	75	150	670
40	REC				0.042	4.29					112	7					90			15					
41																									
42						RVW					Total Time	PRE-TIME			INTRA-TIME					IMMD POST	SURVEY EXPERIENCE				
43	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX		EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX		MIN	25th	MED	75th	MAX
44	REF	77470	Special treatm	32	0.038			2.09			55						55								
45	CURRENT	77299	Unlisted procedure,		#DIV/0!						0														
46	SVY	77293	Respiratory m	49	0.049	1.00	2.00	2.20	4.00	8.00	45				10	30	45	55	120		0	5	12	25	53
47	REC				0.044	2.00					45						45								



**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

**CPT Long Descriptor:**

- 77280 Therapeutic radiology simulation-aided field setting; simple
  - 77285 Therapeutic radiology simulation-aided field setting; intermediate
  - 77290 Therapeutic radiology simulation-aided field setting; complex
  - 77293 Respiratory motion management simulation  
(List separately in addition to code for primary procedure)  
(Use +77293 in conjunction with 77295, 77301)
  - 77295 3-dimensional radiotherapy plan, including dose volume histograms
- 

**Global Period:** 77280, 77285, 77290 & 77295 XXX and 77293 ZZZ

**Meeting Date:** January 2013

**Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:**

ASTRO convened a panel that included a number of experts familiar with these services to evaluate the direct practice expense inputs for these procedures.

**You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison. You must provide an explanation for the selection of reference codes. Reference Code Rationale:**

For the four existing codes, ASTRO included the current direct practice expense inputs as well as the recommended inputs for the procedures. We also included the direct practice expense inputs for CPT codes that are sometimes billed with the procedures as a point of reference to ensure there is no double counting. ASTRO included recommendations for the new code. One of the existing codes 77014 can serve as a reference code for this new procedure.

**If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:**

N/A

**Please describe in detail the clinical activities of your staff:**

**Pre Service Clinical Activities**

N/A

**Intra-Service Clinical Labor Activities**

*CPT codes 77280*

The radiation therapist will first prepare the CT room. This will include positioning the CT table at its lowest position, placing any pads on the table and setting the moveable patient positioning lasers at their zero position. The Radiation Therapist will gather and ready any necessary supplies for patient marking.

The radiation therapist will then greet the patient and give them a brief explanation of the simulation procedure and its expected duration. The patient will be led to the changing area and instructed to change into the appropriate exam gown.

After gowning, the radiation therapist will bring the patient into the CT room and verify the patient's identity according to department policy. The therapist will explain the CT procedure in detail, ask if they have any questions or concerns and provide any additional information as necessary. The therapist will then take a face photo of the patient. The therapist will assist the patient onto the CT table and place them into the appropriate position. The patient's arms and legs will then be positioned according to scan protocol and/or patient comfort considerations. Knee wedges, arm straps and other pads may be added as needed to ensure patient comfort and stability. The patient positioning lasers are used to verify patient alignment. Markers are placed on the patient's skin as directed by the radiation oncologist.

After verifying with the radiation oncologist the extent of the area to be scanned, the therapist manually moves the patient into the CT unit bore checking for sufficient clearance between the patient, table and the CT unit. The table is then positioned using the internal CT lasers to the start position for the scanning sequence. The radiation therapist chooses the appropriate scanning parameters at the CT console and takes AP and lateral scout images.

The scout images are shown to the radiation oncologist and reviewed. Adjustments are made to patient position as necessary to improve patient alignment and/or comfort. Scout images are then repeated and the final patient positioning verified. At this point the field of view for the scan, including the superior/inferior scan extent, is set by the therapist. The patient is then scanned and the images are reconstructed.

The scan images are then reviewed by the radiation therapist and radiation oncologist. It is verified that the patient position is acceptable, that the scan extends sufficiently in the superior/inferior directions, and that no part of the patient's skin contour is cut off. The image quality of the scan is also noted, in particular any artifacts that might arise from contrast agents or metallic implants.

The scan images are then sent to the virtual simulation workstation where the radiation oncologist places the treatment fields and sets isocenter. The radiation therapist then generates digitally reconstructed radiographs (DRR's) from the virtual treatment fields.

The therapist then exports the isocenter coordinates to the laser system which projects the isocenter position onto the patient. The therapist tattoos the patient with the projected isocenter position as well as any other ancillary leveling and positioning marks that will be used for patient set up on the treatment unit. The therapist documents these tattoos with photos. The therapist then assists the patient off of the CT table and takes them back to the changing area.

Back in the CT room, the therapist exports the scan images and DRR's to the PACS system and the radiation therapy planning computer and uploads the patient face and tattoo photos into the record and verify system. The therapist then completes the simulation documentation and prepares the patient set up instructions for use at the treatment unit. The pads and other positioning devices are then removed from the CT table. The table and other equipment is then cleaned and disinfected and unused supplies are put away.

#### CPT Code 77285

The radiation therapist will first prepare the CT room. This will include positioning the CT table at its lowest position, installing any immobilization devices or pads on the table and setting the moveable patient positioning lasers at their zero position. The Radiation Therapist will gather and ready any necessary supplies for patient marking.

The radiation therapist will then greet the patient and give them a brief explanation of the simulation procedure and its expected duration. The patient will be led to the changing area and instructed to change into the appropriate exam gown.

After gowning, the radiation therapist will bring the patient into the CT room and verify the patient's identity according to department policy. The therapist will explain the CT procedure in detail, ask if they have any questions or concerns and provide any additional information as necessary. The therapist will then take a face photo of the patient. The therapist will assist the patient onto the CT table and place them into the appropriate position. This may involve placing the patient into immobilization devices such as a mold or mask or other supporting devices as appropriate. The patient's arms and legs will then be positioned according to scan protocol and/or patient comfort considerations. Knee wedges, arm straps and other pads may be added as needed to ensure patient comfort and stability. The patient positioning lasers are used to verify patient alignment. Markers for the first treatment area are placed on the patient's skin as directed by the radiation oncologist.

After verifying with the radiation oncologist the extent of the area to be scanned, the therapist manually moves the patient into the CT unit bore checking for sufficient clearance between the patient, table and immobilization devices and the CT unit. The table is then positioned using the internal CT lasers to the start position for the scanning sequence. The radiation therapist chooses the appropriate scanning parameters at the CT console and takes AP and lateral scout images.

The scout images are shown to the radiation oncologist and reviewed. Adjustments are made to patient position as necessary to improve patient alignment and/or comfort. The scout images may indicate that an alternative patient position would be advantageous in which case the patient

positioning sequence would be repeated. Scout images are then repeated and the final patient positioning verified. At this point the field of view for the scan, including the superior/inferior scan extent, is set by the therapist. The patient is then scanned and the images are reconstructed.

The scan images are then reviewed by the radiation therapist and radiation oncologist. It is verified that the patient position is acceptable, that the scan extends sufficiently in the superior/inferior directions, and that no part of the patient's skin contour is cut off. The image quality of the scan is also noted, in particular any artifacts that might arise from contrast agents or metallic implants.

The patient is then repositioned, as necessary, for scanning of the second treatment area. New markers are placed on the patient's skin, clearances are checked and AP and lateral scout images are obtained as described above. They are reviewed, patient position is adjusted as necessary and scouts are repeated. After approval by the radiation oncologist, the second treatment area of the patient is scanned.

Both sets of scan images are then sent to the virtual simulation workstation where the radiation oncologist places the treatment fields and sets isocenters for both treatment areas. The radiation therapist then generates digitally reconstructed radiographs (DRR's) for both sites from the virtual treatment fields.

The therapist then exports the isocenter coordinates for the first treatment site to the laser system which projects the isocenter position onto the patient. The therapist tattoos the patient with the projected isocenter position as well as any other ancillary leveling and positioning marks that will be used for patient set up on the treatment unit. This process is then repeated for the second treatment area. The therapist documents the tattoos for both sites with photos. The therapist then assists the patient off of the CT table and takes them back to the changing area.

Back in the CT room, the therapist exports the scans and DRR's to the PACS system and the radiation therapy planning computer and uploads the patient face and tattoo photos into the record and verify system. The therapist then completes the simulation documentation and prepares the patient set up instructions for use at the treatment unit. The immobilization equipment and other devices are then removed from the CT table. The table and other equipment is then cleaned and disinfected and unused supplies are put away.

#### CPT Code 77290

The radiation therapist will first prepare the CT room. This will include positioning the CT table at its lowest position, installing the customized immobilization device that was fabricated for the patient and setting the moveable patient positioning lasers at their zero position. The Radiation Therapist will gather and ready any necessary supplies for patient marking.

The radiation therapist will then greet the patient and give them a brief explanation of the simulation procedure and its expected duration. The patient will be led to the changing area and instructed to change into the appropriate exam gown.

After gowning, the radiation therapist will bring the patient into the CT room and verify the patient's identity according to department policy. The therapist will explain the CT procedure in detail, ask if they have any questions or concerns and provide any additional information as

necessary. The therapist will then take a face photo of the patient. The therapist will assist the patient onto the CT table and place them into the immobilization device. This consists of an angled support structure which holds the patient's torso and arms in positions which permit optimum treatment geometry. The support structure incorporates a customized mold for the patient to ensure reproducibility of the patient's position. Treatment of the breast and supraclavicular area require complicated treatment beam geometry and it is vital that the patient be positioned correctly and reproducibly. Extra time is required for such positioning. Knee wedges, straps and other pads may be added as needed to ensure patient comfort and stability. The patient positioning lasers are used to verify patient alignment. Markers are placed on the patient's skin as directed by the radiation oncologist.

After verifying with the radiation oncologist the extent of the area to be scanned, the therapist manually moves the patient into the CT unit bore checking for sufficient clearance between the patient, table and immobilization devices and the CT unit. This must be checked very carefully due to the size of the immobilization device and the position of the patient's arm over her head. The table is then positioned using the internal CT lasers to the start position for the scanning sequence. The radiation therapist chooses the appropriate scanning parameters at the CT console and takes AP and lateral scout images.

The scout images are shown to the radiation oncologist and reviewed. Adjustments are made to patient position as necessary to improve patient alignment and/or comfort. The scout images may indicate that an alternative arm position or angle of the patient's torso would be advantageous in which case the immobilization device would be modified and the patient positioning sequence would be repeated. Scout images are then repeated and the final patient positioning verified. At this point the field of view for the scan, including the superior/inferior scan extent, is set by the therapist. The patient is then scanned and the images are reconstructed.

The scan images are then reviewed by the radiation therapist and radiation oncologist. It is verified that the patient position is acceptable, that the scan extends sufficiently in the superior/inferior directions, and that no part of the patient's skin contour is cut off. The image quality of the scan is also noted, in particular any artifacts that might arise from contrast agents or metallic implants.

The scan images are then sent to the virtual simulation workstation where the radiation oncologist places the treatment fields for both the breast and the nodal areas and sets one or more isocenters for those beams. The radiation therapist then generates digitally reconstructed radiographs (DRR's) from the virtual treatment fields.

The therapist then exports the isocenter coordinates to the laser system which projects the isocenter position onto the patient. The therapist tattoos the patient with the projected isocenter position as well as any other ancillary leveling and positioning marks that will be used for patient set up on the treatment unit. If multiple isocenters will be utilized, each will be exported, projected onto the patient and tattooed. The therapist documents all of the tattoos with photos. The therapist then assists the patient off of the CT table and takes them back to the changing area.

Back in the CT room, the therapist exports the scans and DRR's to the PACS system and the radiation therapy planning computer and uploads the patient face and tattoo photos into the

record and verify system. The therapist then completes the simulation documentation and prepares the patient set up instructions for use at the treatment unit. The immobilization equipment and other devices are then removed from the CT table. The table and other equipment is then cleaned and disinfected and unused supplies are put away.

CPT code 77293 -- ZZZ

The Radiation Therapist (RT) positions the respiratory transducers (infrared reflective device, respiratory sensing belt, active breathing control, etc.) on the patient and verifies connectivity with the 4D CT scanning system and/or respiratory signal processing computer.

The physicist then assists the physician in coaching the patient to achieve an optimal yet natural breathing cycle consistent with minimizing respiratory excursion. The resultant transducer signal is tracked over a length of time similar to what will be necessary to acquire the 4D data set. The respiratory cycle duration is measured. The coaching and tracking process is repeated to assure that the measured respiratory cycle characteristics are reproducible and will be typical of the cycle that will occur when the patient is treated.

In consultation with the physician and physicist, a decision is made as to triggering on phase or amplitude, the computer system is programmed to reflect that choice and a sample trigger data set is run to assure that the respiratory cycle will be properly segmented by the trigger signal. If the segmentation is sub-optimal, the transducer placement – coaching- tracking and triggering analysis is repeated.

Based upon the analysis of the respiratory cycle, appropriate cine and/or pitch parameters are calculated. A set of orthogonal scout images is acquired and the desired scan positions are set. The slice thickness, slice number, pitch/cine time and x-ray output parameters are optimized based on tube heating/cooling characteristics and maximum slice number constraints. The RT then adjusts the scan position parameters to be congruent with the initial CT simulation image data set and acquires the 4D data set. The physicist and physician observe both the progression of the scan acquisition and the integrity of the triggering signal overlaid on the respiratory cycle curve. If significant anomalies in the respiratory cycle curve occur the coaching/positioning/ respiratory cycle confirmation/ scan acquisition process is repeated.

At the conclusion of the raw data acquisition, the physicist adjusts the recorded respiratory trigger signal to account for minor deviations in the respiratory cycle. A 4D reconstruction is then implemented, generally creating a segmented series of 10 image data sets, each imaging 10% of the respiratory cycle. The physicist then reviews the resultant 4D data set in both static and Cine modes with the physician, and if acceptable, creates a Maximum Intensity Projection data Set (MIP) and an average or ungated data set. The RT then transmits the entire series (10 respiratory segments, MIP and Average) to a processing station for the physician to create an ITV or series of GTV's.

CPT Code 77295

The dosimetrist reviews the patient chart and prescription and receives guidance from the physician as to the particular issues related to the development of the 3-D isodose plan. The dosimetrist then enters the patient demographics into the Radiation Therapy Planning (RTP) computer, verifying that the patient name and medical record number are identical across the RTP system, the Record and Verify (RV) system and the CT simulation system.

The dosimetrist then imports the CT simulation image data sets into the RTP system and reviews each data set for completeness and appropriate planning characteristics. The dosimetrist contours the basic 3D organs at risk structures (i.e. skin) and then reviews the contours with the physician, making modifications as directed. As the physician draws the 3-D GTV, CTV and PTV structures, and critical structures, the dosimetrist assists as necessary, and then modifies adjacent or overlapping OAR structures using Boolean operators to avoid over-determined constraints during the development of the 3D isodose plan.

Based upon the contour sets designed/approved by the physician, the dosimetrist positions the isocenter to allow the optimal linac beam configuration, assigns beam energies, initial field sizes, gantry and table angles and beam weights in consultation with the physicist. The collimation of the beams is reviewed with the physician and adjusted as necessary with the aid of beams-eye views overlaid on digitally reconstructed radiographs (DRRs). A 3-D plan is then generated using the beam-modeling algorithm recommended by the physicist. Dose volume histograms are generated from the 3-D dose matrix of the plan, and beam parameters (beam energies, initial field sizes, gantry and table angles and beam weights) are adjusted as necessary. Additional trials (typically 3-4) with modified beam parameters are created and the dose volume histograms and isodose curve displays are compared to assist in plan optimization. The resultant 3-D information is reviewed with the physicist and physician and additional modifications are made as directed.

Once the physician has made a final decision on the 3-D isodose plan, the dosimetrist generates final treatment beam DRR's and orthogonal set-up DRR's, locks and archives the plan, exports it to the RV system, creates and reviews treatment field definitions in the RV system based upon the data imported from the RTP system and creates the treatment delivery notes for the Radiation Therapist to use during the patient treatment.

Lastly, the dosimetrist verifies that the beam delivery parameters transmitted from the RV system are correctly implemented on the linear accelerator delivery computer console.

**Post-Service Clinical Labor Activities:**

N/A

## Tab 14: Respiratory Motion Management Simulation Revised PE Recommendations

Attached are the updated recommendations for Tab 14. There are three sets of codes in this tab – the first are simulation codes, the second is a planning code and the third is an add-on code for respiratory motion management.

### Simulation

The recommendations for 77280 and 77285 are the same right now as the revised recommendations from yesterday. The changes from the original recommendations are outlined below.

#### CPT Code 77280

- Removed 3 minutes based on the comment yesterday regarding the film to digital workgroup
  - *Line 42: Send images to RTP PACs..... Zeroed out from 1 min (line 69 original)*
  - *Line 50: Take digital face photo...Zeroed out from 1 min (line 44 original)*
  - *Line 59: Take digital pictures of field...Zeroed out from 1 min (line 53 original)*
- Reduced *Prepare and Position* from 4 min to 2 min (line 59 original). We did not reallocate any of those positioning minutes.
- Line 35: *Scan and Recon* Reduced from 6 min to 5 min (line 64 original)
- Line 39: *Mark/Tattoo patient* Reduce from 4 min to 3 min (line 68 original)

#### CPT Code 77285

- Removed 3 minutes based on the comment yesterday regarding the film to digital workgroup
  - *Line 42: Send images to RTP PACs..... Zero out from 1 min (line 69 original)*
  - *Line 50: Take digital face photo...Zeroed out from 1 min (line 44 original)*
  - *Line 59: Take digital pictures of field...Zeroed out from 1 min (line 53 original)*
- Reduced *Prepare and Position* from 8 min to 2 min (line 59 original). We did not reallocate any of those positioning minutes.

As directed by the committee, we further modified the inputs for 77290 and explain those changes below.

#### CPT Code 77290

- Reduced *Prepare Room, equipment and supplies* from 5 to 2
- Removed 3 minutes based on the comment yesterday regarding the film to digital workgroup
  - *Line 42: Send images to RTP PACs..... Zero out from 1 min (line 69 original)*
  - *Line 50: Take digital face photo...Zeroed out from 1 min (line 44 original)*
  - *Line 59: Take digital pictures of field...Zeroed out from 1 min (line 53 original)*
- Reduced *Prepare and Position* from 12 min to 2 min (line 59 original). We reallocated 6 of those 10 minutes. Details below.
  - *Check clearance, mark and take scout images..... was 8 now 10 \*\*\*\*reallocation*
  - *Adjust patient position..... original 4 now 6 \*\*\*\*reallocation*
  - *Set FOV, scan range..... Scan range 1 now 3 \*\*\*\* reallocation*

### Relationship Between the Three Codes

One of the concerns identified by the PE subcommittee was the relationship for these activities between the three codes. We have explained those relationships below.

#### Remains the same for all 3 codes:

The time for the following activity remains the same between all three codes.

	77280	77285	77290
<i>review scan, export to workstation</i>	2	2	2



Step increase between the 3 codes:

For the activities listed below, there are step increases between the three codes based on complexity, number of fields and anatomical information.

	77280	77285	77290
<i>Check clearance mark and take scout images, show to physician</i>	4	8	10
<i>adjust patient position and retake scouts</i>	2	4	6
<i>set FOV, scan range, patient specific x-ray technique</i>	1	2	3
<i>set virtual fields, generate DRR's</i>	1	2	6

Times based on the number of sites:

For the activities listed below, there is a relationship between the three codes based on the number of treatment sites.

	77280	77285	77290
<i>scan and Recon</i>	5	8	6
<i>mark/tattoo patient</i>	3	6	6
<i>Set LAP Laser system and export</i>	2	4	2

**Equipment Times**

We included the following lines/activities in our equipment times (rows/cells 27, 29, 31 and 43):

- 77280 Total equipment times reduced from 38 to 27 min
- 77285 Total equipment times reduced from 58 to 43 min
- 77290 Total equipment times reduced from 66 to 48 min

---

**Planning**

The second code we are presenting is 77295 a radiation dosimetric planning code. This is an existing code that has been resequenced in the CPT book. This code is for the development and planning of a three dimensional conformal plan with dose volume histogram, analysis of the critical structures, and target volumes.

- We deleted *review prescription, charts* 3 min
- We deleted *enter patient demographics into computer* 2 min
- We also deleted the 5 minutes on the record and verify equipment
- The total equipment time will go down from 170 to 165 (rows/cells 31)

---

**Respiratory Motion Management**

The final code is an add-on code 77293. It is an add-on code that describes the work of acquisition, processing, analysis and definition of a four dimensional target (i.e. a tumor that moves through the breathing cycle like some lung cancers).

We reorganized the activities on the spreadsheet to better follow the standard format. The recommended times were maintained. The equipment times were calculated with rows/cells 31, 32 and 45.

	A	B	C	F	G	H	I	J	K	L	M	N	O	P	Q
1															
2	<b>Note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.</b>			<b>77280</b>	<b>77280</b>	<b>77285</b>	<b>77285</b>	<b>77285</b>	<b>77285</b>	<b>77290</b>	<b>77290</b>				
	<b>Meeting Date: January 2013</b>			Therapeutic radiology simulation-aided field setting; simple	Therapeutic radiology simulation-aided field setting; simple	Therapeutic radiology simulation-aided field setting; intermediate	Therapeutic radiology simulation-aided field setting; intermediate	Therapeutic radiology simulation-aided field setting; intermediate	Therapeutic radiology simulation-aided field setting; intermediate	Therapeutic radiology simulation-aided field setting; complex	Therapeutic radiology simulation-aided field setting; complex				
3	<b>Tab: Tab 14</b>	<b>CMS Code</b>	<b>Staff Type</b>	<b>Current Inputs</b>	<b>SURVEYED CODE</b>	<b>Current Inputs</b>	<b>SURVEYED CODE</b>	<b>Current Inputs</b>	<b>SURVEYED CODE</b>	<b>Current Inputs</b>	<b>SURVEYED CODE</b>				
	<b>Specialty:Respiratory Motion Management Simulation</b>														
4	<b>LOCATION</b>			<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>
5	<b>GLOBAL PERIOD</b>														
6	<b>TOTAL CLINICAL LABOR TIME</b>			<b>31</b>	<b>0</b>	<b>34</b>	<b>0</b>	<b>50</b>	<b>0</b>	<b>52</b>	<b>0</b>	<b>70</b>	<b>0</b>	<b>61</b>	<b>0</b>
7	<b>TOTAL PRE-SERV CLINICAL LABOR TIME</b>			<b>9</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>9</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>9</b>	<b>0</b>	<b>0</b>	<b>0</b>
8	Radiation Therapist			8				8				8			
9	Registered Nurse			1				1				1			
10	<b>TOTAL SERVICE PERIOD CLINICAL LABOR TIME</b>			<b>22</b>	<b>0</b>	<b>34</b>	<b>0</b>	<b>41</b>	<b>0</b>	<b>52</b>	<b>0</b>	<b>61</b>	<b>0</b>	<b>61</b>	<b>0</b>
11	Radiation Therapist			22		34		41		52		61		61	
12	<b>TOTAL POST-SERV CLINICAL LABOR TIME</b>			<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
13	<b>PRE-SERVICE</b>														
14	<b>Start: Following visit when decision for surgery or procedure made</b>														
15	Complete pre-service diagnostic & referral forms														
16	Coordinate pre-surgery services	L051A	RN	1				1				1			
17	Schedule space and equipment in facility	LO50C	RadTherapist	1				1				1			
18	Provide pre-service education/obtain consent	LO50C	RadTherapist	3				3				3			
19	Follow-up phone calls & prescriptions														
20	Other Clinical Activity - specify: Simulator QA	LO50C	RadTherapist	4				4				4			
21	<b>End: When patient enters office/facility for surgery/procedure</b>														
22	<b>SERVICE PERIOD</b>														
23	<b>Start: When patient enters office/facility for surgery/procedure:</b>														
24	Greet patient, provide gowning, ensure appropriate medical records are available	LO50C	RadTherapist	4		3		4		3		4		3	
25	Obtain vital signs														
26	Provide pre-service education/obtain consent														
27	Prepare room, equipment, supplies	LO50C	RadTherapist	2		2		2		2		5		2	
28	Setup scope (non facility setting only)														
29	Prepare and position patient/ monitor patient/ set up IV	LO50C	RadTherapist	2		2		2		2		3		2	
30	Sedate/apply anesthesia														
31	<b>Intra-service/Perform Procedure</b>					20				36				43	
32	Check clearance mark and take scout images, show to physician	LO50C	RadTherapist			4				8				10	
33	adjust patient position and retake scouts	LO50C	RadTherapist			2				4				8	
34	set FOV, scan range, patient specific x-ray technique	LO50C	RadTherapist			1				2				3	
35	scan and Recon	LO50C	RadTherapist			5				8				6	
36	review scan, export to workstation	LO50C	RadTherapist			2				2				2	
37	set virtual fields, generate DRR's	LO50C	RadTherapist			1				2				6	
38	Set LAP Laser system and export	LO50C	RadTherapist			2				4				2	
39	mark/tattoo patient	LO50C	RadTherapist			3				6				6	
40	<b>Post-Service</b>														
41	Monitor pt. following service/check tubes, monitors, drains	LO50C	RadTherapist	3				3							
42	Send images to RTP, PACS	LO50C	RadTherapist												
43	Clean room/equipment by physician staff	LO50C	RadTherapist			3				3		3		3	
46	Complete diagnostic forms, lab & X-ray requisitions														
47	Simulation note, prepare set up instructions	LO50C	RadTherapist			4				6				8	
48	Review/read X-ray, lab, and pathology reports														
49	Other Clinical Activity - specify:														
50	-take digital face photo and enter into computer	LO50C	RadTherapist	1				2				1			
51	-fluoro with physician for preliminary x-ray	LO50C	RadTherapist	1				2				4			
52	-mark borders on patient and take preliminary x-ray	LO50C	RadTherapist	1				2				2			
53	-develop x-ray	LO50C	RadTherapist	2				2				2			
54	-have physician make corrections	LO50C	RadTherapist					1				1			
55	-remark corrections and take AP and Lateral film	LO50C	RadTherapist					5				5			
56	-develop x-ray	LO50C	RadTherapist					2				2			
57	-show to physician for approval	LO50C	RadTherapist					1				1			
58	-take separation measurements and make contour	LO50C	RadTherapist					2				4			
59	-take digital pictures of fields and enter into computer	LO50C	RadTherapist	2				3				4			
60	-tattoo AP and Lateral isocenters	LO50C	RadTherapist	2				4				4			
61	-remove clamp and clean up patient	LO50C	RadTherapist									2			
62	-enter data into chart	LO50C	RadTherapist	2				3				3			
63	-schedule return appointment for patient	LO50C	RadTherapist					1				1			
64	Assist Physician											10			
68	<b>End: Patient leaves office</b>														

	A	B	C	F	G	H	I	J	K	L	M	N	O	P	Q
1															
2	<b>Note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.</b>														
3	<b>Meeting Date: January 2013</b> <b>Tab: Tab 14</b> <b>Specialty:Respiratory Motion Management Simulation</b>	<b>CMS Code</b>	<b>Staff Type</b>	<b>77280</b> <small>Therapeutic radiology simulation-aided field setting; simple</small> <b>Current Inputs</b>	<b>77280</b> <small>Therapeutic radiology simulation-aided field setting; simple</small> <b>SURVEYED CODE</b>	<b>77285</b> <small>Therapeutic radiology simulation-aided field setting; intermediate</small> <b>Current Inputs</b>	<b>77285</b> <small>Therapeutic radiology simulation-aided field setting; intermediate</small> <b>SURVEYED CODE</b>	<b>77290</b> <small>Therapeutic radiology simulation-aided field setting; complex</small> <b>Current Inputs</b>	<b>77290</b> <small>Therapeutic radiology simulation-aided field setting; complex</small> <b>SURVEYED CODE</b>						
4	<b>LOCATION</b>			<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>
5	<b>GLOBAL PERIOD</b>														
69	<b>POST-SERVICE Period</b>														
70	<b>Start: Patient leaves office/facility</b>														
71	Conduct phone calls/call in prescriptions														
79	Other Clinical Activity - <i>specify:</i>														
80	<b>End: with last office visit before end of global period</b>														

	A	B	C	F	G	H	I	J	K	L	M	N	O	P	Q
1															
2	<b>Note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.</b>														
	<b>Meeting Date: January 2013</b>			<b>77280</b>		<b>77280</b>		<b>77285</b>		<b>77285</b>		<b>77290</b>		<b>77290</b>	
	<b>Tab: Tab 14</b>			Therapeutic radiology simulation-aided field setting; simple		Therapeutic radiology simulation-aided field setting; simple		Therapeutic radiology simulation-aided field setting; intermediate		Therapeutic radiology simulation-aided field setting; intermediate		Therapeutic radiology simulation-aided field setting; complex		Therapeutic radiology simulation-aided field setting; complex	
3	<b>Specialty:Respiratory Motion Management Simulation</b>	<b>CMS Code</b>	<b>Staff Type</b>	<b>Current Inputs</b>		<b>SURVEYED CODE</b>		<b>Current Inputs</b>		<b>SURVEYED CODE</b>		<b>Current Inputs</b>		<b>SURVEYED CODE</b>	
4	<b>LOCATION</b>			<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>
5	<b>GLOBAL PERIOD</b>														
81	<b>MEDICAL SUPPLIES</b>	<b>CODE</b>	<b>UNIT</b>												
82	pack, minimum multi-specialty visit	SA048	pack												
83	Alcohol swabs	SJ053		1		1		2		1		4		1	
84	Barium Paste	SH014										8			
85	Catheter, balloon, rectal pressure	SD017										1			
86	Catheter, Foley	SD024										1			
87	Catheter plug	SD013										1			
88	label for microscopic slides	SL085		1				2				2			
89	film, x-ray 14in x 17in	SK034		2		2		4		2		4		2	
90	x-ray developer solution	SK089		2		2		4		2		4		2	
91	Gauze, 4x4	SG055		2		2		4		2		4		2	
92	Gloves, sterile	SB024						1				1			
93	Gown, patient	SB026		1		1		1		1		1		1	
94	lubricating jelly	SJ032										1			
95	Needle, 18-27g	SC029		1		1		3		1		3		1	
96	Pillow case	SB037		1		1		1		1		1		1	
97	Renograffin-60	SH060										50			
98	skin marking ink (tattoo)	SK073		2		2		5		2		5		2	
99	skin marking pen, sterile (Skin Scribe)	SK075		1		1		1		1		1		1	
100	syringe 50-60ml	SC056										2			
101	Tray, catheter insertion (w-o catheter)	SA063										1			
102	x-ray fixer solution	SK092		11		11		22		11		22		11	
103	water, sterile inj	SH075										50			
104	Paper	SK057													
105															
106	<b>EQUIPMENT</b>	<b>CODE</b>													
107	Room, CT	EL007				27				43				50	
108	Virtual Simulation Package (NEW)	NEW				0				0				0	
109	radiation virtual simulation system	ER057		22		27		41		43		61		50	
110	laser targeting system	ER039		22				41				61			
111	IMRT x-ray fouro-based	ER007		22				41				61			
112	Record and Verify	ED011				5				5				5	
113	camera, digital	ED004		10		5		25		5		25		5	
114	Film alternator	ER029		10		10		10		10		10		10	
115	Film processor	ED025		3		3		5		3		5		3	

	A	B	C	F	G	H	I
1	<b>REVISED</b>						
2	<b>Note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.</b>			<b>77014</b>		<b>77293</b>	
3	Meeting Date: January 2013 Tab: Tab 14 Specialty:Respiratory Motion Management Simulation	CMS Code	Staff Type	CT guidance for placement of radiation therapy fields  Current Inputs		Respiratory motion management simulation	
4	LOCATION			Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD						
6	TOTAL CLINICAL LABOR TIME			18	0	40	0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			0	0	0	0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			18	0	40	0
9	Radiation Therapist			18		17	
10	Medical Physicist					23	
11	TOTAL POST-SERV CLINICAL LABOR TIME			0	0	0	0
12	PRE-SERVICE						
21	SERVICE PERIOD						
22	Start: When patient enters office/facility for surgery/procedure:						
23	Greet patient, provide gowning, ensure appropriate medical records are available						
24	Obtain vital signs						
25	Provide pre-service education/obtain consent						
26	Prepare room, equipment, supplies	LO50C	RadTherapist	2			
27	Setup scope (non facility setting only)						
28	Prepare and position patient/ monitor patient/ set up IV	LO50C	RadTherapist	2			
29	Sedate/apply anesthesia						
30	Intra-service						
31	Placement of transducer sensors	LO50C	RadTherapist			2	
32	Assist physician in performing procedure			14		36	
33	coach patient	L152A	Med Physicist				
34	Select phase/amplitude gating and re-acquire trace	L152A	Med Physicist			1	
35	dry run of sensor system, adjust if needed	L152A	Med Physicist			5	
36	measure respiratory period, calculate cine and /or pitch parameters	L152A	Med Physicist			3	
37	take scout images, show to physician	LO50C	RadTherapist			2	
38	adjust scan range to meet maximum slice constraints and tube heating constraints	L152A	Med Physicist			2	
39	Correlate FOV placement with initial planning scans	LO50C	RadTherapist			1	
40	scan	LO50C	RadTherapist			10	
41	adjust respiratory cycle phase markers	L152A	Med Physicist			2	
42	data set processing and reconstruction, transfer to workstation	L152A	Med Physicist			5	
43	MIP image processing	L152A	Med Physicist			5	
44	Post-Service						
45	Transfer Images	LO50C	RadTherapist			2	
46	Monitor pt. following service/check tubes, monitors, drains						
47	Clean room/equipment by physician staff						
59	End: Patient leaves office						
60	POST-SERVICE Period						
61	Start: Patient leaves office/facility						
62	Conduct phone calls/call in prescriptions						
70	Other Clinical Activity - specify:						
71	End: with last office visit before end of global period						
72	MEDICAL SUPPLIES	CODE	UNIT				
73	pack, minimum multi-specialty visit	SA048	pack				
74	film xray			3			
75	computer media, dvd	SK013		1			
76	x-ray envelope	SK091		1			
77							
78	EQUIPMENT	CODE					
79	Room, CT	EL007		14		40	
80	Virtual Simulation Package (NEW)	NEW				0	
81	4D Simulation Package (New)	NEW				0	
82	Film alternator	ER029		4			
83	Film processor	ED025		4			



	A	B	C	F	G	H	I
1	<b>REVISED</b>						
2	<b>Note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.</b>			<b>77295</b>		<b>77295</b>	
3	Meeting Date: January 2013 Tab: Tab 14 Specialty:Respiratory Motion Management Simulation	CMS Code	Staff Type	Therapeutic radiology simulation-aided field setting; 3-dimensional  Current Inputs		Therapeutic radiology simulation-aided field setting; 3-dimensional  SURVEYED CODE	
4	LOCATION			Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			XXX	XXX	XXX	XXX
6	TOTAL CLINICAL LABOR TIME			170	0	165	0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			0	0	0	0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			170	0	165	0
9	Medical Physicist			15		15	
10	Medical Dosimetrist			155		150	
11	TOTAL POST-SERV CLINICAL LABOR TIME			0	0	0	0
12	PRE-SERVICE						
21	SERVICE PERIOD						
22	Start: When patient enters office/facility for surgery/procedure:						
23	Review prescription, charts	L063A	CMD	3			
24	Greet patient, provide gowning						
25	Obtain vital signs						
26	Provide pre-service education/obtain consent						
27	Prepare room, equipment, supplies						
28	Setup scope (non facility setting only)						
29	Prepare and position patient/ monitor patient/ set up IV						
30	Sedate/apply anesthesia						
31	Intra-service/Perform Procedure					165	
32	Enter patient demographics into computer	L063A	CMD	2			
33	Import CT images and review	L063A	CMD	4		4	
34	Create basic 3D patient structures and review with physician	L063A	CMD	25		25	
35	Assist physician with PTVs and CTVs	L063A	CMD	13		13	
36	create isocenter, enter beam geometries, energy field sizes	L063A	CMD	13		13	
37	assist physician with field collimation	L063A	CMD	8		8	
38	generate plan, analyze for PTV course in 3 dimensions,	L063A	CMD	35		35	
39	review BEV, adjust beam weights	L063A	CMD	10		10	
40	Run DVHs and review	L063A	CMD	15		15	
41	Review with physician and adjust if necessary	L063A	CMD	10		10	
42	Physicist review of beam geometry, weights, energy, isodose clouds, dose-volume histograms	L152A	MedPhysicist	15		15	
43	Print DRRs, label and file, export information to RV	L063A	CMD	10		10	
44	Verify parameters at treatment machine	L063A	CMD	7		7	
45	Post-Service						
46	Monitor pt. following service/check tubes, monitors, drains						
47	Clean room/equipment by physician staff						
48	Clean Scope						
49	Clean Surgical Instrument Package						
50	Complete diagnostic forms, lab & X-ray requisitions						
51	Review/read X-ray, lab, and pathology reports						
52	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
53	Other Clinical Activity - specify:						
59	End: Patient leaves office						
60	POST-SERVICE Period						
61	Start: Patient leaves office/facility						
62	Conduct phone calls/call in prescriptions						
70	Other Clinical Activity - specify:						
71	End: with last office visit before end of global period						
72	MEDICAL SUPPLIES	CODE	UNIT				
73	pack, minimum multi-specialty visit	SA048	pack				
74	Paper	SK057		3		3	
75							
76	EQUIPMENT	CODE					
77	computer workstation	ED015		170		165	
78							

## AMA/Specialty Society RVS Update Committee Summary of Recommendations

October 2012

### Molecular Pathology Workgroup-Tier 1

The CPT Editorial Panel developed a new coding structure to describe molecular pathology services, based on the efforts and recommendations of the Molecular Pathology Coding Workgroup convened beginning in October 2009. This service is a new category I molecular pathology code and is among the last and lowest volume of the Tier 1 codes developed by the AMA CPT Molecular Pathology Coding Workgroup (MPCW). These services were previously reported with a series of “stacking codes.” The RUC understands that payment for these services is currently based on a mixture of payment methodologies, including the physician fee schedule and the clinical lab fee schedule. CMS requested that the RUC review data provided by the College of American Pathologists to provide the Agency with more information as a policy is developed to determine which payment schedule is appropriate for these services.

At the September 2011 RUC meeting, the Molecular Pathology Tier 2 codes were valued and the specialty society crosswalked the values for low volume Tier 1 Molecular Pathology codes, with inadequate survey data, to the Tier 2 Molecular Pathology codes. This was done by comparing the exons requiring interpretation included in the Tier 2 level codes with the new Tier 1 code. CPT code 81161 *DMD (dystrophin) (eg, Duchenne/Becker muscular dystrophy) deletion analysis, and duplication analysis, if performed* is a new Molecular Pathology Tier 1 code that is also a low volume service. The specialty society gained approval from the Research Subcommittee to base their work value recommendation on a direct crosswalk to a Tier 2 level code. The RUC agrees that this method will maintain relativity and rank order within the molecular pathology family of services.

The specialty society explained, and the RUC agreed, that the work RVU for this service could be best derived from crosswalking it directly to Tier 2 CPT code 81407 *Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform) SCN1A (sodium channel, voltage-gated, type 1, alpha subunit) (eg, generalized epilepsy with febrile seizures), full gene sequence* (RUC Recommended work RVU = 1.85) with 60 minutes of intra-service time. Code 81161 involves duplication/deletion analysis of the DMD gene which has 79 exons. Code 81407 also includes the “...analysis of duplication/deletion variants of > 50 exons” and requires 60 minutes of intra-service time. The RUC agreed that the physician time and work required to perform code 81407 should be accurately assimilated to the time and work of 81161. The RUC also compared the surveyed service to 88323 *Consultation and report on referred material requiring preparation of slides* (work RVU=1.83, intra-time=56 minutes), and agreed that the reference code requires similar time to perform as compared to the surveyed code, 56 minutes and 60 minutes, respectively. **The RUC recommends a work RVU of 1.85 for CPT code 81161.**

**New Technology/New Services List**

The RUC noted that CPT code 81161, along with all the Molecular Pathology family of services, are new services and should be placed on the New Technology/New services list.

**Practice Expense**

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

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
● 81161	DMD (dystrophin) (eg, Duchenne/Becker muscular dystrophy) deletion analysis, and duplication analysis, if performed	XXX	1.85





June 7, 2012

Brenda Lewis, DO  
Chair  
Research Subcommittee  
RVS Update Committee  
American Medical Association  
515 North State Street  
Chicago, IL 60654

RE: Additional Tier 1 Molecular Pathology CPT Code

Dear Doctor Lewis;

The College of American Pathologists (CAP) will be presenting physician work and practice expense for one new category I molecular pathology code at the October 2012 AMA-RUC meeting. This new service is among the last and lowest volume of the Tier 1 codes developed by the AMA CPT Molecular Pathology Coding Workgroup (MPCW).

After considering our previous survey efforts last year when CAP performed a survey of 68 new molecular pathology services, CAP's RBRVS workgroup believes that a full survey of this code performed by ultra-specialized molecular pathologists would yield much less than the typical minimum number of 30 survey respondents that the RUC typically desires.

At the September 2011 RUC meeting, CAP cross walked the values for low volume Tier 1 Molecular Pathology codes for which we did not receive adequate survey data to the Tier 2 Molecular Pathology level codes. This was done by comparing the exons requiring interpretation included in the Tier 2 level codes with the new Tier 1 code. As this new Tier 1 code under consideration represents another low volume service, we believe that cross walking the new code to Tier 2 level code represents the best option to maintain relativity and rank order within the molecular pathology family. If surveyed, we would anticipate a very low physician work survey response rate for this service.

CAP requests that the RUC's Research Subcommittee accept the following relative value cross walk for our new molecular pathology service to value its professional component for this service. The practice expense subcommittee will separately determine the practice expense recommendations for this code.

**The new molecular pathology service with direct crosswalk code is listed below:**

- 81161 DMD (*dystrophin*) (eg, Duchenne/Becker muscular dystrophy) deletion analysis, and duplication analysis, if performed

# College of American Pathologists

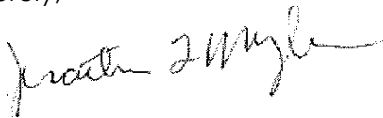
## Physician Work Cross-walk to:

**81407** - Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform) SCN1A (sodium channel, voltage-gated, type 1, alpha subunit) (eg, generalized epilepsy with febrile seizures), full gene sequence (**RUC Recommended Work RVU = 1.85, Intra-service Work Time = 60 minutes, IWPOT = 0.031**)

**Rationale:** 81161 involves duplication/deletion analysis of the DMD gene which has 79 exons. Code 81407 is recommended for the crosswalk as it includes the "...analysis of duplication/deletion variants of > 50 exons."

If you have any questions or concerns, please contact, Todd Klemp, Assistant Director of Economic and Regulatory Affairs at (847) 832-7403 or tklemp@cap.org.

Sincerely,



Jonathan L. Myles, MD, FCAP  
RUC Advisor  
College of American Pathologists

cc: Edith Hambrick, MD, JD, CMS  
Pam Johnson, CAP Staff  
Rosa Karbowiak, AMA  
Todd Klemp, CAP Staff  
Sherry Smith, AMA  
Ayanna Wooding, CAP Staff

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 81161      Tracking Number

Original Specialty Recommended RVU: **1.85**Presented Recommended RVU: **1.85**

Global Period: XXX

RUC Recommended RVU: **1.85**

CPT Descriptor: DMD (dystrophin) (eg, Duchenne/Becker muscular dystrophy) deletion analysis, and duplication analysis, if performed

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 4-year-old boy presents to his pediatrician with a history of difficulty with climbing stairs and rising from a sitting position. Physical examination reveals proximal lower extremity weakness. Serum creatine kinase is significantly elevated at 50 times the upper limit of the reference range. The patient had a now deceased maternal uncle who was affected with Duchenne muscular dystrophy. An anticoagulated peripheral blood sample is submitted for duplication and deletion analysis to assess the patient's DMD mutation status.

Percentage of Survey Respondents who found Vignette to be Typical: 0%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: High quality genomic DNA isolated from whole blood is subjected to multiplex ligation-dependent probe amplification (MLPA), which involves hybridization and ligation of multiple pairs of oligonucleotide probes specific for the 79 exons and alternative exon 1 of the DMD gene to assess dosage of each exon. The pathologist examines peak heights and calculated ratios of individual exons to control gene sequences to determine dosage status for all exons tested in the DMD gene. The pathologist composes a report which specifies the patient's mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: None

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	10/2012				
<b>Presenter(s):</b>	Jonathan Myles, MD, FCAP, Aaron Bossler, MD, PhD, and Roger Klein, MD, JD				
<b>Specialty(s):</b>	College of American Pathologists				
<b>CPT Code:</b>	81161				
<b>Sample Size:</b>	0	<b>Resp N:</b>	0	<b>Response:</b>	0.0 %
<b>Description of Sample:</b>					
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>					
<b>Survey RVW:</b>					
<b>Pre-Service Evaluation Time:</b>					
<b>Pre-Service Positioning Time:</b>					
<b>Pre-Service Scrub, Dress, Wait Time:</b>					
<b>Intra-Service Time:</b>					
<b>Immediate Post Service-Time:</b>	_____				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	_____	99291x	99292x		
<b>Other Hospital time/visit(s):</b>	_____	99231x	99232x	99233x	
<b>Discharge Day Mgmt:</b>	_____	99238x	99239x	99217x	
<b>Office time/visit(s):</b>	_____	99211x	12x	13x	14x 15x
<b>Prolonged Services:</b>	_____	99354x	55x	56x	57x
<b>Sub Obs Care:</b>	_____	99224x	99225x	99226x	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

<b>CPT Code:</b>	81161	<b>Recommended Physician Work RVU: 1.85</b>			
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>	
<b>Pre-Service Evaluation Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>	
<b>Pre-Service Positioning Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>	
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>	
<b>Intra-Service Time:</b>		<b>60.00</b>			
<b>Immediate Post Service-Time:</b>	<b>0.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	99217x 0.00	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status?

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? Yes

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
81407	XXX	1.85	RUC Time

CPT Descriptor Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform) SCN1A (sodium channel, voltage-gated, type 1, alpha subunit) (eg, generalized epilepsy with febrile seizures), full gene sequence

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		
<u>CPT Descriptor 1</u>				
<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		
<u>CPT Descriptor 2</u>				

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
88323	XXX	1.83	RUC Time

CPT Descriptor Consultation and report on referred material requiring preparation of slides

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code:** 0      **% of respondents:** 0.0 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 81161</b>	<b>Key Reference CPT Code: 81407</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	60.00	60.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>60.00</b>	<b>60.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)**(of those that selected Key  
Reference code)**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered		
--	--	--

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed		
--	--	--

Urgency of medical decision making		
------------------------------------	--	--

**Technical Skill/Physical Effort (Mean)**

Technical skill required		
--------------------------	--	--

Physical effort required		
--------------------------	--	--

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality		
---	--	--

Outcome depends on the skill and judgment of physician		
--	--	--

Estimated risk of malpractice suit with poor outcome		
--	--	--

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity		
----------------------------------	--	--

Intra-Service intensity/complexity		
------------------------------------	--	--

Post-Service intensity/complexity		
-----------------------------------	--	--

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUR analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

This new service is among the last and lowest volume of the Tier 1 codes developed by the AMA CPT Molecular Pathology Coding Workgroup (MPCW). Duchenne patients are children, and the average life expectancy is only 25 years. There are only 400 – 600 live male births with DMD (and probably 50 with Becker muscular dystrophy, which is also caused by Dystrophin) in the U.S. per year.

After considering our previous survey efforts last year when CAP performed a survey of 68 new molecular pathology services, CAP's RBRVS workgroup believes that a full survey of this code performed by ultra-specialized molecular pathologists would yield much less than the typical minimum number of 30 survey respondents that the RUC typically desires.

At the September 2011 RUC meeting, CAP cross walked the values for low volume Tier 1 Molecular Pathology codes for which we did not receive adequate survey data to the Tier 2 Molecular Pathology level codes. This was done by comparing the exons requiring interpretation included in the Tier 2 level codes with the new Tier 1 code. As this new Tier 1 code under consideration represents another low volume service, we believe that cross walking the new code to Tier 2 level code represents the best option to maintain relativity and rank order within the molecular pathology family. If surveyed, we would anticipate a very low physician work survey response rate for this service.

CAP recommends the following relative value cross walk for our new molecular pathology service to value its professional component. The practice expense subcommittee will separately determine the practice expense recommendations for this code. The research subcommittee approved this methodology during the summer of 2012.

**The new molecular pathology service with direct crosswalk code is listed below:**

- 81161      *DMD (dystrophin)* (eg, Duchenne/Becker muscular dystrophy) deletion analysis, and duplication analysis, if performed

**Physician Work Cross-walk to:**

**81407** - Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform) SCN1A (sodium channel, voltage-gated, type 1, alpha subunit) (eg, generalized epilepsy with febrile seizures), full gene sequence (**RUC Recommended Work RVU = 1.85, Intra-service Work Time = 60 minutes, IWPUR = 0.031**)

**Rationale:** 81161 involves duplication/deletion analysis of the DMD gene which has 79 exons. Code 81407 is recommended for the crosswalk as it includes the "...analysis of duplication/deletion variants of > 50 exons."

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will be 407,194 for 2011 based on the most recent Medicare data available of 83912.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology                      How often? Rarely

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 50

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Duchenne patients are children, and the average life expectancy is only 25 years. There are only 400 – 600 live male births with DMD (and probably 50 with Becker muscular dystrophy, which is also caused by Dystrophin) in the U.S. per year. CAP does not anticipate many Duchenne patients will become Medicare beneficiaries.

Carrier testing wouldn't occur in Medicare patients, and CMS wouldn't pay for it anyway because it is not for the benefit of the Medicare patient.

Specialty Pathology                      Frequency 50                      Percentage 100.00 %

Specialty                      Frequency                      Percentage                      %

Specialty                      Frequency                      Percentage                      %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. It would be extremely rare to test a Medicare patient, Duchenne patients are children.

Specialty                      Frequency                      Percentage                      %

Specialty                      Frequency                      Percentage                      %

Specialty                      Frequency                      Percentage                      %

Do many physicians perform this service across the United States?

## Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 81407



## SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
3	<b>ISSUE: Molecular Pathology Workgroup-Tier 1 (81161X)</b>																		
4	<b>TAB: 11</b>																		
5	Source	CPT	Long Descriptor	Resp	IWPUT	RVW					Total Time	PRE-TIME			INTRA-TIME				
6						MIN	25th	MED	75th	MAX		EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX
7	REF	81407	Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform) SCN1A (sodium channel, voltage-gated, type 1, alpha subunit) (eg, generalized epilepsy with febrile seizures), full gene sequence		0.031			1.85			60						60		
8	New Code	81161	DMD (dystrophin) (eg, Duchenne/Becker muscular dystrophy) deletion analysis, and duplication analysis, if performed	0	NA						Crosswalk								
9	REC	81161	DMD (dystrophin) (eg, Duchenne/Becker muscular dystrophy) deletion analysis, and duplication analysis, if performed		0.031			1.85			60						60		

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor:

DMD (dystrophin) (eg, Duchenne/Becker muscular dystrophy) deletion analysis, and duplication analysis, if performed

Global Period: XXX

Meeting Date: October 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

All practice expenses were cross-walked to already reviewed Tier 2 code 81407 (April 2011). CAP's expert panel reviewed these cross-walked PE inputs (highlighted in yellow on the spreadsheet) and made minor edits in supplies to account for the difference in the typical service procedures.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:  
81407 is the direct cross-walk code

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

N/A

Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

N/A

**AMA/Specialty Society Update Process**  
**Practice Expense Summary of Recommendation**  
**Non Facility Direct Inputs**

CPT Long Descriptor:

DMD (dystrophin) (eg, Duchenne/Becker muscular dystrophy) deletion analysis, and duplication analysis, if performed

Global Period: \_XXX Meeting Date: \_October 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

All practice expenses were cross-walked to already reviewed Tier 2 code 81407 (April 2011). CAP's expert panel reviewed these cross-walked PE inputs (highlighted in yellow on the spreadsheet) and made minor edits in supplies to account for the difference in the typical service procedures.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code

Rationale:

81407 is the direct cross-walk code

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Molecular DNA analyses based on specific code.

Service Clinical Labor Activities:

NONE

Post-Service Clinical Labor Activities:

Clean up, document filing, and other activities, see spreadsheet.

	A	B	C	D	E
1	AMA Specialty Society RVS Update Committee Recommendation			\$ 81,161.00	81407 April 2011 RUC Rec
2	Meeting Date: October 2012 Specialty: Pathology  Typical Batch Size - 2			DMD (dystrophin) (eg, Duchenne/Becker muscular dystrophy) deletion analysis, and duplication analysis, if performed	Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform)
3		CMS Code	Staff Type	Minutes	Minutes
4	Global Period			XXX	XXX
5	TOTAL CLINICAL LABOR TIME			158	158
6	Lab Tech	L033A		18	18
7	Cytotechnologist	L045A		140	140
8	TOTAL PRE-SERV CLINICAL LABOR TIME			147	147
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME				
10	TOTAL POST-SERV CLINICAL LABOR TIME			11	11
11	PRE-SERVICE				
12	Start: When preparing containers/requisitions for physician begins				
13	Confirm orders	L033A	Lab Tech	1	1
14	Accession specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6	6
15	DNA Extraction	L045A	Cytotechnologist	4	4
16	PCR Set-up	L045A	Cytotechnologist	36	36
17	PCR Gel (L8: 28products)	L045A	Cytotechnologist	20	20
18	PCR Post Processing 1	L045A	Cytotechnologist	37	37
19	Post PCR Processing 2	L045A	Cytotechnologist	31	31
20	Post PCR Processing 3	L045A	Cytotechnologist	10	10
21	Review sample and prepare data for physician interpretation	L045A	Cytotechnologist	2	2
22	End: When specimen is ready for examination by physician				
23	Service Period				
24					
25	Post-Service Period				
26	Start: When specimen examination by physician is complete				
27	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2	2
28	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2	2
29	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2	2
30	Clean Room	L033A	Lab Tech	2	2
31	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2	2
32	Perform scheduled data management back-up	L033A	Lab Tech	1	1
33	End: When specimen, chemical waste and record handling is complete				
34	SUPPLIES		Type of Unit		
35	DNA isolation kit		reaction	1	1
36	Gown	SB027	item	1	1
37	Gloves, nonsterile	SB022	pair	5	5
38	Bleach 10%	SL020	ml	1.5	1.5
39	High fidelity hot start Taq polymerase		ul	15	15
40	PCR buffer		ul	300	300
41	MgCl2		ul	90	90
42	F Primer X 30		ul	X	2
43	R Primer X 30		ul	X	2
44	F Primer X 80		ul	2	
45	R Primer X 80		ul	2	
46	dNTPs		ul	60	60
47	PCR grade water	SL244	ul	2040	2040
48	Ethidium bromide (10 mg/ml)	SL239	ul	10	10
49	DNA ladder, 100bp		ul	10	10
50	Loading buffer with dye	SL210	ul	40	40
51	Agarose ultrapure		g	1.6	1.6
52	Agarose NuSieve GTG		g	3.2	3.2
53	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	200	200
54	Masking tape		inch	24	24
55	96 Capillary array		item	1/200	1/200
56	Cycle sequencing kit		item	X	480
57	Cycle sequencing purification plates		each	X	1
58	Optical 96 well reaction plate		each	1	1
59	Sequencing primers		ul	X	120
60	0.2 mL strip tubes		each	8	8
61	0.2 ml PCR tubes		each	31	31
62	Milli-Q water		ml	35	35
63	Exonuclease I / Shrimp alkaline phosphatase		ul	X	60
64	Septa		each	0.3	0.3
65	Sequencing cassette		each	X	1
66	Polymer		ul	30/125	30/125
67	Formamide	SL192	ul	900	900
68	15 mL centrifuge tubes	SL241		2	2
69	50 mL centrifuge tubes			2	2
70	2 mL plastic tubes		each	30	30
71	Running buffer		ul	80	80
72	0.5 mL microcentrifuge tubes			40	40
73	Barrier pipet tips1000 uL		ul	7	7
74	Barrier pipet tips 200 uL		each	60	60
75	Barrier pipet tips 20uL		each	420	420
76	Extraction tubs		each	4	4
77	Extraction tip assembly		each	1	1
78					
79	Equipment				
80	Analytical balance		EP004	2	2
81	Capillary electrophoresis instrument, 96 well - MLPA/Fragment			84	84
82	Capillary electrophoresis MLPA/Fragment software			84	84
83	Centrifuge		EP059	3	3
84	Cooling block			3	3
85	Gel electrophoresis apparatus with power supply		EP063	30	30
86	Gel imaging system		EP062	8	8
87	Micro-volume spectrophotometer with specimen retention technology			1	1
88	Nucleic acid extraction instrument			5	5
89	Nucleic acid workstation			36	36
90	Pipet set		EP071	45	45
91	Thermal cycler			141	141
92	Water bath		EP043	10	10

AMA/Specialty Society RVS Update Committee Summary of Recommendations  
*CMS-Other - Utilization over 500,000 and CMS High Expenditure Procedural Codes screens*

October 2012

**Immunohistochemistry**

In April 2011, the Relativity Assessment Workgroup (RAW) identified CPT code 88342 as a “CMS/Other” valued service with Medicare utilization of 500,000 or more. In addition, the code was identified by CMS as a High Expenditure Procedural code and in January 2012, the specialty society submitted an Action Plan to the RAW stating that referral to the CPT Editorial Panel was necessary. When CPT code 88342 was valued in 2003, the pathologist viewed one antibody per slide. However, since that review multiple antibodies can now be viewed per slide and the service was being reported for multiple units during the same session. Therefore, the College of American Pathologists (CAP) requested a CPT code change proposal to provide proper clarity to the service through a better definition of code 88342 and the establishment of a new add-on code 88343. The base code will now be reported once for the first separately identifiable antibody and the add-on service will be billed for each additional separately identifiable antibody thereafter.

**88342 Immunohistochemistry or immunocyto-chemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear; first separately identifiable antibody per slide**

The RUC reviewed the survey results from 198 pathologists and agreed with the specialty society that 20 minutes of intra-service time accurately accounts for the physician work involved in this service. The RUC then reviewed the survey respondents’ estimated work RVUs and agreed with the specialty that a work RVU of 0.60, the survey 25<sup>th</sup> percentile and less than the current work RVU of 0.80, is appropriate for CPT code 88342. To justify this value, the RUC reviewed the key reference service and MPC code 88305 *Level IV - Surgical pathology, gross and microscopic examination* (work RVU= 0.75) and agreed that the reference code should be valued higher than 88342 because it has 5 additional minutes of intra-service time, with similar intensity and complexity. In addition, the RUC compared the surveyed code to CPT code 88387 *Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); each tissue preparation (eg, a single lymph node)* (work RVU= 0.62) and agreed that since both codes have identical intra-service time, 20 minutes, they should be valued similarly. **The RUC recommends a work RVU of 0.60 for CPT code 88342.**

**88343 Immunohistochemistry or immunocytochemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear; each additional separately identifiable antibody per slide**

The RUC reviewed the survey results from 133 pathologists and agreed with the specialty society that 10 minutes of intra-service time accurately accounts for the physician work involved in this service. The RUC then reviewed the survey respondents’ estimated work RVUs and agreed with the specialty that the respondents’ 25<sup>th</sup> percentile work RVU of 0.56 is too similar to the work RVU, 0.60, of the base code. To determine an appropriate value for 88343, the RUC reviewed CPT code 88313 *Special stain including interpretation and report; Group II, all other (eg, iron, trichrome), except stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry* (work RVU= 0.24) and agreed that both services have similar physician work and intra-service time, 10 minutes and 13 minutes, respectively. Therefore, the RUC agreed that 88343 should be directly crosswalked to the CPT code 88313, with a work RVU of 0.24, and the understanding that 88343 is a more intense and complex service. The RUC also compared the surveyed code to CPT code 36405 *Venipuncture, younger than age 3 years*,

*necessitating physician's skill, not to be used for routine venipuncture; scalp vein* (work RVU= 0.31) and agreed that while both services have identical intra-service time, 10 minutes, the reference code has some pre and post time and should be valued higher than 88343. Finally, the RUC compared 88343 to the base code 88342 and agreed that with half the intra-service time, 10 minutes compared to 20 minutes, 88343 is appropriately valued at a work RVU of 0.24. **The RUC recommends a work RVU of 0.24 for CPT code 88343.**

#### **Practice Expense:**

The RUC accepted the direct practice expense inputs for all three CPT codes in the family as submitted by the specialty and approved by the Practice Expense Subcommittee.

#### **Work Neutrality:**

The RUC discussed the work neutrality impact of the new reporting structure. It is anticipated that the add-on service 88343 will be billed 10% of the time with 88342. Since the typical scenario in which multiple antibodies would be reviewed in the same session involves the prostate, the specialty estimated 10% of immunohistochemistry services are reported concerning the prostate. Therefore, when providers previously billed multiple units of 88342 the resultant work RVU was 1.70 (0.85 x 2). Under the new reporting structure, this same service will receive 0.84 work RVUs (0.60 + 0.24). The RUC's recommendation for this code will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

<b>CPT Code</b>	<b>Tracking Number</b>	<b>CPT Descriptor</b>	<b>Global Period</b>	<b>Work RVU Recommendation</b>
▲ 88342	B1	Immunohistochemistry <u>or immunocytochemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear (including tissue immunoperoxidase); first separately identifiable each antibody per slide</u>	XXX	0.60
● 88343	B2	each additional separately identifiable antibody per slide (List separately in addition to code for primary procedure)  (Use 88343 in conjunction with 88342)  (When multiple antibodies are applied to the same slide, use one unit of 88342 for the first separately identifiable antibody and one unit of 88343 for each additional separately identifiable antibody)	XXX	0.24

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 88342	Tracking Number	Original Specialty Recommended RVU: <b>0.60</b>
		Presented Recommended RVU: <b>0.60</b>
Global Period: XXX		RUC Recommended RVU: <b>0.60</b>

CPT Descriptor: Immunohisto-chemistry or immunocyto-chemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear; first separately identifiable antibody per slide

(When multiple antibodies are applied to the same slide, use one unit of 88342 for the first separately identifiable antibody and one unit of 8834XX for each additional separately identifiable antibody)

(Do not report 88342 in conjunction with 88360 or 88361 for the same antibody)

(For quantitative or semiquantitative immunohistochemistry, see 88360, 88361)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: Microscopic examination of a CD15 immunohistochemical antibody stain performed on a lymph node of a 25-year-old male with suspected Hodgkin lymphoma.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: The pathologist examines positive control tissue known to contain cells which express CD15 to verify that the procedure is working and the stain is optimized. The pathologist also examines the negative control to check for nonspecific binding and false positive staining. The patient sample is then microscopically examined. The pathologist interprets the staining pattern and determines its significance in its histologic and cellular location. The findings are correlated with the corresponding H&E stained slide, clinical history, previous tissue samples and laboratory tests, and are reported.

Description of Post-Service Work: N/A

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	10/2012				
<b>Presenter(s):</b>	Jonathan Myles, MD and Michael McEachin, MD				
<b>Specialty(s):</b>	Pathology				
<b>CPT Code:</b>	88342				
<b>Sample Size:</b>	2060	<b>Resp N:</b>	198	<b>Response:</b> 9.6 %	
<b>Description of Sample:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	5.00	200.00	<b>500.00</b>	1000.00	9100.00
<b>Survey RVW:</b>	0.24	0.60	<b>0.75</b>	1.10	3.80
<b>Pre-Service Evaluation Time:</b>			<b>0.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>0.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>0.00</b>		
<b>Intra-Service Time:</b>	3.00	12.00	<b>20.00</b>	30.00	70.00
<b>Immediate Post Service-Time:</b>	<b>0.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

<b>CPT Code:</b>	88342	<b>Recommended Physician Work RVU: 0.60</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>20.00</b>		
<b>Immediate Post Service-Time:</b>	<b>0.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00



**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
88305	XXX	0.75	RUC Time

CPT Descriptor Level IV - Surgical pathology, gross and microscopic examination ...**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
11000	000	0.60	RUC Time	102,183

CPT Descriptor 1 Debridement of extensive eczematous or infected skin; up to 10% of body surface

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
76700	XXX	0.81	RUC Time	1,036,657

CPT Descriptor 2 Ultrasound, abdominal, real time with image documentation; complete

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
88387	XXX	0.62	RUC Time

CPT Descriptor Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); each tissue preparation (eg, a single lymph node)**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.****Number of respondents who choose Key Reference Code: 52      % of respondents: 26.2 %****TIME ESTIMATES (Median)**

	<b>CPT Code: 88342</b>	<b>Key Reference CPT Code: 88305</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	20.00	25.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

<b>Median Total Time</b>	<b>20.00</b>	<b>25.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.32	3.75
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.08	3.61
--	------	------

Urgency of medical decision making	4.07	3.73
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.22	3.93
--------------------------	------	------

Physical effort required	3.26	3.17
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.25	3.92
---	------	------

Outcome depends on the skill and judgment of physician	4.49	4.15
--	------	------

Estimated risk of malpractice suit with poor outcome	4.30	3.96
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity		
----------------------------------	--	--

Intra-Service intensity/complexity	3.94	3.80
------------------------------------	------	------

Post-Service intensity/complexity		
-----------------------------------	--	--

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

CPT code 88342 was identified by the AMA RUC Relativity Assessment Workgroup (RAW) as a "CMS/Other"-valued code with Medicare utilization 500,000 or more. Upon review of the 88342 code, it became evident

there is confusion regarding the appropriate units of service for this code. The College of American Pathologists requested a CPT change to provide proper clarity to the service through a better definition of code 88342 and the establishment of a new add-on code 8834XX. CAP's expert panel reviewed the survey and developed its recommendations. The expert panel included CAP's CPT/RUC Workgroup, and representatives from general and academic pathology practice settings. The expert panel reviewed the survey results from 198 respondents and compared the recommended RVW, time and intensity/complexity of 88342 to the key reference service (88305) and other pathology codes such as 88387.

The median RVW was 0.75 and a survey median time of 20 minutes. The expert panel felt the survey respondents appropriately estimated the physician time, however the physician work was slightly overestimated. Panel members agreed that the median RVW was too high in comparison to the intensity and work of the key reference service, CPT code 88305 (Work RVU = 0.75, 25 minutes total time). The panel also reviewed the work and intensities of 88172, 88312, and 88387. They agreed that the intensity of 88342 is identical to that of 88305. The expert panel concluded that the survey's 25<sup>th</sup> percentile work RVU of 0.60 was appropriate and provides proper rank order amongst these services.

**CAP recommends the RVW value of 0.60, and 20 minutes of intra-service time.**

---

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.
- 

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 88342

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology                      How often? Commonly

Specialty Clinical Laboratory                      How often? Commonly

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 6883445

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Approximately 50% of the patients are Medicare beneficiaries. There are 3,824,136 estimated claims listed in the RUC database for 2011. This number multiplied by 2 equals 7,648,272. 90% of these are estimated for 88342 under the new coding structure, which results in an estimate of 6,883,445.

Specialty Clinical Laboratory	Frequency 4276684	Percentage 62.12 %
Specialty Pathology	Frequency 2310084	Percentage 33.55 %
Specialty Dermatology	Frequency 196178	Percentage 2.84 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3,441,722 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 90% Estimated 2011 global and 26 Medicare claims data from 2012 V2 RUC Database.

Specialty Clinical Laboratory	Frequency 2138342	Percentage 62.13 %
Specialty Pathology	Frequency 1155042	Percentage 33.56 %
Specialty Dermatology	Frequency 98089	Percentage 2.84 %

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 88342

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 88343	Tracking Number	Original Specialty Recommended RVU: <b>0.24</b>
		Presented Recommended RVU: <b>0.24</b>
Global Period: XXX		RUC Recommended RVU: <b>0.24</b>

CPT Descriptor: Immunohisto-chemistry or immunocyto-chemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear; each additional separately identifiable antibody per slide

(Use 88343 in conjunction with 88342)

(When multiple antibodies are applied to the same slide, use one unit of 88342 for the first separately identifiable antibody and one unit of 88343 for each additional separately identifiable antibody)

(Do not report 88342 in conjunction with 88360 or 88361 for the same antibody)

(For quantitative or semiquantitative immunohistochemistry, see 88360, 88361)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: Microscopic examination of an immunohistochemical P504S antibody stain after examination of the first antibody, HMWK (34βE12) in a cocktail of P504S and HMWK (34βE12) performed on a prostate needle core biopsy from a 66 year-old male with elevated PSA.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: NA

Description of Intra-Service Work: After examination of the first antibody, HMWK (34βE12), the pathologist examines positive control tissue known to contain cells which express the second antibody in the cocktail, P504S, to verify that the procedure is working and the stain is optimized for the second antibody. The patient sample is then microscopically examined. The pathologist interprets the staining pattern and determines its significance in its histologic and cellular location. The findings are correlated with the staining pattern of the 34βE12 antibody staining and reported.

Description of Post-Service Work: NA

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	10/2012				
<b>Presenter(s):</b>	Jonathan Myles, MD and Michael McEachin, MD				
<b>Specialty(s):</b>	Pathology				
<b>CPT Code:</b>	88343				
<b>Sample Size:</b>	2060	<b>Resp N:</b>	133	<b>Response:</b> 6.4 %	
<b>Description of Sample:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	30.00	100.00	500.00	10000.00
<b>Survey RVW:</b>	0.22	0.56	0.75	1.10	2.80
<b>Pre-Service Evaluation Time:</b>			0.00		
<b>Pre-Service Positioning Time:</b>			0.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.00		
<b>Intra-Service Time:</b>	3.00	10.00	15.00	30.00	60.00
<b>Immediate Post Service-Time:</b>	<b>0.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

<b>CPT Code:</b>	88343	<b>Recommended Physician Work RVU: 0.24</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		0.00	0.00	0.00
<b>Pre-Service Positioning Time:</b>		0.00	0.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	0.00	0.00
<b>Intra-Service Time:</b>		10.00		
<b>Immediate Post Service-Time:</b>	<b>0.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00		

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
88305	XXX	0.75	RUC Time

CPT Descriptor Level IV - Surgical pathology, gross and microscopic examination ...**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
94010	XXX	0.17	RUC Time	1,296,698

CPT Descriptor 1 Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
36405	XXX	0.31	RUC Time	1

CPT Descriptor 2 Venipuncture, younger than age 3 years, necessitating physician's skill, not to be used for routine venipuncture; scalp vein

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
88313	XXX	0.24	RUC Time

CPT Descriptor Special stain including interpretation and report; Group II, all other (eg, iron, trichrome), except stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 34      % of respondents: 25.5 %

**TIME ESTIMATES (Median)**

	CPT Code: 88343	Key Reference CPT Code: 88305	Source of Time RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	10.00	25.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>10.00</b>	<b>25.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.20	3.77
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.08	3.72
--	------	------

Urgency of medical decision making	4.22	3.92
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.36	4.06
--------------------------	------	------

Physical effort required	3.35	3.31
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.39	3.98
---	------	------

Outcome depends on the skill and judgment of physician	4.57	4.23
--	------	------

Estimated risk of malpractice suit with poor outcome	4.40	4.05
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity		
----------------------------------	--	--

Intra-Service intensity/complexity	4.11	3.82
------------------------------------	------	------

Post-Service intensity/complexity		
-----------------------------------	--	--

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*



CPT code 88342 was identified by the AMA RUC Relativity Assessment Workgroup (RAW) as a "CMS/Other"-valued code with Medicare utilization 500,000 or more. Upon review of the 88342 code, it became evident there is confusion regarding the appropriate units of service for this code. The College of American Pathologists requested a CPT change to provide proper clarity to the service through a better definition of code 88342 and the establishment of a new add-on code 88343. The creation of add on code 88343 separates the physician work of each additional separately identifiable antibody per slide. CAP's expert panel reviewed the survey and developed its recommendations. The expert panel included CAP's CPT/RUC Workgroup, and representatives from general and academic pathology practice settings. The expert panel reviewed the survey results from 133 respondents and compared the recommended RVW, time and intensity/complexity of 88342 to the key reference service (88305) and other pathology codes such as 88313.

The survey had a response rate of 133 out of 2060 surveyed. The median RVW was 0.75 and a survey median time of 15 minutes. The expert panel felt the survey respondents overestimated the physician time and work for this add-on service. Panel members agreed that the median RVW was too high in comparison to the intensity and work of the key reference service, CPT code 88305 (Work RVU = 0.75, 25 minutes total time). The panel also reviewed the work and intensities of other codes on the reference service list and agreed that the intensity of 88343 is lower than that of 88305. Therefore, CAP's expert panel agreed that the survey's median time and 25<sup>th</sup> percentile work RVU of 0.54 were too high. The Panel agreed that a crosswalk recommendation was more appropriate for this service as a recommendation below the 25<sup>th</sup> percentile was being made. They agreed that the overall work of 88343 is similar to that of 88313 which has a similar total time of 13 minutes with a Work RVU of 0.24.

The work of 88313 and 88343 is comparable. 88313 involves the microscopic examination of a histologic special stain and the add-on service 88343 involves Microscopic examination of an immunohistochemical P504S antibody stain after examination of the first antibody. They are both ancillary studies and both involve stains performed on a biopsy specimen. CAP's expert panel concluded that the work of 88343 is more intense than 88313 and requires slightly less time, therefore the survey's 25<sup>th</sup> percentile physician time of 10 minutes was considered typical rather than the 50<sup>th</sup> percentile. **CAP recommends that physician work of 88313 be cross-walked to new CPT code 88343 for a relative physician work value of 0.24, and 10 minutes of intra-service time.**

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 88342

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Clinical Laboratory                      How often? Commonly

Specialty Pathology                      How often? Commonly

Specialty Dermatology                      How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 764827

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. CAP estimates that utilization of this code will be 10% of the current 88342 utilization. 88342 Medicare volume represents approximately 50% of the claims. These numbers are estimated from Medicare estimates for 2011 from the RUC Database 2012 v2.

Specialty Clinical Laboratory	Frequency 475187	Percentage 62.12 %
-------------------------------	------------------	--------------------

Specialty Pathology	Frequency 256676	Percentage 33.56 %
---------------------	------------------	--------------------

Specialty Dermatology	Frequency 21798	Percentage 2.85 %
-----------------------	-----------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 382,414 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. CAP estimates that utilization of this code will be 10% of the current 88342 utilization. 88342 Medicare volume represents approximately 50% of the claims. These numbers are estimated from Medicare estimates for 2011 from the RUC Database 2012 v2

Specialty Clinical Laboratory	Frequency 237594	Percentage 62.13 %
-------------------------------	------------------	--------------------

Specialty Pathology	Frequency 128338	Percentage 33.55 %
---------------------	------------------	--------------------

Specialty Dermatology	Frequency 10899	Percentage 2.85 %
-----------------------	-----------------	-------------------

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 88342

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
3	ISSUE: Immunohistochemistry																			
4	TAB: 12																			
5						RVW				Total	PRE-TIME			INTRA-TIME					IMMD	
6	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
7	REF	88305	Level IV - Surgical pathology, gross and microscopic examination	165	0.030			0.75			25						25			
8	CURRENT	88342	Immunohistochemistry (including tissue immunoperoxidase), each antibody	NA	0.031			0.85			27						27			
9	SVY	88342	Immunohisto-chemistry or immunocyto-chemistry, each separately identifiable antibody	198	0.038	0.24	0.60	0.75	1.10	3.80	20				3	12	20	30	70	
10	REC	88342	Immunohisto-chemistry or immunocyto-chemistry, each separately identifiable antibody	198	0.030	0.60					20						20			
11	SVY	88343	Immunohisto-chemistry or immunocyto-chemistry, each separately identifiable antibody	133	0.050	0.22	0.56	0.75	1.10	2.80	15				3	10	15	30	60	
12	REC	88343	Immunohisto-chemistry or immunocyto-chemistry, each separately identifiable antibody	133	0.024	0.24					10						10			
13																				

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor:

Immunohisto-chemistry or immunocyto-chemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear; first separately identifiable antibody per slide

(When multiple antibodies are applied to the same slide, use one unit of 88342 for the first separately identifiable antibody and one unit of 8834XX for each additional separately identifiable antibody)

(Do not report 88342 in conjunction with 88360 or 88361 for the same antibody)

(For quantitative or semiquantitative immunohistochemistry, see 88360, 88361)

Global Period: XXX Meeting Date: October 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Individuals with expertise in this service were consulted through a series of conference calls in order to develop the typical practice expense inputs. CAP's expert panel reviewed and compiled PE inputs and made adjustments to the clinical labor, supplies, and equipment. These inputs were further refined with individual pathologists who perform this service.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:  
88342 is the service being revised.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

N/A

Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

N/A

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor:

Immunohisto-chemistry or immunocyto-chemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear; first separately identifiable antibody per slide

(When multiple antibodies are applied to the same slide, use one unit of 88342 for the first separately identifiable antibody and one unit of 8834XX for each additional separately identifiable antibody)

(Do not report 88342 in conjunction with 88360 or 88361 for the same antibody)

(For quantitative or semiquantitative immunohistochemistry, see 88360, 88361)

Global Period: XXX Meeting Date: October 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Individuals with expertise in this service were consulted through a series of conference calls in order to develop the typical practice expense inputs. CAP's expert panel reviewed and compiled PE inputs and made adjustments to the clinical labor, supplies, and equipment. These inputs were further refined with individual pathologists who perform this service.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: 88342 is the service being revised.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Initially, the immunohistochemistry stain order is verified and accessioned into the laboratory information system. Control blocks have been previously embedded in paraffin as per routine histology procedures and are specific for each immunohistochemical antibody used. The histotechnologist pulls and verifies the patient tissue block and the correct control block and carefully cuts the positive control tissue on the microtome per routine histology procedures. The patient tissue block is then cut on the microtome and placed on the same slide with the positive control tissue. The patient tissue block is then again cut on the microtome and placed on a separate slide for the negative control.

The slides then are placed in the isotemp oven, incubated for 60 minutes, and removed.

Patient data is entered into the Ventana Ultra system with the specific antibodies to be used. Slide barcode labels are generated and placed on slides.

The histotechnologist typically then removes the detection kit and antibodies from refrigerator, loads the antibody, detection kit dispensers and required reagents onto the reagent tray and places the tray on the automated slide stainer. The slides are loaded onto the automated slide stainer, and the equipment is started. The slides are removed from the instrument after they are stained, placed in a slide holder, and rinsed in soapy water so that the coverslip material is removed. Slides are then dehydrated, cleared, and coverslipped by hand with permanent mounting media.

Positive and negative control slides are reviewed. Workload recordings are logged, and the slides and paperwork are collated. Slides and paperwork are then delivered to the pathologist.

Service Clinical Labor Activities:

None.

Post-Service Clinical Labor Activities:

Typically, the histotechnologist then re-files the block, unloads and stores the antibody, the detection kit and reagents. The lab technician cleans the equipment and work station in the histology lab. The lab technician then disposes the hazardous waste material and specimens.

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor:

Immunohisto-chemistry or immunocyto-chemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear; each additional separately identifiable antibody per slide

(Use 88343 in conjunction with 88342)

(When multiple antibodies are applied to the same slide, use one unit of 88342 for the first separately identifiable antibody and one unit of 88343 for each additional separately identifiable antibody)

(Do not report 88342 in conjunction with 88360 or 88361 for the same antibody)

(For quantitative or semiquantitative immunohistochemistry, see 88360, 88361)

Global Period: XXX Meeting Date: October 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Individuals with expertise in this service were consulted through a series of conference calls in order to develop the typical practice expense inputs. CAP's expert panel reviewed and compiled PE inputs and made adjustments to the clinical labor, supplies, and equipment. These inputs were further refined with individual pathologists who perform this service.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:  
88342 is the service being revised.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

N/A

Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

N/A

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor:

Immunohisto-chemistry or immunocyto-chemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear; each additional separately identifiable antibody per slide

(Use 88343 in conjunction with 88342)

(When multiple antibodies are applied to the same slide, use one unit of 88342 for the first separately identifiable antibody and one unit of 88343 for each additional separately identifiable antibody)

(Do not report 88342 in conjunction with 88360 or 88361 for the same antibody)

(For quantitative or semiquantitative immunohistochemistry, see 88360, 88361)

Global Period: XXX Meeting Date:   October 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Individuals with expertise in this service were consulted through a series of conference calls in order to develop the typical practice expense inputs. CAP's expert panel reviewed and compiled PE inputs and made adjustments to the clinical labor, supplies, and equipment. These inputs were further refined with individual pathologists who perform this service.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: 88342 is the service being revised.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Prepare positive control block by confirming the control tissue ID.

The histotechnologist typically then removes the detection kit and antibodies from refrigerator, loads the secondary antibody, detection kit dispensers and required reagents onto the reagent tray and places the tray on the automated slide stainer. Check positive and negative controls.

Service Clinical Labor Activities:

None.

Post-Service Clinical Labor Activities:

Unload and store antibody, detection kit and reagents.



	A	B	C	D	E	F	G	H	I
	AMA Specialty Society Recommendation								
1	<b>Final Recommendation from the PE Subcommittee</b>							<b>Previously Recommended</b>	
2				<b>88342</b>		<b>88343</b>		<b>88342</b>	
3	Meeting Date: October 2012 Tab: 12 Specialty: Pathology	CMS Code	Staff Type	Immunohisto-chemistry or immunocyto-chemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear; first separately identifiable antibody per slide		Immunohisto-chemistry or immunocyto-chemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear; each additional separately		Immunohisto-chemistry or immunocyto-chemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear; first separately identifiable	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			XXX	XXX	XXX	XXX	XXX	XXX
6	TOTAL CLINICAL LABOR TIME			31.0	NA	4.0	NA	74 *	NA
7	TOTAL HISTOTECHNOLOGIST	L037B	Histotech	21.0	NA	4.0	NA	74*	NA
8	TOTAL LAB TECHNICIAN	L033A	Lab Tech	10.0	NA	0.0	NA	0	NA
9	TOTAL PRE-SERV CLINICAL LABOR TIME			24.0	NA	3.0	NA	2.0	NA
10	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			0.0	NA	0.0	NA	62.0	NA
11	TOTAL POST-SERV CLINICAL LABOR TIME			7.0	NA	1.0	NA	20.0	NA
12	<b>PRE-SERVICE</b>								
13	<b>Start: When physician order for stain is received</b>								
14	Verify order and accession immunohistochemical stain order in laboratory information system	L033A	Lab Tech	1				2	
15	Pull and verify tissue block and control block	L037B	Histotech	1					
16	Prepare positive control block to include the following: Confirm control tissue ID. Embed tissue in paraffin. Take cassette out of embedding chamber, open cassette, put paraffin in bottom of embedding mold, embed tissue, put cassette on top of mold and fill mold with paraffin. Put mold on cold plate. Take embedded specimen out of mold, transfer to cutting cold plate. Add paraffin to embedding melting pot and clean embedding center.	L037B	Histotech	1		1			
17	Cut patient tissue and place on slide with positive control to include the following: - Section paraffin block in microtome, place section in water bath; label and place on microscopic slide from waterbath includes change and insert knife, rough-cut block.	L037B	Histotech	3					
18	Cut positive control tissue and place on slide	L037B	Histotech	3					
19	Cut patient tissue and place on negative control slide	L037B	Histotech	2					
20	Place slides in oven and incubate for 60 minutes, remove from oven	L033A	Lab Tech	1					
21	Enter patient data, computational prep for antibody testing, generate and apply bar codes to slides, and enter data for automated slide stainer	L037B	Histotech	5					
22	Load the primary antibody (load secondary if applicable), detection kit dispensers and required reagents onto the reagent tray and place the tray on the automated slide stainer. Load the slides onto the automated slide stainer, and start stainer. Prime machine with reagents.	L037B	Histotech	3		2			
23	Remove slides from automated slide stainer. Rinse slides in soapy water to remove the coverslip material. Load slides on to cover rack.	L033A	Lab Tech	1					
24	Dehydrate to xylene through progressive alcohols, clear and coverslip by hand with permanent mounting media	L033A	Lab Tech	1					
25	Review positive and negative control slides	L037B	Histotech	1					
26	Complete workload recording logs. Collate slides and paperwork. Deliver to pathologist.	L033A	Lab Tech	1					
27	<b>End: When specimen is ready for examination by physician</b>								
28	<b>SERVICE PERIOD</b>								
29	Prepare specimen for manual/automated processing	L037B	Histotech					20	
30	Process specimen for slide preparation (includes processing, embedding, sectioning and recuts, centrifugation, routine and special staining, coverslipping, quality control function, maintaining specimen tracking, logs and labeling)	L037B	Histotech					40	
31	Assemble and deliver slides with paperwork to pathologist	L037B	Histotech					2	
32	<b>POST-SERVICE Period</b>								
33	<b>Start: When specimen examination by physician is complete</b>								
34	Refile block, unload and store antibody, detection kit and reagents	L037B	Histotech	2		1			
35	Clean equipment and work station in histology lab	L033A	Lab Tech	4					
36	Prepare, pack and transport specimens and records for in-house storage and external storage (where applicable)	L037B	Histotech					7	
37	Clean room/equipment following procedure (including any equipment maintenance that must be done after the procedure)	L037B	Histotech					5	
38	Hazardous waste disposal	L033A	Lab Tech	1					
39	Verify results and complete work load recording logs	L037B	Histotech					8	
40	<b>End: When specimen, waste and record handling is complete</b>								

	A	B	C	D	E	F	G	H	I
	AMA Specialty Society Recommendation								
1	<b>Final Recommendation from the PE Subcommittee</b>							<b>Previously Recommended</b>	
2				<b>88342</b>		<b>88343</b>		<b>88342</b>	
3	Meeting Date: October 2012 Tab: 12 Specialty: Pathology			Immunohisto-chemistry or immunocyto-chemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear; first separately identifiable antibody per slide		Immunohisto-chemistry or immunocyto-chemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear; each additional separately		Immunohisto-chemistry or immunocyto-chemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear; first separately identifiable	
		<b>CMS Code</b>	<b>Staff Type</b>						
4	<b>LOCATION</b>			<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>
5	<b>GLOBAL PERIOD</b>			<b>XXX</b>	<b>XXX</b>	<b>XXX</b>	<b>XXX</b>	<b>XXX</b>	<b>XXX</b>
41	<b>MEDICAL SUPPLIES</b>	<b>CODE</b>	<b>UNIT</b>						
42	gloves, non-sterile, nitrile	SB023	pair	1				1	
43	AEC buffer	SL002	ml					2	
44	AEC chromogen	SL003	ml					0.12	
45	antibody HMB-45	SL011	ml					0.12	
46	background block	SL017	ml					5	
47	biotinylated link (mouse, rabbit)	SL019	ml					0.4	
48	clearing agent (Histo-clear)	SL026	ml					16	
49	hematoxylin reagent	SL077	ml					8	
50	label for microscope slides	SL085	item					4	
51	mounting media (Histomount)	SL095	ml					2	
52	peroxide block	SL102	ml					50	
53	phosphate buffered saline packet (Zeus)	SL106	item					1	
54	positive control slide	SL112	item					1	
55	slide, microscope	SL122	item	2				4	
56	streptavidin label	SL142	ml					0.4	
57	tissue revival soln	SL145	ml					50	
58	gown, staff, impervious	SB027	item	0.2				1	
59	blade, microtome	SF004	item	0.3				1	
60	cover slip, glass	SL030	item	2				4	
61	Confirm anti-CD15 Mouse Monoclonal Antibody (Ventana 760-2504)	1	ml	0.1					
62	E-bar labels (Ventana 1358501)	2	item	2					
63	E-Bar Printer Ribbon (Ventana 1632900) (prints 8100 labels)	3	item	0.00024691					
64	Permanent marking pen	4	item	0.0065					
65	Reaction buffer 10X (Ventana 950-300)	3	ml	6		3			
66	Liquid coverslip (Ventana 650-010)	3	ml	12		6			
67	SSC (10X) (Ventana 950-110)	3	ml	4.8					
68	EZ Prep (10X) (Ventana 950-102)	3	ml	3					
69	Cell Conditioning 1 (Ventana 950-124)	5	ml	3					
70	Hematoxylin II (Ventana 790-2208)	6	ml	0.2					
71	Bluing reagent (Ventana 760-2037)	6	ml	0.2					
72	Cover slip glue/Mounting media	7	ml	0.5					
73	95% ethanol	SL248	ml	50					
74	100% ethanol	SL189	ml	50					
75	Xylene	SL151	ml	50					
76	soap, liquid, antibacterial	SM024	oz	0.1					
77	250 Test Prep Kit # 78 (Ventana 786-3034)	8	item			0.004			
78	monoclonal rabbit anti-AMACR, clone 13 H4 (Cell Marque)	9	ml			0.1			
79	UltraView Universal DAB Detection Kit	10	ml	0.2					
80	UtraView Universal Alkaline Phosphatase Red Detection Kit	11	ml			0.2			
81	Wipes, lens cleaning (per wipe) (Kimwipe)	SM027	item	2					
82	Bleach	SL020	ml	10					
83	Eye shield,non-fog	SG049	item	0.1					
84	Specimen, solvent, and formalin disposal cost	cost sht /invoices	dollars	0.35					
85	gauze, non-sterile 4in x 4in	SG051	item	4		2			
86	<b>EQUIPMENT</b>	<b>CODE</b>							
87	hood, ventilator with blower	EP019						10	
88	microscope, compound	EP024		20		10		33	
89	slide dryer	EP034						30	
90	water bath, general purpose (lab)	EP043		8				5	
91	microtome	ER041		8				5	
92	Benchmark ULTRA automated slide preparation system	invoice		15		33			
93	E-Bar II Barcode Slide Label System	see line 92		3					
94	solvent recycling system	EP038		12				30	
95	decloaking chamber (DC2002)	EP009						30	
96	isotemp, oven	EP049		4					
97	hood, fume	EP017		1					
98	Laboratory Information System with maintenance contract	invoice		2					
99	Copath System Software	invoice		2					
100									
101	* The RUC submitted recommendation from August 2001 indicated a total of 84 minutes in the detailed steps, However the summarization totaled 74 minutes, and that is what AMA Specialty Society was taken out of the service period time. 100% Histotechnologist time.								

AMA/Specialty Society RVS Update Committee Summary of Recommendations  
*MPC List Screen*

January 2013

**Optical Endomicroscopy**

In the 2012 Medicare Physician Fee Schedule (MFS) Final Rule the Centers for Medicare and Medicaid Services (CMS) requested that the RUC review CPT codes 43235 and 45378. At the February 2012 CPT Editorial Panel meeting, the specialty societies presented two new endoscopic procedures for optical endomicroscopy: 43206 and 43252 as well as one new pathology procedure for optical endomicroscopy: 88375 *Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session*. In the final rule, CMS stated that if new codes are introduced within a family, the entire family should be reviewed in order to maintain relativity and avoid separate valuations of codes within a specific family. Because the existing family of codes were scheduled for review at either the October 2012 or January 2013 RUC meetings, the RUC agreed with the specialty societies that survey and review of the family of codes should be delayed in order to maintain relativity and meet CMS standards. CPT code 88375 was surveyed and presented at the January 2013 RUC meeting.

**88375 *Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session***

Prior to reviewing the survey results, the RUC reviewed the survey methodology, as approved by the Research Subcommittee, used by the specialty society to ascertain responses to this low volume procedure. The survey results consisted of a random survey of College of American Pathologists (CAP) members combined with outreach to pathologists identified by a specific vendor. The RUC reviewed the survey results from practicing pathologists and recommend the following physician time components: pre-service time of 5 minutes and intra-service time of 25 minutes.

The RUC agreed with the specialty society that the survey 25<sup>th</sup> percentile work RVU of 1.08 is an accurate measure of the physician work involved in this service. To validate this value, the RUC compared the surveyed code to key reference service 88331 *Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen* (work RVU= 1.19) and agreed that although the pathologist will review more images (in real time) during an optical endomicroscopy session, the intensity and urgency of reviewing frozen sections during surgery accounts for the greater physician work in the reference code. The RUC also reviewed CPT codes 11311 *Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm* (work RVU= 1.10) and 88121 *Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology* (work RVU= 1.00) and noted that both codes have identical intra-service time, 25 minutes, as the surveyed code and justifies the recommended work value for 88375. **The RUC recommends a work RVU of 1.08 for CPT code 88375.**

**Practice Expense:**

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

**New Technology:**

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

<b>CPT Code (•New)</b>	<b>Tracking Number</b>	<b>CPT Descriptor</b>	<b>Global Period</b>	<b>Work RVU Recommendation</b>
88375	NN39	Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session <u>(Do not report 88375 in conjunction with 43206 or 43252)</u> <u>(For biopsy specimen pathology use 88305)</u>	XXX	1.08

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 88375      Tracking Number   NN39

Original Specialty Recommended RVU: **1.08**Presented Recommended RVU: **1.08**

Global Period: XXX

RUC Recommended RVU: **1.08**

CPT Descriptor: Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session

(Do not report 88375 in conjunction with 43206 or 43252)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 57-year-old female with reflux symptoms unresponsive to pharmacologic therapy undergoes EGD. A suspicious 3 cm segment in the distal esophagus is identified and endoscopic biopsies are taken with real-time interpretive assessment of the optical endomicroscopy images by a pathologist to identify the areas of highest yield for biopsy for subsequent anatomic pathology examination.

Percentage of Survey Respondents who found Vignette to be Typical: 85%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The pathologist reviews the clinical history and referral information.

Description of Intra-Service Work: The pathologist reviews the optical endomicroscopy images in real-time, and informs and guides the endoscopist through concurrent verbal, electronic or telephone communication regarding the need for, and topography from which to obtain, specimens. The pathologist issues a report of the interpretation of the image(s) and any recommendations made.

Description of Post-Service Work: N/A

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	01/2013				
<b>Presenter(s):</b>	Jonathan Myles, MD, Michael McEachin, MD, and John Hart, MD				
<b>Specialty(s):</b>	College of American Pathologists				
<b>CPT Code:</b>	88375				
<b>Sample Size:</b>	3247	<b>Resp N:</b>	20	<b>Response:</b>	0.6 %
<b>Description of Sample:</b>	Random, manufactures list, and targeted through internet search				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	2.00	<b>13.00</b>	21.00	500.00
<b>Survey RVW:</b>	0.70	1.08	<b>1.40</b>	1.83	4.00
<b>Pre-Service Evaluation Time:</b>			<b>10.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>0.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>0.00</b>		
<b>Intra-Service Time:</b>	10.00	20.00	<b>25.00</b>	34.00	60.00
<b>Immediate Post Service-Time:</b>	<b>8.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

<b>CPT Code:</b>	88375	<b>Recommended Physician Work RVU: 1.08</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>5.00</b>	<b>0.00</b>	<b>5.00</b>
<b>Pre-Service Positioning Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>25.00</b>		
<b>Immediate Post Service-Time:</b>	<b>0.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? Yes

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
88331	XXX	1.19	RUC Time

CPT Descriptor Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
78315	XXX	1.02	RUC Time	97,695

CPT Descriptor 1 Bone and/or joint imaging; 3 phase study

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
78494	XXX	1.19	RUC Time	2,213

CPT Descriptor 2 Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
95819	XXX	1.08	RUC Time

CPT Descriptor Electroencephalogram (EEG); including recording awake and asleep**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.****Number of respondents who choose Key Reference Code: 7      % of respondents: 35.0 %****TIME ESTIMATES (Median)**

	<b>CPT Code: 88375</b>	<b>Key Reference CPT Code: 88331</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	5.00	0.00	
Median Intra-Service Time	25.00	25.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

<b>Median Total Time</b>	<b>30.00</b>	<b>25.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.83	4.83
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.33	3.17
Urgency of medical decision making	4.83	4.67

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.00	4.00
Physical effort required	3.33	3.33

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.67	4.50
Outcome depends on the skill and judgment of physician	4.83	4.83
Estimated risk of malpractice suit with poor outcome	4.17	4.33

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.83	2.33
Intra-Service intensity/complexity	4.50	4.33
Post-Service intensity/complexity	2.50	2.50

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The College of American Pathologists (CAP) conducted 3 separate survey efforts to obtain physician work data on CPT code 88375 - Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session.



Each survey was identical. The first survey effort was a random survey of 3,063 CAP members for which we received 9 respondents. The second survey effort was to 5 pathologists who were identified by one of the equipment vendors, and we received 2 respondents. The third survey effort was to 179 pathologists identified from a list of medical centers that had contact with the same vendor. There were 9 respondents from this third survey effort. There were a total of 20 respondents from the three surveys. In collating the data, CAP assumed that the second and third survey efforts were non-random and the first survey effort to be random. The random and non-random method of data collection was previously approved by the RUC's Research Subcommittee. Below are the survey results of the random, non-random, and combined data:

	Non Random	Random	Combined	Combined		
				Pre Time	Intra- Time	Post Time
Low	0.75	0.70	0.70	2	10	2
25th percentile	1.29	0.75	1.08	10	20	5
Median	1.50	1.10	1.40	10	25	8
75th percentile	2.50	1.50	1.83	10	34	10
High	4.00	2.60	4.00	20	60	30

CAP convened an expert panel composed of its Economic Affairs Committee, the Economic Affairs Committee CPT/RUC Workgroup, and representative members of academic and community practice. The expert panel reviewed the survey results and compared the physician work to previously RUC valued services which include:

- 1) 88331- Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen (Work RVU = 1.19, 25 minutes intra time, IWPUT = 0.0476, RUC Reviewed October 2010).
- 2) 88333 - Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), initial site (Work RVU = 1.20, 25 minutes intra time, IWPUT = 0.048, RUC Reviewed April 2005, MPC listed).
- 3) 88173 - Cytopathology, evaluation of fine needle aspirate; interpretation and report (Work RVU = 1.39, 15 minutes pre-service, 25 minutes intra, 10 minutes post, IWPUT = 0.0332, RUC Reviewed April 2010, MPC listed).
- 4) 95819 - Electroencephalogram (EEG); including recording awake and asleep (Work RVU = 1.08, 5 minutes pre time, 15 minutes intra time, 10 minutes post, IWPUT = 0.0496, RUC Reviewed August 2005, MPC listed)
- 5) 99213 - Office or other outpatient visit for the evaluation and management of an established patient, (Work RVU = 0.97, 3 minutes pre-service, 15 minutes intra service, 5 minute post, IWPUT = 0.0527, RUC reviewed February 2006, MPC listed).

CAP believes the combined survey data provides the best assistance in the valuation of 88375. Including all of the survey data from all survey sources allows a sufficient number of respondents to make meaningful recommendations; each individual survey did not contain sufficient response rates to make conclusive recommendations. Although our survey respondents indicated there is 10 minutes of pre-service time, the expert panel felt a pre-service evaluation time of 5 minutes was more appropriate. In addition, consulted experts indicated the intra-service time has ranged from greater than 60 minutes to as low as 10 minutes, however typically the intra-service time is 25 minutes. The expert panel felt that there is no post-service time and therefore CAP is not recommending any post-service time. **CAP recommends a physician work relative value of 1.08, pre-service time of 5 minutes, and an intra-service time of 25 minutes.** The recommended work RVU of 1.08 provides an IWPUT of 0.0387.

CAP's experts and economic panel compared the physician work of new service 88375 to its key reference service 88331 and understood that although the pathologist will review more images (in real time) during an optical endomicroscopy session, the intensity and urgency of reviewing frozen sections during surgery accounts for the greater physician work in 88331. **CAP believes the 25<sup>th</sup> percentile survey physician work RVU of 1.08, 5 minutes of pre-service, and the survey's median 25 minute intra-service time, properly rank this new service amongst similar pathology services and other services listed on the RUC's MPC listing.**

---

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. N/A

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 88399 - Unlisted surgical pathology procedure

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology                      How often? Rarely

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Optical endomicroscopy procedures are now performed approximately 2,000 times per year and pathologist interpretation is not typically necessary. The CAP believes 1,000 is a maximum estimate based on the current total number of optical endomicroscopy procedures of 2,000 per year.

Specialty Pathology                      Frequency 1000                      Percentage 100.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 25 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The CAP believes 50% of the typical patients are and will be Medicare beneficiaries.

Specialty Pathology                      Frequency 500                      Percentage 100.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? No

## Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 86335

# SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
10	<b>ISSUE:</b> Optical Endomicroscopy (88375) <b>TAB:</b> 15 <b>Specialty</b> College of American Pathologists																			
11																				
12																				
13																				
14																				
15	Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE-TIME			INTRA-TIME					IMMD
16						MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
17	REF	88331	Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen	65	0.048			1.19			25						25			0
18	SVY	88375	Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session	20	0.027			1.08			43	10					25			8
19	REC	88375	Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session	20	0.039			1.08			25	5					25			0

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor:

Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session

(Do not report 88375 in conjunction with 43206 or 43252)

Global Period: \_XXX

Meeting Date: \_\_January 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

CAP convened an expert panel composed of its Economic Affairs Executive Committee, the Economic Affairs Committee CPT/RUC Workgroup, and representative members of academic and community practice as well as technical experts in the field.

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:  
88331 was chosen as the key reference code for the physician work survey. Code 88375 is similar to code 88331 in that each code requires a time sensitive interpretation and significant interaction between the procedural physician and pathologist.

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time: No additional time beyond standards recommended

4. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Clinical labor staff typically coordinates the scheduling of the pathologist work with the endoscopist and the initial review/entering of patient information into the LIS system.

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

N/A

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor:

Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session

(Do not report 88375 in conjunction with 43206 or 43252)

Global Period: XXX Meeting Date: January 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

CAP convened an expert panel composed of its Economic Affairs Executive Committee, the Economic Affairs Committee CPT/RUC Workgroup, and representative members of academic and community practice as well as technical experts in the field.

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

88331 was chosen as the key reference code for the physician work survey. Code 88375 is similar to code 88331 in that each code requires a time sensitive interpretation and significant interaction between the procedural physician and pathologist.

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time: No additional time beyond standards recommended

4. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: Clinical labor staff typically coordinates the scheduling of the pathologist work with the endoscopist and the initial review/entering of patient information into the LIS system.

Intra-Service Clinical Labor Activities: Clinical labor staff sets up the optical endomicroscopy equipment and assures that all items and records are accessible to the pathologist. Setting the equipment and monitors in place, and making sure all are in working order as it is critical for the real time image review.

After the images are reviewed, all equipment is properly shut down, necessary maintenance functions are performed, cleaned, and stored.

Additional patient findings/images and information are entered and images are transferred and stored in the laboratory.

**CPT Code: \_\_88375**  
**Specialty Society('s)\_College of American Pathologists**

Post-Service Clinical Labor Activities:

None typically at this time.

	A	B	C	D	E	F	G
1				<b>REFERENCE CODE</b>			
2	Post PE Subcommittee Review			<b>88331</b>		<b>88375</b>	
3	Meeting Date: January 2013 Tab: 15 Specialty: Pathology	CMS Code	Staff Type	Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen		Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session (Do not report 88375 in conjunction with 43206 or 43252)	
4	LOCATION			Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			XXX	XXX	XXX	XXX
6	TOTAL CLINICAL LABOR TIME			40.0	0.0	3.0	1.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			5.0	0.0	1.0	1.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			35.0	0.0	2.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
10	PRE-SERVICE			Aug-01	Aug-01		
11	Start: Following visit when decision for surgery or procedure made						
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA				
13	Coordinate pre-surgery services	L037B	Histotechnologist			1	1
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA				
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA				
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA				
17	Other Clinical Activity - Transport specimen from OR to frozen section suite	L033A	Lab Technician	5			
18	End: When patient enters office/facility for surgery/procedure						
19	SERVICE PERIOD						
20	Start: When patient enters office/facility for surgery/procedure:						
21	Assist pathologist with gross specimen examination (including performance of intraoperative frozen sections)	L037B	Histotechnologist	10			
22	Prepare specimen for manual/automated processing	L037B	Histotechnologist	1			
23	Process specimen for slide preparation (includes processing, embedding, sectioning and recuts, centrifugation, routine and special staining, coverslipping, quality control function, maintaining specimen tracking, logs and labeling)	L037B	Histotechnologist	12			
24	Assemble and deliver slides with paperwork to pathologist	L037B	Histotechnologist	2			
25	Prepare room, equipment, and setup video monitoring system						
26	Prepare and position patient/ monitor patient/ set up IV						
27	Sedate/apply anesthesia						
28	Intra-service						
29	Assist physician in performing service						
30	Post-Service						
31	Monitor pt. following service/check tubes, monitors, drains						
32	Clean room/equipment following procedure (including any equipment maintenance that must be done after the procedure)	L037B	Histotechnologist	10			
33							
34	Clean Scope						
35	Clean Surgical Instrument Package						
36	Enter/transfer patient image data and information to lab storage system	L037B	Histotechnologist			2	
37	Review/read X-ray, lab, and pathology reports						
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
39	Other Clinical Activity - specify:						
43	End: Patient leaves office						
44	POST-SERVICE Period						
45	Start: Patient leaves office/facility						
46	Conduct phone calls/call in prescriptions						
55	End: with last office visit before end of global period						



	A	B	C	D	E	F	G
1				<b>REFERENCE CODE</b>			
2	Post PE Subcommittee Review			<b>88331</b>		<b>88375</b>	
3	<b>Meeting Date: January 2013</b> <b>Tab: 15</b> <b>Specialty: Pathology</b>	<b>CMS Code</b>	<b>Staff Type</b>	Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen		Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session (Do not report 88375 in conjunction with 43206 or 43252)	
4	<b>LOCATION</b>			<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>
5	<b>GLOBAL PERIOD</b>			<b>XXX</b>	<b>XXX</b>	<b>XXX</b>	<b>XXX</b>
56	<b>MEDICAL SUPPLIES</b>	<b>CODE</b>	<b>UNIT</b>				
57	blade, microtome	SF004		<b>1</b>			
58	eye shield, non-fog	SG049		<b>2</b>			
59	scalpel with blade, surgical (#10-20)	SF033		<b>1</b>			
60	stain, frozen section, H&E (1ml per slide)	SL134		<b>1</b>			
61	mask, surgical	SB033		<b>2</b>			
62	gloves, non-sterile, nitrile	SB023		<b>2</b>			
63	embedding cassette	SL058		<b>1</b>			
64	cover slip, glass	SL030		<b>2</b>			
65	histology freezing spray (Freeze-it)	SL078		<b>0.1</b>			
66	OCT Tissue-Tek	SL097		<b>2</b>			
67	slide, microscope	SL122		<b>2</b>			
68	label for microscope slides	SL085		<b>2</b>			
69	bleach	SL020		<b>50</b>			
70	wipes, lens cleaning (per wipe) (Kimwipe)	SM027		<b>1</b>			
71	mounting media (Histomount)	SL095		<b>0.2</b>			
72	lab coat, staff	SB030	item	<b>1</b>			
74	<b>EQUIPMENT</b>	<b>CMS code</b>					
75	grossing station w-heavy duty disposal	EP015		<b>10</b>			
76	Microscope, compound	EP024		<b>15</b>			
77	Cryostat	EQ092		<b>8</b>			
78	Surgical Pathology Optical Image Processing and Review Station	Price list				<b>25</b>	
79	Laboratory Information System with maintenance contract	invoices and info submitted recently				<b>2</b>	
80	Copath System Software	invoices and info submitted recently				<b>2</b>	

AMA/Specialty Society RVS Update Committee Summary of Recommendations

October 2012

**Breath Hydrogen Methane Test-PE Only**

In May 2012, this CPT code 91065 *Breath hydrogen test (eg, for detection of lactase deficiency, fructose intolerance, bacterial overgrowth, or oro-cecal gastrointestinal transit)* (RVU = 0.20) was editorially revised by the CPT Editorial Panel to include measurement for hydrogen and methane levels. The CPT modification did not alter the physician work related to the interpretation. The majority, but not all of the population produce hydrogen gas. Approximately 15% of patients are methane producers rather than hydrogen producers, therefore each breath specimens must be measured for both hydrogen and methane levels. The RUC reviewed the specialty societies recommended direct practice expense inputs and revised the clinical staff time, medical supplies, and equipment to match standards established by the PE Subcommittee. **The RUC reviewed and approved the direct practice expense inputs with modifications as recommended by the Practice Expense Subcommittee.**

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲91065	H1	<p>Breath hydrogen <u>or methane</u> test (eg, for detection of lactase deficiency, fructose intolerance, bacterial overgrowth, or oro-cecal gastrointestinal transit)</p> <p><u>(Report 91065 once for each administered challenge)</u></p> <p>(For H. pylori breath test analysis, use 83013 for non-radioactive [C-13] isotope or 78268 for radioactive [C-14] isotope)</p> <p>(91100 has been deleted)</p>	000	<p>0.20</p> <p>(No Change)</p>

**AMA/Specialty Society Update Process**  
**Practice Expense Summary of Recommendation**  
**Non Facility Direct Inputs**

CPT Long Descriptor:

Breath hydrogen or methane test (eg, for detection of lactase deficiency, fructose intolerance, bacterial overgrowth, or oro-cecal gastrointestinal transit)

Global Period: 000 Meeting Date: 10/2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The AGA and ASGE surveyed physicians from a broad range of geographic locations with differing practice circumstances and settings - academic, public and community; solo, small/medium/large single- and multi-specialty groups - who typically perform this service. A committee comprised of representatives from AGA and ASGE served as the consensus panel to review and finalize these recommendations.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- Follow-up phone calls & prescriptions

Service Clinical Labor Activities:

- Greet patient, provide gowning, ensure appropriate medical records are available
- Obtain vital signs
- Provide pre-service education/ obtain consent
- Prepare room, equipment and supplies
- Prepare and position patient/ monitor patient/ set up IV
- Sedate/apply anesthesia
- Assist physician in performing procedure
- Clean room/equipment by physician staff
- Complete diagnostic forms, lab and x-ray requisitions
- Check dressing and wound/home care instructions/ coordinate office visits/prescriptions

Post-Service Clinical Labor Activities:

- Conduct phone calls /call in prescriptions

	A	B	C	D	E	F	G
1				<b>REFERENCE CODE</b>			
2				<b>91065</b>		<b>91065</b>	
3	Meeting Date: 10/2012 Tab: 15 Specialty: AGA, ASGE	CMS Code	Staff Type	Breath hydrogen test (eg, for detection of lactase deficiency, fructose intolerance, bacterial overgrowth, or oro-cecal gastrointestinal transit)		Breath hydrogen or methane test (eg, for detection of lactase deficiency, fructose intolerance, bacterial overgrowth, or oro-cecal gastrointestinal transit)	
4	LOCATION			Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD					000	000
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	62.0	19.0	48.0	22.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	9.0	19.0	9.0	19.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	53.0	0.0	36.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	0.0	3.0	3.0
10	<b>PRE-SERVICE</b>						
11	Start: Following visit when decision for surgery or procedure made						
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	3	3	3	3
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA	3	5	3	5
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5		5
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3	3	3	3
17	Other Clinical Activity - <i>specify</i> :						
18	End: When patient enters office/facility for surgery/procedure						
19	<b>SERVICE PERIOD</b>						
20	Start: When patient enters office/facility for surgery/procedure:						
21	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	5		3	
22	Obtain vital signs	L037D	RN/LPN/MTA	3		3	
23	Review history, systems, and medications	L037D	RN/LPN/MTA	3		0	
24	Enter preservice information into EMR	L037D	RN/LPN/MTA				
25	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	5		3	
26	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2		2	
27	Setup scope (non facility setting only)						
28	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	2		2	
29	Sedate/apply anesthesia						
30	<b>Intra-service</b>						
31	Assist physician in performing procedure	L037D	RN/LPN/MTA	13		13	
32	<b>Post-Service</b>						
33	Monitor pt. following service/check tubes, monitors, drains			5		2	
34	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	10		3	
35	Enter procedure information into EMR	L037D	RN/LPN/MTA				
36	Clean Scope						
37	Clean Surgical Instrument Package						
38	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA	2		2	
39	Review/read X-ray, lab, and pathology reports						
40	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	3		3	
41	Other Clinical Activity - <i>specify</i> :						
42	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			n/a		n/a	
43	Dischrg mgmt (1.0 x 99238) (enter 12 min)			n/a		n/a	
44	Dischrg mgmt (1.0 x 99239) (enter 15 min)			n/a		n/a	
45	End: Patient leaves office						

	A	B	C	D	E	F	G
1				<b>REFERENCE CODE</b>			
2				<b>91065</b>		<b>91065</b>	
3	<b>Meeting Date: 10/2012</b> <b>Tab: 15</b> <b>Specialty: AGA, ASGE</b>	<b>CMS Code</b>	<b>Staff Type</b>	Breath hydrogen test (eg, for detection of lactase deficiency, fructose intolerance, bacterial overgrowth, or oro-cecal gastrointestinal transit)		Breath hydrogen or methane test (eg, for detection of lactase deficiency, fructose intolerance, bacterial overgrowth, or oro-cecal gastrointestinal transit)	
4	<b>LOCATION</b>			<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>
5	<b>GLOBAL PERIOD</b>					<b>000</b>	<b>000</b>
46	<b>POST-SERVICE Period</b>						
47	<b>Start: Patient leaves office/facility</b>						
48	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA			<b>3</b>	<b>3</b>
49	<b>Office visits: List Number and Level of Office Visits</b>			<b># visits</b>	<b># visits</b>	<b># visits</b>	<b># visits</b>
50	99211 16 minutes		16				
51	99212 27 minutes		27				
52	99213 36 minutes		36				
53	99214 53 minutes		53				
54	99215 63 minutes		63				
55	<b>Total Office Visit Time</b>			<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>
56	Other Clinical Activity - <i>specify:</i>						
57	<b>End: with last office visit before end of global period</b>						
58	<b>MEDICAL SUPPLIES</b>	<b>CODE</b>	<b>UNIT</b>				
59	Substrate, D-Xylose, 25 gm Packet	SD241	item	<b>1</b>		<b>1</b>	
60	Water Barriers/Dust Traps (5/Pk)	SD244	item	<b>1</b>		<b>1</b>	
61	Syringe, 35 ml, Monoject, Plastic	SC094	item	<b>1</b>		<b>1</b>	
62	stop cock, 4-way	SC050	item	<b>1</b>		<b>1</b>	
63	bite block	SD006	item	<b>1</b>		<b>1</b>	
64	Tee-Connector, Plastic	SD242	item	<b>1</b>		<b>1</b>	
65	Flutter Valve for Tee-Connector	SD225	item	<b>1</b>		<b>1</b>	
66	QuinGas-3, 150 H2, 75 CH4, 6% CO2, BreathTracker SC Calib	SD234	cc	<b>1</b>		<b>1</b>	
67	Single Patient Discard Bag, 400 ml	SD236	item	<b>1</b>		<b>1</b>	
68	mask, surgical, with face shield	SB034	item	<b>1</b>		<b>1</b>	
69	gown, staff, impervious	SB027	item	<b>1</b>		<b>1</b>	
70	Sivrite-4	SD237	g	<b>7.5</b>		<b>7.5</b>	
71	Filter, Foam Plug (10/Pk)	SD224	item	<b>1</b>		<b>1</b>	
72	lubricating jelly (K-Y) (5gm uou)	SJ032	item	<b>4</b>		<b>4</b>	
73	cap, surgical	SB001	item	<b>1</b>		<b>1</b>	
74	desiccant-absorber	SL048	item	<b>1</b>		<b>1</b>	
75	'biohazard specimen transport bag	SM008	item	<b>1</b>		<b>1</b>	
76	pack, minimum multi-specialty visit	SA048	pack			<b>1</b>	
77	gauze, non-sterile 4in x 4in	SG051	item			<b>1</b>	
78	gloves, non-sterile	SB022	pair			<b>1</b>	
79	<b>EQUIPMENT</b>	<b>CODE</b>					
80	table, exam	EF023		<b>51</b>		<b>36</b>	
81	BreathTrackerDigital SC Instrument, with support stand and patient sample drying tube	EQ294		<b>20</b>		<b>24</b>	
82	light, surgical	EF014		<b>51</b>			
83	suction machine (Gomco)	EQ235		<b>20</b>			

AMA/Specialty Society RVS Update RUC Summary of Recommendations  
*Codes Reported Together 75% or More Screen*

January 2013

**Percutaneous Closure Patent Ductus Arteriosus**

In October 2012, the CPT Editorial Panel established new code 93582 *Percutaneous transcatheter closure of patent ductus arteriosus* with moderate sedation inherent to report percutaneous transcatheter closure of patent ductus arteriosus and editorially revised the parenthetical note following three codes (93462, 93561 and 93562) for proper reporting of these services.

The RUC reviewed the survey results from 41 cardiologists for 93582 and determined that the survey 25<sup>th</sup> percentile work RVU of 14.00 and median intra-service time of 60 minutes appropriately accounts for the physician work and time required to perform this service. The RUC compared the surveyed service to code 92941 *Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel* (RUC recommended work RVU of 12.32 and 70 minutes intra-service time). The RUC reviewed the intra-service description for 93582 and determined that although the surveyed service requires 10 minutes less intra-service time it is more intense compared to the reference code. The specialty societies noted that the physicians who perform this service 20 or more times a year indicated a higher intra-service time of 75 minutes, which supports the comparison to 92941. The RUC agreed that the surveyed service is a rare procedure, therefore the physicians who are more familiar with performing it, more appropriately assessed the time required. Lastly, the RUC noted that 92941 is typically performed on an adult, whereas 93582 is performed on an infant and the work intensity difference between these two services is appropriate.

To gauge the work value differential between performing the same service on a child versus an adult the RUC compared 93530 *Right heart catheterization, for congenital cardiac anomalies* (work RVU=4.22) to 93451 *Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed* (work RVU = 2.72). The differential is 55% between these two services. The RUC reviewed 59076 *Fetal shunt placement, including ultrasound guidance* (work RVU = 8.99) and multiplied it by the observed child/adult work differential ( $8.99 \times 1.55 = 13.95$ ), which results in a work RVU approximately the same as the survey 25<sup>th</sup> percentile work RVU. **The RUC recommends a work RVU of 14.00 for CPT code 93582.**

**RUC Database Flag**

The RUC recommends flagging this code in the RUC database as not to use to validate physician work because the median survey intra-time may not reflect the appropriate intra-service time compared to those who frequently perform this service.

**Practice Expense**

There are no direct practice expense inputs recommended for this service.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<b>Category I</b> <b>Surgery</b> <b>Cardiovascular System</b> <b>Heart and Pericardium</b> <b>Aortic Anomalies</b> 33820            Repair of patent ductus arteriosus; by ligation 33822                      by division, younger than 18 years 33824                      by division, 18 years and older (For percutaneous transcatheter closure of patent ductus arteriosus, use 93582)				
<b>Category I</b> <b>Medicine</b> <b>Cardiovascular</b> <b>Cardiac Catheterization</b>				
✚93462            Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (List separately in addition to code for primary procedure) (Use 93462 in conjunction with 93452, 93453, 93458, 93459, 93460, 93461, 93653, 93654)				



**Injection Procedures**

◎93561 Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; with cardiac output measurement (separate procedure)

◎93562 subsequent measurement of cardiac output

(Do not report 93561, 93562 in conjunction with 93451-93462, 93582)

(For radioisotope method of cardiac output, see 78472, 78473, or 78481)

**Repair of ~~Septal~~ Structural Heart Defect**

◎●93582

U1

Percutaneous transcatheter closure of patent ductus arteriosus

(93582 includes congenital right and left heart catheterization, catheter placement in the aorta, and aortic arch angiography, when performed.

(Do not report 93582 in conjunction with 36013, 36014, 36200, 75600, 75605, 93451-93461, 93530, 93531, 93532, 93533, 93567)

(For other cardiac angiographic procedures performed at the time of transcatheter PDA closure, see 93563, 93564, 93565, 93566, 93568 as appropriate)

(For left heart catheterization by transseptal puncture through intact septum or by transapical puncture performed at the time of transcatheter PD A closure, use 93462)

(For repair of patent ductus arteriosus by ligation, see 33820, 33822, 33824)

(For intracardiac echocardiographic services performed at the time of transcatheter PDA closure, use 93662. Other echocardiographic services provided by a separate physician are reported using the appropriate echocardiography service codes, 93315, 93316, 93317)

000

14.00

37204	U2	Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck	000	RUC recommends Referral to CPT Editorial Panel for Deletion
75894	U3	Transcatheter therapy, embolization, any method, radiological supervision and interpretation	XXX	RUC recommends Referral to CPT Editorial Panel for Revision

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 93582	Tracking Number U1	Original Specialty Recommended RVU: <b>14.00</b>
		Presented Recommended RVU: <b>14.00</b>
Global Period: 000		RUC Recommended RVU: <b>14.00</b>

CPT Descriptor: Percutaneous transcatheter closure of patent ductus arteriosus

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 10-month old presents for evaluation of a continuous heart murmur and is discovered to have a hemodynamically significant patent ductus arteriosus (PDA) by transthoracic echocardiography. The child is asymptomatic with good growth and appetite, yet has moderate left heart enlargement due to chronic left-to-right shunting via the PDA. Due to concern for the long-term effects of this volume overload the child is referred for catheter based intervention.

Percentage of Survey Respondents who found Vignette to be Typical: 71%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 44%

Is moderate sedation inherent to this procedure in the office setting?

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The patient's history, records, laboratory and diagnostic tests are reviewed. This may include review of the echocardiographic or other imaging studies. Physical examination is conducted. A clinical note is generated summarizing the clinical information if a recent note is not available. The patient is prepared for the procedure with careful documentation of baseline clinical findings such as vital signs, arterial pulses, allergies, electrocardiographic findings, laboratory results, family contact information, and other data. Appropriate pharmacologic therapy important for patient safety is ensured. Additional pre-procedure functions include writing orders for adequate sedation and patient support, and a review of study arrangements and procedures with technical, nursing and other assisting personnel. Appropriate communication is conducted with the patient and family as well as other medical professionals as needed. The procedure is reviewed with the patient and family. The risks and benefits of the procedure are presented, as well as the alternatives. Informed consent is obtained. Necessary equipment, instruments and supplies for the procedure are confirmed to be available and operational. The patient is positioned on the procedural table, attached to cardiac electrodes and an oxygen saturation monitor. A sterile table is prepared. The potential access sites are scrubbed in sterile fashion. A sterile drape is placed over the patient. The injection manifold and hemodynamic monitoring tubes and cables are set up. The patient's information is loaded in the hemodynamic monitoring equipment and into the angiographic digital archive in order to retain the data from the upcoming study. A "Time Out" occurs during which confirmation of critical information is ensured, such as the patient's identity, planned procedure, access route, allergies, completion of the consent process, availability of proper equipment, and any unusual circumstances which might influence the procedure. Conscious sedation is administered for those patients who have not required general anesthesia.

Description of Intra-Service Work: Percutaneous venous access is obtained, typically through the femoral vein. A thin-walled needle is inserted percutaneously into the vein through which a flexible guide wire is inserted into the vein. The needle is removed over the wire, a sheath/dilator system is inserted over the guide wire, the dilator is removed, and sidearm of the sheath is flushed to remove any clot or air. A pulmonary artery catheter is inserted through the sheath, a balloon on the tip of the catheter is inflated, and congenital right heart catheterization is performed. The catheter is passed through to the inferior vena cava, superior vena cava, right atrium, right ventricle and into the pulmonary artery. As the catheter tip passes through the heart into the lungs, pressure measurements are obtained within each cardiac chamber or major vessel. The catheter may be advanced further to a point that the balloon tip occludes the pulmonary artery. The pressure transduced from the tip of the catheter in this position represents a pulmonary wedge pressure, an indirect measurement of left atrial and left ventricular end diastolic pressure. Oxygen saturation measurements are obtained to assess for intracardiac shunts and to assess cardiac output. Blood gas measurements may also be performed. Measurements of cardiac output may be obtained. The shunt fraction is calculated. Serial injections may be performed through the catheter to measure thermodilution cardiac output.

A thin-walled needle is inserted percutaneously into a peripheral artery, through which a flexible guide wire is inserted into the artery. The needle is removed over the wire, a sheath/dilator system is inserted over the guide wire, the dilator is removed, and the sidearm of the sheath is flushed to remove any clot or air. An appropriate catheter is inserted over the wire through the sheath into the arterial system under fluoroscopic guidance. The catheter is advanced retrograde through the arterial system to the ascending aorta. The wire is removed and the catheter is attached to the pressure manifold. Pressure is measured in the aortic root. The catheter is then used to cross the aortic valve retrograde into the left ventricle. Left ventricular pressure is measured. The catheter is carefully pulled back across the aortic valve to assess for an aortic valve gradient. The catheter is then pulled back across the aortic arch and then into the descending aorta to assess for coarctation of the aorta.

The pigtail catheter is withdrawn to the level of the patent ductus arteriosus and biplane thoracic aortography is performed to visualize the ductus. More than one aortogram may be required to assess the ductus. Quantitative angiographic measurements are performed on the PDA. The length of the PDA and the diameters of the aortic end, pulmonary end, and body of the PDA are calculated.

Appropriate anticoagulation is administered to therapeutic levels. A catheter is advanced from the femoral artery and placed in the aorta and directed toward the patent ductus arteriosus. Another catheter is advanced into the left pulmonary artery (LPA) at the level of the PDA. A guide wire is advanced through the aortic catheter and attempts are initiated to cross the PDA from the aorta into the LPA. Frequently this requires several different catheters to find the best shape to direct the wire into the PDA. This requires several catheter exchanges over a guide wire to position the different catheters in the aorta at the level of the PDA. Multiple repositioning of the catheter(s) and multiple attempts to cross the PDA are generally required. This frequently also requires multiple angulations of the camera to help direct the wire across. Once the wire is across the PDA marking its location, a separate wire is advanced through the catheter in the LPA and a similar approach is used to try to direct a wire from the LPA across the PDA into the aorta. If this is not successful (as the wire is working against flow from the aorta through the ODA to the LPA), a loop snare is advanced through the PA catheter and positioned in the LPA at the position of the PDA entry site. The snare is used to capture the wire coming from the aorta across the PDA and into the LPA. Typically this requires multiple repositioning of the PA catheter. Once the wire is passed through the snare, the snare is tightened to capture the wire and the wire is brought back through the right heart chambers and out through the femoral vein sheath. This creates a "rail" from the femoral vein, through the right heart, through the LPA, across the PDA into the aorta, and down the aorta to the femoral artery and then out of the body. Exquisite attention is required to prevent wire trauma to the pulmonary valve, tricuspid valve and the subvalvular apparatus.

Once a wire position is established from the LPA across the PDA to the aorta, an appropriate catheter is advanced over the wire from the femoral vein through the right heart, through the PDA and into the descending aorta. The wire is withdrawn through the catheter and replaced with a stiff wire. Next a delivery sheath is advanced over the wire from the femoral vein through the right heart, through the LPA, across the PDA into the aorta, and down into the descending aorta. The sheath is flushed. An appropriate size occlude device is selected. A pigtail catheter is now advanced from the femoral artery up to the level of the PDA again and connected to a power injector. The occluder is advanced through the delivery sheath to near the distal end of the sheath. The sheath is withdrawn back to the aortic entrance to the PDA. The distal end of the occluder is extruded from the sheath and the sheath and occlude are pulled back to seat the device in the aortic entrance to the PDA. Biplane aortogram is performed to ensure the device is seated appropriately at the aortic end. The sheath is then withdrawn while holding tension on the occluder delivery cable to keep it in place. The device is thus deployed in the PDA back to its pulmonary end. Biplane aortogram is now performed to ensure the device is seated appropriately at both the

aortic and pulmonary ends. If the device is not appropriately seated or sized, the delivery sheath is advanced over the device to recapture the occluder. The occluder is removed and the same procedure is performed with a better sized device. Once the device is in proper position angiographically, the device is released by unscrewing its delivery cable from the occluder. At this point, the patient is monitored for device embolization under fluoroscopy.

The patient is then observed for a period of time to ensure the device does not move. Aortography is typically performed again to assess PDA closure and to ensure no aortic trauma. The pigtail is used to recross the aortic valve and remeasure left ventricular end diastolic pressure to ensure the left ventricle is tolerating the increased afterload. The occluder delivery sheath is removed over a wire and a pulmonary artery catheter is often used to repeat the right heart catheterization to assess hemodynamics using the same technique as described for the initial right heart catheterization.

The patient's arterial pressure, electrocardiogram, and oxygen saturation are constantly monitored through the procedure. All catheters are removed once angiography is completed. Images are reviewed to ensure no additional views are required before leaving the procedure suite. Angiography of the access site may be performed to assess for any complications and suitability for a percutaneous closure device. The catheters and sheaths are removed and hemostasis is achieved by appropriate means by the physician or technician under the physician's supervision.

Description of Post-Service Work: Angiographic images and hemodynamics are reviewed and a formal report is generated. The patient family and the referring physician are notified of the results. When appropriate, a plan of management is developed and implemented and discussed with the patient and family. The patient is observed to ensure no bleeding from the access site prior to disposition. Post procedural vital signs and telemetry are monitored to ensure no immediate complication.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	01/2013				
<b>Presenter(s):</b>	Richard Wright, MD; Cliff Kavinsky, MD				
<b>Specialty(s):</b>	ACC, SCAI				
<b>CPT Code:</b>	93582				
<b>Sample Size:</b>	86	<b>Resp N:</b>	41	<b>Response:</b> 47.6 %	
<b>Description of Sample:</b>	Random: survey was distributed to the entire SCAI membership to identify volunteers and surveys were sent to those who indicated they would complete.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	6.00	<b>12.00</b>	20.00	40.00
<b>Survey RVW:</b>	5.00	14.00	<b>15.00</b>	18.00	24.30
<b>Pre-Service Evaluation Time:</b>			<b>65.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>15.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>15.00</b>		
<b>Intra-Service Time:</b>	20.00	60.00	<b>60.00</b>	90.00	150.00
<b>Immediate Post Service-Time:</b>	<b>45.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

3 -FAC Straightforward Patient/Difficult Procedure

<b>CPT Code:</b>	93582	<b>Recommended Physician Work RVU: 14.00</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>33.00</b>	<b>33.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>3.00</b>	<b>3.00</b>	<b>0.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>15.00</b>	<b>15.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>60.00</b>		
<b>Immediate Post Service-Time:</b>	<b>45.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
93580	000	17.97	RUC Time

CPT Descriptor Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
-----------------------	---------------	-----------------	--------------------	---

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
-----------------------	---------------	-----------------	--------------------	---

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
---------------------------------	---------------	-----------------	--------------------

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code:** 33      **% of respondents:** 80.4 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 93582</b>	<b>Key Reference CPT Code: 93580</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	51.00	30.00	
Median Intra-Service Time	60.00	120.00	
Median Immediate Post-service Time	45.00	60.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

<b>Median Total Time</b>	<b>156.00</b>	<b>210.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.21	3.55
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.18	3.61
--	------	------

Urgency of medical decision making	2.85	2.97
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.88	4.03
--------------------------	------	------

Physical effort required	3.33	3.48
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.61	3.91
---	------	------

Outcome depends on the skill and judgment of physician	4.03	4.24
--	------	------

Estimated risk of malpractice suit with poor outcome	3.82	4.12
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.85	3.09
----------------------------------	------	------

Intra-Service intensity/complexity	3.52	3.82
------------------------------------	------	------

Post-Service intensity/complexity	2.94	3.09
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Code 93582 will be used to report transcatheter repair of patent ductus arteriosus (PDA closure). This service has previously been reported with codes 37204 and 75894. These two codes are used to report a wide array of cardiovascular



embolization procedures, and were identified as frequently reported together. ACC, ACR, SIR, and SVS referred the issue to CPT for creation of new bundled codes for relevant services. 93582 addresses only the transcatheter PDA closure service.

An email seeking survey volunteers was sent to the entire membership of the Society for Cardiovascular Angiography and Interventions (SCAI). Surveys were distributed to those who responded, a method previously accepted as random by the RUC. The survey was completed by physicians who have experience providing the service.

A RUC panel from ACC and SCAI reviewed the preservice time and selected package 4 for a difficult procedure on a difficult patient undergoing a procedure in a facility with adjustment to the time for scrub/dress/wait to reflect the survey.

The key reference service is 93580, Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant. Survey respondents indicated that 93582 takes less time and is less intense/complex to perform than 93580. The median survey RVU was 15.00.

We recommend a work RVU of 14.00, the survey 25<sup>th</sup> percentile. The RUC panel determined it is more appropriate than the median for this service. The resulting increase in intensity compared to the key reference code is reasonable since this rare procedure is performed by few cardiologists on infants.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) In 2010, code 37204 (reported with 75894) appeared on the RAW screen identifying codes reported together 75% or more with recommendation made by ACC, ACR, SIR and SVS to refer this service to CPT for the development of new bundled codes that will more accurately reflect the current clinical practice of these procedures. Codes 37204/75894 are currently used to report a very wide array of cardiovascular embolization procedures. This proposal seeks to create a bundled code specific for reporting transcatheter PDA closure. Additionally, commercial carriers' coding guidelines for PDA have not been consistent across the country with at least one carrier recommending use of an unlisted code for one type of transcatheter PDA closure. Using an unlisted code to report such a well-established, typically covered procedure creates an undue burden on practices performing these procedures and carriers claims processing systems.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty cardiology                      How often? Rarely

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 4800

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Without a specific code to report and track utilization for transcatheter PDA closure, we do not have precise utilization estimates. The preliminary number of U.S. births in 2010 was 4,000,279. (Source: [http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60\\_02.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_02.pdf); viewed 6/6/12). From available sources (<http://emedicine.medscape.com/article/891096-overview#a0156>), PDA occurs in 0.002 to 0.008%, supporting estimates of 2,000 to 32,000 babies born each year suffering from PDA. Depending on the physiology, PDA may be treated medically or surgically using either open or transcatheter-based techniques. Using the highest estimates of incidence, and assuming that 15% of these children eventually require treatment using the minimally invasive transcatheter techniques, approximately 4,800 patients could be treated each year with transcatheter PDA closure.

Specialty cardiology	Frequency less than 4800	Percentage 100.00 %
----------------------	--------------------------	---------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States?

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 93580

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
12	ISSUE: Percutaneous Closure of Patent Ductus Arteriosis																			
13	TAB: 16																			
14						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
15	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
16	REF	93580	Percutaneous	33	0.133			17.97			210	30					120			60
17	CURRENT	37204+ 75894	Transcatheter		0.064			18.77			383	60	15	20			253			35
18	SVY	93582	Percutaneous	41	0.201	5.00	14.00	15.00	18.00	24.30	200	65	15	15	20	60	60	90	150	45
19	REC	93582			0.201	14.00					156	33	3	15			60			45
20																				

## AMA/Specialty Society RVS Update Committee Summary of Recommendations

January 2013

### **Percutaneous Alcohol Ablation of Septum**

In October 2012, the CPT Editorial Panel created new code 93583 *Percutaneous transcatheter septal reduction therapy (eg, alcohol septal ablation) including temporary pacemaker insertion when performed* to describe percutaneous transcatheter alcohol septal ablation, a procedure that reduces septal thickness to improve left ventricular outflow tract obstruction in patients with hypertrophic cardiomyopathy.

The specialty society indicated that this is a low volume service, with fewer than 60 physicians actively performing this service in the United States. However, the specialty societies gathered 29 responses with a median service performance rate of 5 in the last year. Given this, the RUC was confident that the survey respondents had adequate knowledge of the service and accurately valued the physician work required to perform this service at the survey 25<sup>th</sup> percentile (work RVU of 14.00).

The specialty societies indicated the pre-service work for this procedure necessitates a detailed analysis and review of all the echocardiographic measurements performed ahead of time, review the coronary angiogram, understanding exactly which tiny hair-like structures the physician will go to before starting the procedure and the physician must have a meticulous plan prior to entering the lab. The RUC determined that 58 minutes pre-time, 90 minutes intra-service time and 40 minutes immediate post-service time is appropriate to perform this service. The RUC compared the surveyed code to key reference service 93580 *Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant* (work RVU = 17.97 and 120 minutes intra-service time) and determined that 93580 requires 30 minutes more intra-service time to perform but requires less mental effort, technical skill and psychological stress than 93583, in which you are inducing a heart attack. The RUC also compared 93583 to 37229 *Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed* (work RVU = 14.05 and 120 minutes intra-service time) to support the recommended value. **The RUC recommends a work RVU of 14.00 for CPT code 93583.**

#### **New Technology**

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

#### **Practice Expense**

This service is primarily performed in a facility and does not have direct practice expense inputs.

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<b>Category I</b> <b>Surgery</b> <b>Cardiovascular System</b> <b>Heart and Pericardium</b> <b>Cardiac Valves</b> <b>Aortic Valve</b> 33416          Ventriculomyotomy (-myectomy) for idiopathic hypertrophic subaortic stenosis (eg, asymmetric septal hypertrophy) (For percutaneous transcatheter septal reduction therapy, use 93583)				
<b>Medicine</b> <b>Cardiovascular</b> <b>Cardiac Catheterization</b> <b>Repair of Septal Structural Heart Defect</b>				
⊙●93583	V1	Percutaneous transcatheter septal reduction therapy (eg, alcohol septal ablation) including temporary pacemaker insertion when performed	000	14.00

		<p><u>(Code 93583 includes insertion of temporary pacemaker, when performed, and left heart catheterization)</u></p> <p><u>(Do not report 93583 in conjunction with 33210, 93452, 93453, 93458, 93459, 93460, 93461, 93531, 93532, 93533, 93565)</u></p> <p><u>(Code 93583 includes left anterior descending coronary angiography for the purpose of roadmapping to guide the intervention. Do not report 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93563 for coronary angiography performed during alcohol septal ablation for the purpose of roadmapping, guidance of the intervention, vessel measurement and completion angiography)</u></p> <p><u>(Diagnostic cardiac catheterization procedures may be separately reportable when no prior catheter-based diagnostic study of the treatment zone is available, the prior diagnostic study is inadequate, or the patient's condition with respect to the clinical indication has changed since the prior study or during the intervention. Use the appropriate codes from 93451, 93454, 93455, 93456, 93457, 93530, 93563, 93564, 93566, 93567, 93568)</u></p> <p><u>(Do not report 93583 in conjunction with 33210, 33211)</u></p> <p><u>(Do not report 93463 for the injection of alcohol for this procedure)</u></p> <p><u>(For intracardiac echocardiographic services performed at the time of alcohol septal ablation, use 93662)</u></p> <p><u>(Other echocardiographic services provided by a separate physician are reported using the appropriate echocardiography services codes, 93312, 93313, 93314, 93315, 93316, 93317)</u></p> <p><u>(For surgical ventriculomyotomy [-myectomy] for idiopathic hypertrophic subaortic stenosis, use 33416)</u></p>		
--	--	--	--	--



**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 93583	Tracking Number V1	Original Specialty Recommended RVU: <b>18.00</b>
		Presented Recommended RVU: <b>18.00</b>
Global Period: 000		RUC Recommended RVU: <b>14.00</b>

CPT Descriptor: Percutaneous transcatheter septal reduction therapy (eg, alcohol septal ablation) including temporary pacemaker insertion when performed

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 56-year-old male has functional Class III exertional dyspnea and exercise intolerance (heart failure) attributed to hypertrophic cardiomyopathy despite optimal beta-blocker and calcium-channel blocker therapy. Echocardiography demonstrates a ventricular septal thickness of 1.6 cm, a septal to posterior wall ratio of > 1.3 cm with a left ventricular outflow tract gradient of 30 mmHg at rest rising to 60 mmHg during provocation, and systolic anterior motion of the mitral valve further worsening left ventricular outflow tract obstruction and mitral regurgitation.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 100%

Is moderate sedation inherent to this procedure in the office setting?

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The patient's history, records, laboratory and diagnostic tests are reviewed. This may include review of the echocardiographic or other imaging studies. Physical examination is conducted. A clinical note is generated summarizing the clinical information if a recent note is not available. The patient is prepared for the procedure with careful documentation of baseline clinical findings such as vital signs, arterial pulses, allergies, electrocardiographic findings, laboratory results, family contact information, and other data. Appropriate pharmacologic therapy important for patient safety is ensured. Additional pre-procedure functions include writing orders for adequate sedation and patient support, and a review of study arrangements and procedures with technical, nursing and other assisting personnel. Appropriate communication is conducted with the patient and family as well as other medical professionals as needed. The procedure is reviewed with the patient and family. The risks and benefits of the procedure are presented, as well as the alternatives. Informed consent is obtained. Necessary equipment, instruments and supplies for the procedure are confirmed to be available and operational. The patient is positioned on the procedural table, attached to cardiac electrodes and an oxygen saturation monitor. A sterile table is prepared. The potential access sites are scrubbed in sterile fashion. A sterile drape is placed over the patient. The injection manifold and hemodynamic monitoring tubes and cables are set up. The patient's information is loaded in the hemodynamic monitoring equipment and into the angiographic digital archive in order to retain the data from the upcoming study. A "Time Out" occurs during which confirmation of critical information is ensured, such as the patient's identity, planned procedure, access route, allergies, completion of the consent process, availability of proper equipment, and any unusual circumstances which might influence the procedure. Conscious sedation is administered for those patients who have not required general anesthesia



Description of Intra-Service Work: Percutaneous venous access is obtained, typically through the internal jugular or femoral vein. A thin-walled needle is inserted percutaneously into the vein through which a flexible guide wire is inserted into the vein. The needle is removed over the wire, a sheath/dilator system is inserted over the guide wire, the dilator is removed, and sidearm of the sheath is flushed to remove any clot or air. A bipolar temporary pacing electrode catheter is introduced into the vein and passed to the right atrium and then negotiated through the tricuspid valve and finally into the apex of the right ventricle where appropriate capture threshold is demonstrated. Typically this requires several repositionings of the pacing catheter to achieve adequate capture and sensing thresholds.

A thin-walled needle is inserted percutaneously into a peripheral artery, through which a flexible guide wire is inserted into the artery. The needle is removed over the wire, a sheath/dilator system is inserted over the guide wire, the dilator is removed, and the sidearm of the sheath is flushed to remove any clot or air. A second arterial access is obtained in the same manner. An appropriate catheter is inserted over a wire through one of the arterial sheaths under fluoroscopic guidance. The catheter is advanced retrograde through the arterial system to the ascending aorta. The wire is removed and the catheter is attached to the pressure manifold. Pressure is measured in the aortic root. The catheter is then used to cross the aortic valve retrograde into the left ventricle. Left ventricular pressure is measured. The catheter is then exchanged out over a wire for an endhole catheter, which is positioned in the apex of the left ventricle. The catheter is carefully positioned for optimal hemodynamic measurement, which typically requires several repositionings due to catheter induced ventricular ectopy. Pressure transducers are connected to both the endhole catheter and to the second arterial sheath. The transducers are all zeroed. Simultaneous left ventricular and arterial pressures are then measured to assess for the gradient. Next maneuvers are performed to assess for a dynamic component to the gradient. Typically this involves Valsalva maneuver to reduce left ventricular volume, which generally increases the gradient. In addition, the catheter is typically maneuvered to induced premature ventricular contractions. On a post premature ventricular contraction, the gradient is generally increased as well. The endhole catheter is carefully pulled back to just below the aortic valve to ensure that the gradient is eliminated in this location. This ensures that the gradient is truly intraventricular and not at the level of the aortic valve. Next the catheter is pulled back across the aortic valve to assess for any separate aortic valve gradient. Finally, the catheter(s) is used to recross the aortic valve and positioned in the left ventricle for monitoring during the procedure.

Following this, the left ventricular catheter remains in place while a separate left coronary guide catheter is advanced through the second arterial sheath over a wire to the ostium of the left coronary artery. Selective left anterior descending coronary artery angiography is performed to show the trajectory of the left anterior descending artery and all of its septal perforator arteries. The angiographic views best showing the septal perforator arteries and their origins is selected for roadmapping. Appropriate anticoagulation is administered to therapeutic levels. A coronary guide-wire is passed through the left anterior descending coronary artery and then negotiated into the appropriate septal perforator. Due to the sharp angulation of the septal takeoff, it is frequently difficult to maneuver the wire into the appropriate septal. This often requires removing, reshaping, and reintroducing the coronary guidewire. Next, an appropriately sized angioplasty balloon is passed over the guide wire and positioned it in the selected septal perforator, where it is inflated to occlude flow down the septal. Left coronary angiography is performed to document occlusion of the septal perforator artery and proper positioning of the balloon. The coronary guide wire is then removed from the balloon lumen. Injection of contrast is then performed through the balloon lumen to opacify the distal aspect of the septal artery. This is done to ascertain the exact vascular bed of the septal to be infarcted with ethanol and to ensure there is no spillage of contrast retrograde into the left anterior descending coronary or antegrade into the coronary venous system or distant myocardial sites remote from the targeted septal muscle. Once the septal is confirmed to be the appropriate one for the intervention, a mixture of saline and contrast is agitated and injected through the lumen of the balloon. A separate physician performs transthoracic echocardiography (separately reportable) to confirm these findings at this time. The separate echocardiographer ensures that the septal perfusion supplies the target tissue to be ablated and that the septal perfusion does not extend to myocardial sites separate from the septum, such as the papillary muscles or the right ventricle. Depending on the septal artery size, septal thickness and the area delineated, 1 to four ml of absolute ethanol is instilled through the lumen of the inflated balloon catheter at a rate of 1 to 1.5 ml per minute and left in place for 5-10 minutes. During this time, the electrocardiogram is monitored for signs of conduction block and ventricular dysrhythmias, blood pressure is monitored to ensure no hypotension, the gradient is monitored, and the electrocardiogram and the patient are monitored for any signs of acute coronary ischemia to suggest compromise of the left anterior descending artery. If the gradient is not reduced at least 50% from baseline peak values, another septal artery will be injected if available based on coronary anatomy and myocardial contrast echocardiogram guidance (separately reportable) using the same techniques. After the alcohol injection(s) are completed, the balloon lumen is aspirated to clear any residual alcohol, and the balloon and guide are carefully withdrawn as a unit from the coronary and then from the body. Again, the electrocardiogram and the patient are carefully monitored for any signs of ischemia to suggest alcohol spillage into the left anterior descending artery. A completion coronary arteriogram is carried out of the left coronary system to ensure no disruption and to confirm closure of the treated septal branch(es). The guide catheter is removed. At completion of the procedure, the left ventricular catheter

and the second arterial sheath are used to remeasure the final outflow tract gradient following ablation. The temporary pacemaker is sewn in place, where it will remain for at least 24-48 hours, or longer if needed to treat heart block. All catheters are removed once angiography is completed. Images are reviewed to ensure no additional views are required before leaving the procedure suite. Angiography of the access site may be performed to assess for any complications and suitability for a percutaneous closure device. The catheters and sheaths are removed and hemostasis is achieved by appropriate means by the physician or technician under the physician's supervision.

Description of Post-Service Work: Angiographic images and hemodynamics are reviewed and a formal report is generated. The patient family and the referring physician are notified of the results. When appropriate, a plan of management is developed and implemented and discussed with the patient and family. The patient is observed to ensure no bleeding from the access site prior to disposition. Post procedural vital signs and telemetry are monitored to ensure no immediate complication.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	01/2013				
<b>Presenter(s):</b>	Richard Wright, MD; Cliff Kavinsky, MD				
<b>Specialty(s):</b>	ACC, SCAI				
<b>CPT Code:</b>	93583				
<b>Sample Size:</b>	57	<b>Resp N:</b>	29	<b>Response:</b> 50.8 %	
<b>Description of Sample:</b>	Survey of identified expert providers as approved by the Research Subcommittee.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	3.00	<b>5.00</b>	15.00	60.00
<b>Survey RVW:</b>	9.00	14.00	<b>18.00</b>	22.00	30.00
<b>Pre-Service Evaluation Time:</b>			<b>80.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>15.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>15.00</b>		
<b>Intra-Service Time:</b>	45.00	75.00	<b>90.00</b>	120.00	180.00
<b>Immediate Post Service-Time:</b>	<b>40.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	93583	<b>Recommended Physician Work RVU: 14.00</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>40.00</b>	<b>33.00</b>	<b>7.00</b>
<b>Pre-Service Positioning Time:</b>		<b>3.00</b>	<b>1.00</b>	<b>2.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>15.00</b>	<b>5.00</b>	<b>10.00</b>
<b>Intra-Service Time:</b>		<b>90.00</b>		
<b>Immediate Post Service-Time:</b>	<b>40.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? Yes

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
93580	000	17.97	RUC Time

CPT Descriptor Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
37229	000	14.05	RUC Time

CPT Descriptor Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code:** 10      **% of respondents:** 34.4 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 93583</b>	<b>Key Reference CPT Code: 93580</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	58.00	30.00	
Median Intra-Service Time	90.00	120.00	
Median Immediate Post-service Time	40.00	60.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>188.00</b>	<b>210.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.30	3.90
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.40	4.00
Urgency of medical decision making	3.90	3.60

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.10	4.00
Physical effort required	3.90	3.60

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.40	3.80
Outcome depends on the skill and judgment of physician	4.60	4.10
Estimated risk of malpractice suit with poor outcome	4.20	3.70

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.10	3.60
Intra-Service intensity/complexity	4.30	3.90
Post-Service intensity/complexity	4.10	3.50

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Code 93583 will be used to report transcatheter alcohol septal ablation for the treatment of hypertrophic cardiomyopathy. This service has not been previously defined. It has been reported using unlisted code 93799.

Surveys were distributed to a short list of providers known to offer this service. The Research Subcommittee approved this method for this rarely performed service offered by few cardiologists.

A RUC panel from ACC and SCAI reviewed the preservice time and selected package 4 for a difficult procedure on a difficult patient undergoing a procedure in a facility with adjustment to the time for scrub/dress/wait to reflect the survey.

The key reference service is 93580, Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant. Survey respondents indicated that 93583 takes less time than 93580 and is more intense/complex to perform.

This value reflects a similar “active” procedural time and higher intensity/complexity. Reference code 93580 also includes time related to general anesthesia induction, endotracheal intubation with mechanical ventilation, and intraprocedural transesophageal echocardiogram, performed during the procedure by other physicians. In contrast, 93583 is typically performed under conscious sedation versus general anesthesia. It is also performed with angiography by the operator and includes no reduced intensity time for TEE performed by other physicians. Finally, a more complex/difficult patient population undergoes this rare procedure, which aligns with the survey response.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93799

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty cardiology                      How often? Rarely

Specialty                                      How often?

Specialty                                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 2000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Double the Medicare estimate offered below.

Specialty cardiology	Frequency 2000	Percentage 100.00 %
----------------------	----------------	---------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,000

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The prevalence of hypertrophic obstructive cardiomyopathy (HOCM) is believed to be about 0.2% to 0.5% of the general population. HOCM patients may be asymptomatic and HOCM may go undetected. HOCM is a genetic disorder that can cause sudden death in otherwise healthy people. Without a specific code to track percutaneous transcatheter alcohol septal ablation, we do not have precise utilization estimates. We do know, for the past decade, there have been less than 1000 claims per year for the open alternative myectomy procedure (code 33416) reported under the Medicare program. This estimate also seems consistent with cardiology's utilization of roughly 1500 in 2011 for 93799.

Specialty cardiology	Frequency 1000	Percentage 100.00 %
----------------------	----------------	---------------------

Specialty	Frequency 0	Percentage %
-----------	-------------	--------------

Specialty	Frequency	Percentage %
-----------	-----------	--------------

Do many physicians perform this service across the United States? No

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 93580

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
12	ISSUE: Percutaneous Alcohol Septal Ablation																			
13	TAB: 17																			
14						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
15	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
16	REF	93580	Percutaneous	10	0.133			17.97			210	30					120			60
17	CURRENT	n/a			#DIV/0!						0									
18	SVY	93583	Percutaneous	29	0.165	9.00	14.00	18.00	22.00	30.00	240	80	15	15	45	75	90	120	180	40
19	REC	93583			0.134	14.00					188	40	3	15			90			40
20																				
21																				
22																				
23																				
24																				
25																				



## AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2013

### **Mechanical Chest Wall Oscillations-PE Only**

In February 2013 the CPT Editorial Panel created new CPT code 94669 *Mechanical chest wall oscillation to facilitate lung function per session*. In April 2013, the RUC reviewed the practice expense for the new code as well as the other codes in the family of services, CPT codes 94667 *Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; initial demonstration and/or evaluation* and 94668 *Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; subsequent*. This family of services does not include physician work. The PE Subcommittee reviewed the practice expense inputs and noted that the PE Summary of Recommendation states that, “typically, after 30 minutes the machine is powered off and the vest or chest wrap is removed from the patient’s chest.” Practice expense inputs were revised to align with the 30 minutes of therapist intra-service time typical for CPT code 94669. **The RUC reviewed and approved the direct practice expense inputs with modifications as recommended by the Practice Expense Subcommittee.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<p><b>Category I Medicine Pulmonary Pulmonary Diagnostic Testing and Therapies</b></p> <p>Codes 94010- 94799 include laboratory procedure(s) and interpretation of test results. If a separate identifiable evaluation and management service is performed, the appropriate E/M service code including new or established patient office or other outpatient services ( 99201- 99215 ), office or other outpatient consultations ( 99241- 99245 ), emergency department services ( 99281- 99285 ), nursing facility services (99304- 99318 ), domiciliary, rest home, or custodial care services ( 99324- 99337 ), and home services (99341- 99350 ) may be reported in addition to 94010- 94799 .</p> <p>Spirometry (94010) measures expiratory airflow and volumes and forms the basis of most pulmonary function testing. When spirometry is performed before and after administration of a bronchodilator, report 94060. Measurement of vital capacity (94150) is a component of spirometry and is only reported when performed alone. The flow-volume loop (94375) is used to identify patterns of inspiratory and/or expiratory obstruction in central or peripheral airways. Spirometry (94010, 94060) includes maximal breathing capacity (94200) and flow-volume loop (94375), when performed.</p> <p>Measurement of lung volumes may be performed using plethysmography, helium dilution or nitrogen washout. Plethysmography (94726) is</p>				

utilized to determine total lung capacity, residual volume, functional residual capacity, and airway resistance. Nitrogen washout or helium dilution (94727) may be used to measure lung volumes, distribution of ventilation and closing volume. Impulse oscillometry (94728) assesses airway resistance and may be reported in addition to gas dilution techniques. Spirometry (94010, 94060) and bronchial provocation (94070) are not included in 94726 and 94727 and may be reported separately.

Diffusing capacity (94729) is most commonly performed in conjunction with lung volumes or spirometry and is an add-on code to 94726-94728, 94010, 94060, 94070, and 94375.

Pulmonary function tests (94011- 94013) are reported for measurements in infants and young children through 2 years of age.

Pulmonary function testing measurements are reported as actual values and as a percent of predicted values by age, gender, height, and race.

Chest Wall Manipulation for the mobilization of secretions and improvement in lung function can be performed using manual (94667, 94668) or mechanical (94669) methods. Manual techniques include cupping, percussing, and use of a hand-held vibration device. A mechanical technique is the application of an external vest or wrap that delivers mechanical oscillation.

94667	AA1	Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; initial demonstration and/or evaluation	XXX	0.00 (No Change) (PE Input Recommendations Only)
94668	AA2	subsequent	XXX	0.00 (No Change) (PE Input Recommendations Only)

●94669	AA3	Mechanical chest wall oscillation to facilitate lung function per session	XXX	0.00 (PE Input Recommendations Only)
--------	-----	---	-----	---

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor:

**94669 Mechanical chest wall oscillation to facilitate lung function; each session**

Global Period: XXX Meeting Date: April 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: **The ATS convened a consensus panel to develop recommendations for these Practice Expense only codes on March 8, 2013. The composition of this panel included private practice and academic pulmonologists in varying types of practices and locations. ACCP and AARC agreed with the inputs.**
2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale: **CPT 94667 Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; initial demonstration and/or evaluation is a similar code to 94669.**
3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time: **clinical standards are used.**
4. Please describe in detail the clinical activities of your staff:

**Pre-Service** Clinical Labor Activities:

- Prior to the procedure the respiratory therapist or nurse will do a patient assessment which includes a brief history of the patient's secretion clearance and pulmonary status.
- The breath sounds are auscultated and vital signs are taken and recorded.
- The therapist explains HFCWO to the patient.

**Intra-Service** Clinical Labor Activities:

- The chest wrap or vest is applied to the patient and the therapist will assess proper fit using manufacture's standards. A variety of sizes may be tried in order to get the right fit.
- The patient is instructed on how to fasten the wrap or vest in place.
- The hose from the machine is connected to the chest wrap or vest.
- The machine is turned on to the prescribed pressure level and vibrating frequency. Patient comfort is assessed and the therapist may modify the settings to optimize effectiveness.
- The patient is instructed to breathe normally while the vest is vibrating the chest. The patient is coached and encouraged throughout the treatment.
- At prescribed intervals of approximately 10 minutes the machine stops, and the patient is instructed in coughing. The vibration frequency is increased after each coughing session. During the treatment the patient is assessed for any adverse effects and tolerance.
- Typically, after 30 minutes the machine is powered off and the vest or chest wrap is removed from the patient's chest.

**Post-Service** Clinical Labor Activities:

**Tab 15 CPT Code: 94669**  
**Specialty Society('s)\_ATS/ACCP/AARC**

- The patient is instructed to cough and expectorate. Breath sounds are auscultated and vital signs are taken and recorded.
- The treatment results are documented in the medical record.

	A	B	C	D	E	F	G	H	I
1									
2	<b>Note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.</b>			<b>94667 CURRENT INPUTS NO CHANGE</b>		<b>94668 CURRENT INPUTS NO CHANGE</b>		<b>94669</b>	
3	<b>Meeting Date: April 25-28, 2013 Tab: 15 Mechanical Chest Wall Oscillation Specialty: Pulmonary Medicine, American Thoracic Society (ATS)</b>	<b>CMS Code</b>	<b>Staff Type</b>	Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function, initial		Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; subsequent		Mechanical chest wall oscillation to facilitate lung function per session	
4	<b>LOCATION</b>			<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>
5	<b>GLOBAL PERIOD</b>			<b>XXX</b>		<b>XXX</b>		<b>XXX</b>	
6	<b>TOTAL CLINICAL LABOR TIME</b>			<b>35.0</b>	<b>0.0</b>	<b>33.0</b>	<b>0.0</b>	<b>45.0</b>	<b>0.0</b>
7	<b>TOTAL PRE-SERV CLINICAL LABOR TIME</b>	L047C	RN/RT	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>
8	<b>TOTAL SERVICE PERIOD CLINICAL LABOR TIME</b>	L047C	RN/RT	<b>35.0</b>	<b>0.0</b>	<b>33.0</b>	<b>0.0</b>	<b>45.0</b>	<b>0.0</b>
9	<b>TOTAL POST-SERV CLINICAL LABOR TIME</b>	L047C	RN/RT	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>
10	<b>PRE-SERVICE</b>								
11	<b>Start: Following visit when decision for surgery or procedure made</b>								
12	Complete pre-service diagnostic & referral forms								
13	Coordinate pre-surgery services								
14	Schedule space and equipment in facility								
15	Provide pre-service education/obtain consent								
16	Follow-up phone calls & prescriptions								
17	Other Clinical Activity - <i>specify:</i>								
18	<b>End: When patient enters office/facility for surgery/procedure</b>								
19	<b>SERVICE PERIOD</b>								
20	<b>Start: When patient enters office/facility for surgery/procedure:</b>								
21	Greet patient, provide gowning, ensure appropriate medical records are available					<b>2</b>			
22	Obtain vital signs					<b>2</b>			
23	Provide pre-service education/obtain consent	L047C	RN/RT	<b>2</b>		<b>1</b>		<b>2</b>	
24	Prepare room, equipment, supplies	L047C	RN/RT	<b>2</b>		<b>1</b>		<b>2</b>	
25	Setup scope (non facility setting only)								
26	Prepare and position patient/ monitor patient/ set up IV					<b>1</b>			
27	Sedate/apply anesthesia								
28	<b>Intra-service</b>								
29	Assist physician in performing procedure	L047C	RN/RT	<b>20</b>		<b>20</b>		<b>30</b>	
30	<b>Post-Service</b>								
31	Monitor pt. following service/check tubes, monitors, drains	L047C	RN/RT	<b>5</b>				<b>5</b>	
32	Clean room/equipment by physician staff	L047C	RN/RT	<b>3</b>		<b>3</b>		<b>3</b>	
33	Clean Scope								
34	Clean Surgical Instrument Package								
35	Complete diagnostic forms, lab & X-ray requisitions								
36	Review/read X-ray, lab, and pathology reports								
37	Results documented, instructions, coordinate office visits and prescriptions and DME ordered	L047C	RN/RT	<b>3</b>		<b>3</b>		<b>3</b>	
38	Other Clinical Activity - <i>specify:</i>								
39	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			<b>n/a</b>		<b>n/a</b>		<b>n/a</b>	
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)			<b>n/a</b>		<b>n/a</b>		<b>n/a</b>	
41	Dischrg mgmt (1.0 x 99239) (enter 15 min)			<b>n/a</b>		<b>n/a</b>		<b>n/a</b>	
42	<b>End: Patient leaves office</b>								
43	<b>POST-SERVICE Period</b>								
44	<b>Start: Patient leaves office/facility</b>								
45	Conduct phone calls/call in prescriptions								
46	<b>Office visits: List Number and Level of Office Visits</b>			<b># visits</b>	<b># visits</b>	<b># visits</b>	<b># visits</b>	<b># visits</b>	<b># visits</b>
47	99211 16 minutes		16						
48	99212 27 minutes		27						
49	99213 36 minutes		36						
50	99214 53 minutes		53						
51	99215 63 minutes		63						
52	<b>Total Office Visit Time</b>			<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>
53	Other Clinical Activity - <i>specify:</i>								
54	<b>End: with last office visit before end of global period</b>								

	A	B	C	D	E	F	G	H	I
1									
2	<b>Note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.</b>			<b>94667</b> <b>CURRENT INPUTS</b> <b>NO CHANGE</b>		<b>94668</b> <b>CURRENT INPUTS</b> <b>NO CHANGE</b>		<b>94669</b>	
3	<b>Meeting Date: April 25-28, 2013</b> <b>Tab: 15 Mechanical Chest Wall Oscillation</b> <b>Specialty: Pulmonary Medicine, American Thoracic Society (ATS)</b>	<b>CMS Code</b>	<b>Staff Type</b>	Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function, initial		Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; subsequent		Mechanical chest wall oscillation to facilitate lung function per session	
4	<b>LOCATION</b>			<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>
5	<b>GLOBAL PERIOD</b>			<b>XXX</b>		<b>XXX</b>		<b>XXX</b>	
55	<b>MEDICAL SUPPLIES</b>	<b>CODE</b>	<b>UNIT</b>						
56	pack, minimum multi-specialty visit	SA048	pack	<b>1</b>		<b>1</b>		<b>1</b>	
57									
58									
59									
60									
61									
62	<b>EQUIPMENT</b>	<b>CODE</b>							
63	table, exam	EF023	item	<b>35</b>		<b>33</b>		<b>45</b>	
64									
65									
66									
67									



## AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2013

### Ultrasonic Wound Assessment

In February 2013, the CPT Editorial Panel converted Category III code 0183T to a Category I code to report ultrasound wound assessment for low frequency, non-contact, non thermal ultrasound.

The American Podiatric Medical Association (APMA), American Physical Therapy Association (APTA) and American Society of General Surgeons (ASGS) conducted a RUC survey and received an inadequate number of survey responses. The specialty societies noted a wide variation in the survey intra-service time and determined that this was most likely the result of surveying a code and vignette that does not describe a typical wound size, thereby allowing survey respondents to consider whatever their personal typical patient would be. The specialty societies requested and the RUC agreed that this service be carrier priced for CPT 2014. The specialty societies will submit a coding proposal to describe two codes that differentiate the wound size and clearly indicate that the size reported is the total for all wounds treated.

**The RUC recommends that CPT code 97610 be carrier priced for CPT 2014 and refers this issue to the CPT Editorial Panel.**

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<b>Category I Medicine Physical Medicine and Rehabilitation Active Wound Care Management</b>				
●97610	DD1	Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day	XXX	Carrier Price and Refer to CPT

Category III				
D0183T		<del>Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day</del> <u>(0183T has been deleted. To report, use 97610)</u>	XXX	N/A

April 2, 2013

Barbara Levy, MD  
Chair, AMA/Specialty Society RVS Update Committee  
American Medical Association  
515 North State Street  
Chicago, Illinois 60654

Subject: Ultrasonic Wound Assessment (Tab 16)

Dear Dr. Levy,

At the February 2013 CPT meeting, the Editorial Panel approved conversion of Category III CPT Code 0183T Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day to a Category I CPT Code 976XX1 with the same code descriptor. The American Podiatric Medical Association, American Physical Therapy Association, and American Society of General Surgeons agreed to conduct a RUC survey for this new code. Based on the survey results, we have determined that we cannot make a work or practice expense recommendation for 976XX1. This letter provides background and the rationale for our decision.

#### CPT Background

*In February 2007*, representatives of the company that developed the device used in providing low frequency ultrasonic wound therapy presented a coding application for creation of two codes:

- 97xxx Low frequency, non-contact, non-thermal ultrasound, with or without topical application(s), wound assessment, and instruction(s) for ongoing care. Per session; total wound(s) surface area less than or equal to 50 square centimeters.
- 97xxx total wound(s) surface area greater than 50 square centimeters.

The Panel voted to accept Option B with modifications and establish a Category III code for 2008.

006XT Low frequency, non-contact, non-thermal ultrasound, ~~with or without~~ including topical application(s) when performed, wound assessment, and instruction(s) for ongoing care, per ~~session day; total wound(s) surface area less than or equal to 50 square centimeters~~

~~007XT- total wound(s) surface area greater than 50 square centimeters~~

*In October 2009*, a proposal was presented by the representatives for the device company to convert Category III code 0183T to a Category I code. The Panel rejected this proposal and maintained Category III status for the code.

*In February 2011*, a proposal was submitted by representatives of the device company and several Primary Investigators to convert Category III code 0183T to a Category I code. In a cover memo, the

presenters indicated that "establishing consistent payment has been challenging due to the lack of RVUs associated with the Category III CPT codes." The Panel postponed consideration of this request until time certain October 2011 in anticipation of new supporting literature.

*In February 2013, a proposal was submitted by several device company Primary Investigators, along with APMA, APTA, and ASGS to convert Category III code 0183T to a Category I code. Additional published literature was provided to support Category I status.*

#### RUC Survey Discussion

The APMA, APTA, and ASGS conducted a RUC survey and received 14 responses, three of which had no experience in the past 12 months. The key reference code chosen by 13 respondents was 97597 Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less.


We reviewed the survey results and found a wide variation in intra-service time (range = 5-45 minutes) with a median of 20 minutes. This is most likely the result of surveying a code and vignette that does not describe a typical wound size, thereby allowing survey respondents to consider whatever their personal typical patient would be. We are unable to know what size wound the respondents considered for their time estimates. We also noted that code 97597 (first 20 sq cm), which we believe to be a bigger procedure, has an intra-service time of 14 minutes and that the device company brochure describes a typical "treatment" requiring an average time of 5 to 7 minutes (note that treatment is not defined by size).

#### Recommendation

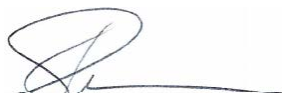
Given the low response rate, the wide variation in the survey intra-time time, and the lack of wound size specification in the code descriptors and vignette, we cannot recommend a work RVU or practice expense details for code 976XX1 at this time. It is clear that there would need to be (at least) two codes that differentiate wound size and clearly indicate that the size reported is the total for all wounds treated before we can recommend a work RVU. The Cat III code 0183T has been carrier priced since 2008. We recommend extending carrier pricing to the new Cat I code 976XX1.

Thank you for your consideration of this information. Our Advisors will be available at the upcoming meeting to answer any questions.

Sincerely,



Seth Rubenstein, DPM  
APMA RUC Advisor



Stephen Levine, PT, DPT  
APTA RUC Advisor



Jay Gregory, MD, FACS  
ASGS RUC Advisor

# AMA/Specialty Society RVS Update Committee Summary of Recommendations

October 2012

## Anogenital Exam Colposcopy-PE Only

In May 2012, this service was editorially revised by the CPT Editorial Panel to reflect change in practice due to new technology. The Practice Expense (PE) Subcommittee discussed the compelling evidence that the technique and knowledge/technology has changed significantly since the last review of this service. Best practice for this exam requires the use of highly trained support staff. The typical exam in an child advocacy center (nonfacility) now requires the expertise of clinical staff at the level of an RN and a specially trained Child Life Specialist (CLS). The PE Subcommittee determined that the specialty met compelling evidence and that the change and addition of clinical staff types are appropriate for this service. The RUC noted that Child Life Specialist is not recognized as a staff type in the CMS direct PE inputs clinical labor types list and is not listed as an occupation by the bureau of labor statistics. The specialty has included supporting documents regarding similar staff types in order to assist with appropriate pricing. **The RUC reviewed and approved the direct practice expense inputs with modifications as recommended by the Practice Expense Subcommittee.**

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲99170	A1	Anogenital examination, <del>with colposcopic magnification magnified</del> , in childhood for suspected trauma, <u>including image recording when performed</u> (For <del>conscious</del> <u>moderate</u> sedation, see 99143-99150)	000	1.75 (No change)

AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
**Facility** Direct Inputs

CPT Long Descriptor: **Anogenital examination with colposcopic or other similar magnification in childhood for suspected trauma**

Global Period: **000** Meeting Date: **October 2012**

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

**An expert panel of pediatric physicians who routinely perform this service convened a series of conference calls to develop consensus direct practice expense input recommendations.**

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes.

Comparison code rationale:

**We utilized the January 2004 PEAC-approved direct practice expense inputs for code 99170 as our reference.**

Please describe in detail the clinical activities of your staff:

**Pre-Service Clinical Labor Activities**

**RN (L051A): N/A**

**Child Life Specialist (CLS): N/A**

**Intra-Service Clinical Labor Activities**

**RN (L051A): N/A**

**Child Life Specialist (CLS): N/A**

**Post-Service Clinical Labor Activities**

**RN (L051A): N/A**

**Child Life Specialist (CLS): N/A**

AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
**Non-Facility** Direct Inputs

CPT Long Descriptor: **Anogenital examination with colposcopic or other similar magnification in childhood for suspected trauma**

Global Period: **000** Meeting Date: **October 2012**

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

**An expert panel of pediatric physicians who routinely perform this service convened a series of conference calls to develop consensus direct practice expense input recommendations.**

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes.

Comparison code rationale:

**We utilized the January 2004 PEAC-approved direct practice expense inputs for code 99170 as our reference.**

Please describe in detail the clinical activities of your staff:

**Pre-Service Clinical Labor Activities**

**RN (L051A): 5 minutes**

- 1) Confirms procedure and types of accompanying tests (1 min)**
- 2) Prepare for anticipated cultures, STD testing, tray configuration (1 min)**
- 3) Prepare necessary equipment (1 min)**
- 4) Create reference file for patient (1 min)**
- 5) Create image of patient's identifying name plate (1 min)**

**Child Life Specialist (CLS): N/A**

**Intra-Service Clinical Labor Activities**

**RN (L051A): ~~7~~70 minutes**

- ~~**1) Prepare room, equipment, supplies (2 min)**~~
- ~~**2) Setup scope (5 min)**~~
- 3) Prepare and position patient/monitor patient/set up IV (2 min)**
- 4) Assist patient in gowning and positioning (5 min)**
- 5) Assist physician in performing procedure (50 min)**
- 5) Clean room/equipment by physician staff (3 min)**
- 6) Clean scope (10 min)**

**Child Life Specialist (CLS): 60 minutes**

- 1) Assess developmental capabilities of the child based on child's age (3 min)**
- 2) Develop strategy to employ during exam to focus child's attention (3 min)**
- 3) Prepare items necessary for patient focus (4 min)**
- 4) Provide distraction to patient during physician's exam (50 min)**

**Post-Service Clinical Labor Activities**

**RN (L051A): 15 minutes**

- 1) Labels all specimens (3 min)**
- 2) Prepares specimens for reliable delivery to and processing by lab (3 min)**
- 3) Collects data from imaging device and downloads them onto processing and imaging computer (5 min)**
- 4) Completion of required forms for medical reporting (4 min)**

**Child Life Specialist (CLS): N/A**





---

## Standard Occupational Classification

---

### **NOTE:**

The information on this page relates to the 2010 SOC, please see the [2000 SOC System](#) for information on the previous version of the SOC.

---

## 31-2011 Occupational Therapy Assistants

**Assist occupational therapists in providing occupational therapy treatments and procedures. May, in accordance with State laws, assist in development of treatment plans, carry out routine functions, direct activity programs, and document the progress of treatments. Generally requires formal training.**

Illustrative examples: *Licensed Occupational Therapist Assistant, Certified Occupational Therapy Assistant*

Broad Occupation: 31-2010 [Occupational Therapy Assistants and Aides](#)

Minor Group: 31-2000 [Occupational Therapy and Physical Therapist Assistants and Aides](#)

Major Group: 31-0000 [Healthcare Support Occupations](#)

[List of SOC Major Groups](#)

[SOC User Guide](#)

**Last Modified Date:** March 11, 2010

---

U.S. Bureau of Labor Statistics | Division of Occupational Employment Statistics, PSB Suite 2135, 2 Massachusetts Avenue, NE  
Washington, DC 20212-0001

[www.bls.gov/OES](http://www.bls.gov/OES) | Telephone: 1-202-691-6569 | [Contact OES](#)



# SUMMARY OF THE 2008 CHILD LIFE PROFESSION COMPENSATION SURVEY RESULTS

---



## CHILD LIFE COMPENSATION SURVEY

In 2008, Child Life Council (CLC) sponsored a large-scale survey of practicing child life specialists to understand the positions held, how much is earned, and the types of benefits received.

CLC engaged Association Research, Inc., an independent research company to conduct a salary survey. More than 3,600 child life professionals in the U.S. and Canada were contacted to participate in the study. The response rate to the Web-based survey was excellent — 44.8% — based on 1,631 responses. Of this group, 94.4% worked in the U.S. and the balance in Canada. Eighty percent were in full-time positions. The confidential Web-based survey gathered individual and institutional demographic data along with the salary and benefits data as self-reported by the respondents.

Three distinct positions are reflected in the summary of survey results:

- Director/Manager/Leader of Child Life Program
- Child Life Specialist with Leadership Responsibilities
- Child Life Specialist

A profile of each position, with a summary of results, is presented on the following pages. As the vast majority of respondents to the survey were U.S.-based and full time, only individuals in those categories were used to create the detailed profiles. There is a separate summary table of full-time salaries in Canada.

### **Explanation of Terminology**

The Salary Table for each position uses statistical measures to describe the whole range of salaries. The mean and median values are the most familiar and commonly used benchmarks. The *mean* (average) is the total of all salaries divided by the number of individual entries reported. The disadvantage of the mean value is that it can be distorted by unusually high or low numbers, whereas the median (mid-point) figure is not influenced by extreme values. The *median* value is the salary right in the middle, after all salaries are arranged from the lowest to highest. Half of all the values are lower than the median and half are higher. In addition to mean and median values, salary quartiles are displayed. The first quartile, for example, is higher than 25% of all others reported, but lower than the remaining 75%. The third quartile is higher than 75% of the field, but lower than the remaining 25%.

Each Salary table also shows how salary levels vary by education, location, and experience. The crosstab for education displays the difference between individuals with a bachelor's degree and those with a master's degree. For location, U.S. Census Districts are used. A final table summarizing benefits offered by job position is included.

Detailed statistical tables and analysis are available in the *Executive Report on Child Life Salaries and Compensation*, published by CLC in July 2008. This inclusive report provides an analysis of salaries and benefits for part-time employees, and contains a separate section covering salaries and benefits for respondents working in Canada. The detailed Salary tables have additional breakouts for gender, credentials, community size, institution or organization type, number of pediatric beds, number of FTE professional staff in the department, as well as number of people supervised. Visit [www.childlife.org](http://www.childlife.org) for more information.

## DIRECTOR/MANAGER/LEADER OF CHILD LIFE PROGRAM

*Position Description: This individual should be a Certified Child Life Specialist with academic preparation at the master's degree level, including all expertise in the areas listed under child life specialist. Responsibilities may include:*

- *Managing the department budget, salaries, and staffing*
- *Evaluating staff, department needs, and overall contributions to organization*
- *Advocating for needs of department and organization*
- *Authorizing and encouraging fundraising and special events for the program and organization*

### **DEMOGRAPHIC HIGHLIGHTS**

AVERAGE AGE	43
MASTER'S DEGREE AS HIGHEST EDUCATION	63%
CERTIFIED CHILD LIFE SPECIALIST (CCLS)	92%
AVERAGE YEARS AS CHILD LIFE PROFESSIONAL	16
AVERAGE NUMBER OF PEDIATRIC HOSPITAL BEDS	139
AVERAGE NUMBER OF PEOPLE SUPERVISED	11
CHILDREN'S HOSPITAL WITHIN HOSPITAL	43%
CHILDREN'S HOSPITAL (FREESTANDING)	31%
LARGE CITY/SUBURB	55%

### **Annual Salary as of January 1, 2008**

#### ***Director/Manager/Leader of Child Life Program***

		Annual Salary as of January 2008					2007-2008 Salary Change
		Number of Respon- dents	Mean	First Quartile 25%	Median 50%	Third Quartile 75%	Median
<b>United States Full-Time</b>							
All Full-time Respondents		155	63,417	53,227	60,000	71,885	4.1%
Highest Education	Bachelor's Degree	56	55,857	44,244	56,000	65,788	4.0%
	Master's Degree	97	67,594	56,000	63,000	76,232	4.2%
U.S. Census District	New England	8	60,645	53,406	60,400	67,132	4.0%
	Middle Atlantic	38	66,694	56,000	60,000	76,042	5.3%
	South Atlantic	28	58,336	51,250	56,767	68,593	3.2%
	East S. Central	9	57,781	39,000	58,240	70,000	3.0%
	West S. Central	17	60,384	47,907	57,800	70,800	4.2%
	East N. Central	16	63,627	44,712	59,299	81,750	4.1%
	West N. Central	10	57,145	43,192	63,030	69,831	5.0%
	Mountain	6	58,178	53,531	56,368	64,378	9.6%
	Pacific	20	73,430	62,000	73,247	88,500	4.6%
Years as Child Life Professional	4 - 9 years	38	54,936	46,500	56,000	62,125	5.9%
	9 years or more	105	67,443	55,359	64,106	76,232	3.8%

## CHILD LIFE SPECIALIST WITH LEADERSHIP RESPONSIBILITIES

*Position Description: This individual should meet the same requirements as a child life specialist, with additional experience, education and/or responsibilities as designated by each child life program.*

*Responsibilities may include:*

- *Supervising child life internship program*
- *Organizing child life volunteer program, job shadows and practicum students*
- *Mentoring junior child life specialists*
- *Grant writing and new program development*
- *Clinical supervision and educator roles*

### **DEMOGRAPHIC HIGHLIGHTS**

AVERAGE AGE	35
BACHELOR'S DEGREE AS HIGHEST EDUCATION	63%
MASTER'S DEGREE	37%
CERTIFIED CHILD LIFE SPECIALIST (CCLS)	96%
AVERAGE YEARS AS CHILD LIFE PROFESSIONAL	9
AVERAGE NUMBER OF PEDIATRIC HOSPITAL BEDS	169
AVERAGE NUMBER OF PEOPLE SUPERVISED	2
CHILDREN'S HOSPITAL WITHIN HOSPITAL	40%
CHILDREN'S HOSPITAL (FREESTANDING)	42%
LARGE CITY/SUBURB	60%

### **Annual Salary as of January 1, 2008**

#### ***Child Life Specialist with Leadership Responsibilities***

		Annual Salary as of January 2008					2007-2008 Salary Change
		Number of Respon- dents	Mean	First Quartile 25%	Median 50%	Third Quartile 75%	Median
<b>United States Full-Time</b>							
All Full-time Respondents		377	44,185	37,515	42,500	49,960	4.2%
Highest Education	Bachelor's Degree	236	42,383	36,058	41,196	47,382	4.2%
	Master's Degree	141	47,199	40,000	46,000	52,825	4.2%
U.S. Census District	New England	27	47,450	40,000	44,500	52,000	4.0%
	Middle Atlantic	54	45,802	40,000	44,500	50,250	3.5%
	South Atlantic	76	41,544	34,403	39,915	44,967	4.6%
	East S. Central	15	37,273	32,000	35,662	43,000	2.5%
	West S. Central	60	41,145	35,988	40,305	44,439	4.2%
	East N. Central	41	42,664	38,000	43,000	47,420	3.7%
	West N. Central	34	41,975	33,272	41,000	49,250	4.2%
	Mountain	21	46,455	38,979	43,825	52,074	4.3%
	Pacific	49	52,370	46,796	52,000	58,526	4.3%
Years as Child Life Professional	3 years or less	79	40,009	33,134	37,960	43,000	4.5%
	4 - 9 years	171	43,088	38,000	42,000	47,840	4.1%
	9 years or more	122	48,810	41,725	48,827	54,105	4.1%

# CHILD LIFE SPECIALIST

*Position Description: This individual typically has earned certification as a child life specialist. Minimal education requirements are at the bachelor's degree level, along with completion of a child life internship. Responsibilities can include:*

- *Understanding of growth and development theory and practice*
- *Understanding and utilization of evidence-based practice concepts, including play, preparation and assessment*
- *Facilitating daily interactions and interventions with patients and staff*
- *Managing unit based volunteers*
- *Organizing special events and special guests*
- *Managing support groups and other regularly scheduled events*

## DEMOGRAPHIC HIGHLIGHTS

AVERAGE AGE	31
BACHELOR'S DEGREE AS HIGHEST EDUCATION	65%
MASTER'S DEGREE	34%
CERTIFIED CHILD LIFE SPECIALIST (CCLS)	92%
AVERAGE YEARS AS CHILD LIFE PROFESSIONAL	5
AVERAGE NUMBER OF PEDIATRIC HOSPITAL BEDS	196
CHILDREN'S HOSPITAL WITHIN HOSPITAL	33%
CHILDREN'S HOSPITAL (FREESTANDING)	53%
LARGE CITY/SUBURB	62%

## Annual Salary as of January 1, 2008

### *Child Life Specialist*

		Annual Salary as of January 2008					2007-2008 Salary Change
		Number of Respon- dents	Mean	First Quartile 25%	Median 50%	Third Quartile 75%	Median
<b>United States Full-Time</b>							
All Full-time Respondents		572	39,775	35,000	39,000	43,134	3.6%
Highest Education	Bachelor's Degree	372	38,870	34,028	38,000	42,137	3.6%
	Master's Degree	199	41,479	36,565	41,000	45,760	3.7%
U.S. Census District	New England	43	41,765	38,700	42,000	45,000	4.6%
	Middle Atlantic	78	41,369	38,000	41,000	44,175	3.4%
	South Atlantic	104	36,253	31,954	35,576	40,000	3.2%
	East S. Central	32	35,672	30,961	34,910	40,775	3.6%
	West S. Central	75	38,896	33,925	38,000	42,952	4.1%
	East N. Central	94	39,262	35,547	37,599	42,520	3.7%
	West N. Central	57	38,314	32,953	37,440	41,839	3.5%
	Mountain	38	42,719	37,360	41,519	45,822	3.2%
	Pacific	49	47,571	41,756	47,590	51,500	4.0%
Years as Child Life Professional	3 years or less	284	37,513	33,168	37,012	41,000	3.4%
	4 - 9 years	168	41,724	37,487	41,319	45,950	4.0%
	9 years or more	81	46,097	41,009	45,000	50,055	3.5%

## Annual Salary by Job Description - Full-time Canada

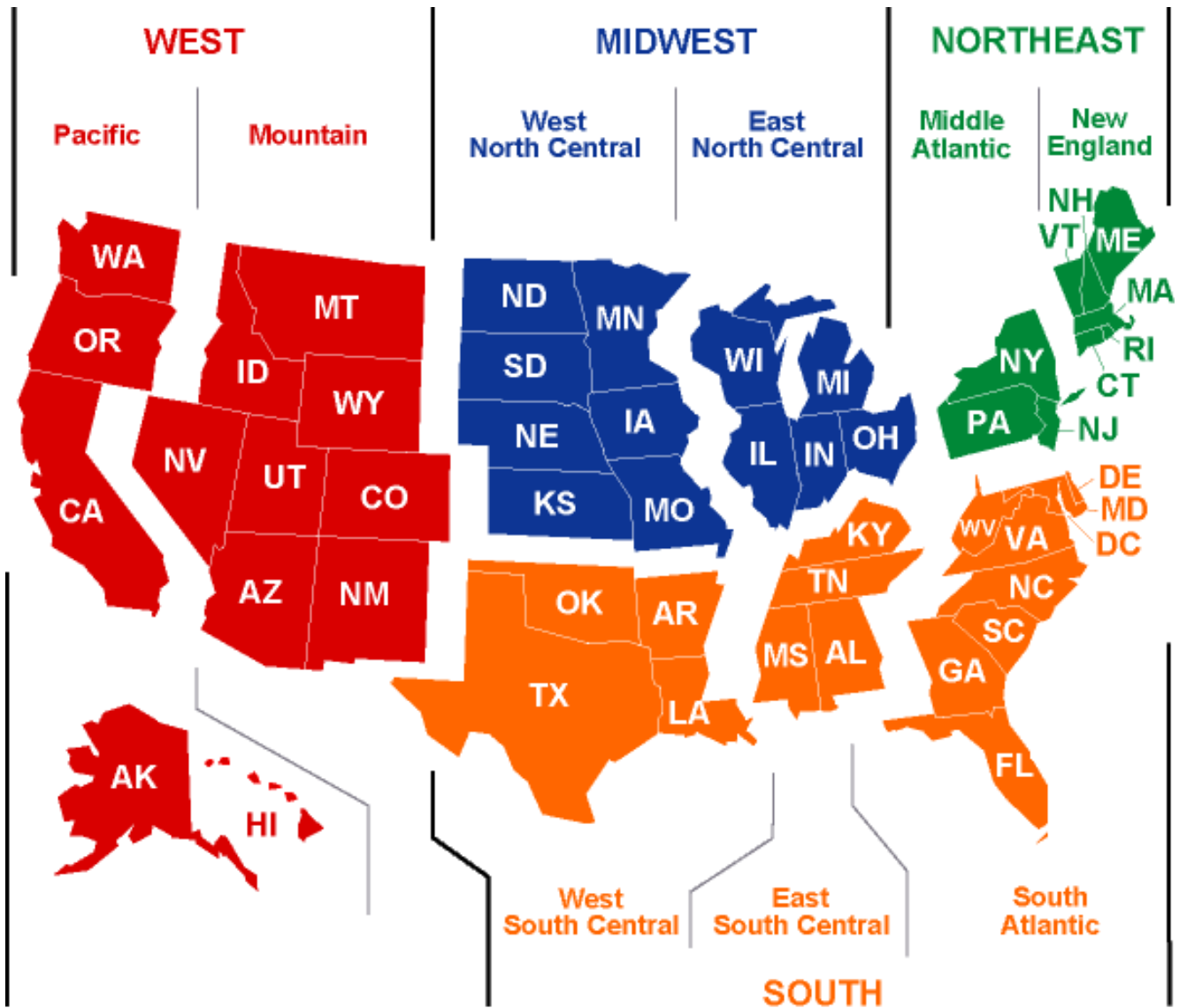
	Annual Salary as of January 2008 (Canadian \$)					2007-2008 Salary Change
	Number of Respon- dents	Mean	First Quartile 25%	Median 50%	Third Quartile 75%	Median
Manager/Director/Leader of Child Life Program	5	62,140	52,000	60,000	73,349	3.4%
Child Life Specialist with Leadership Responsibilities	11	57,805	55,000	56,550	59,000	3.6%
Child Life Specialist	29	55,817	52,000	55,000	59,755	3.5%

## Summary of benefits offered by current position

	Job Position					
	Manager/Director/ Leader of Child Life Program		Child Life Specialis with Leadership Responsibilities		Child Life Specialis	
		Number of Respon- dents		Number of Respon- dents		Number of Respon- dents
<b>United States Full-Time</b>	Percent		Percent		Percent	
Bonus	34.4%	54	29.5%	112	28.2%	163
Cafeteria Plan	27.4%	43	22.4%	85	19.9%	115
Childcare Facilities	35.0%	55	31.1%	118	31.4%	182
Childcare Allowance	14.0%	22	15.8%	60	16.4%	95
Dental	92.4%	145	96.1%	365	94.5%	547
Flexible Spending Plan	82.8%	130	82.4%	313	82.2%	476
Group Life	78.3%	123	74.2%	282	62.5%	362
Health Care Plans	95.5%	150	96.1%	365	94.5%	547
Health Club Membership	39.5%	62	44.5%	169	40.9%	237
Long-Term Care	47.1%	74	51.6%	196	48.4%	280
Long-Term Disability	83.4%	131	82.9%	315	81.5%	472
Short-Term Disability	84.1%	132	86.1%	327	84.5%	489
Maternity Benefits	75.2%	118	73.9%	281	68.7%	398
Paid Vacation	94.3%	148	94.2%	358	92.6%	536
Parking	54.8%	86	52.9%	201	56.6%	328
403(b)/401(k) Retirement Plan	91.1%	143	93.7%	356	92.9%	538
Retiree Medical	28.7%	45	30.5%	116	25.6%	148
Sick Leave	93.0%	146	83.9%	319	86.2%	499
Vision Care	86.0%	135	88.2%	335	84.6%	490
Tuition Reimbursement	84.7%	133	85.8%	326	85.7%	496
Professional Development	86.0%	135	80.8%	307	81.9%	474
Professional Association Dues Reimbursement	36.9%	58	23.2%	88	20.4%	118

Child Life Council, Inc  
11821 Parklawn Drive, Suite 310, Rockville, MD 20852  
[www.childlife.org](http://www.childlife.org)

## U.S. CENSUS REGIONS





	A	B	C	D	E	F	G
1	<b>NOTE: Cell C8 contains a hyperlink with a reference costing source</b>			<b>JANUARY 2004 PEAC-APPROVED INPUTS</b>			
2	<b>FINAL 10-6-12</b>			<b>99170</b>		<b>99170</b>	
3	Meeting Date: October 2012 CPT Code/Tracking Code/RUC Tab: 99170/A1/Tab 13 Specialty: American Academy of Pediatrics (AAP)	CMS Code	Staff Type	Anogenital examination with colposcopic in childhood for suspected trauma		Anogenital examination with colposcopic or other similar magnification in childhood for suspected trauma	
4	LOCATION			Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD						
6	TOTAL CLINICAL LABOR TIME (RN/LPN)	L042A	RN/LPN	65.0	3.0		
7	TOTAL CLINICAL LABOR TIME (RN)	L051A	RN		0.0	76.0	0.0
8	TOTAL CLINICAL LABOR TIME (Child Life Specialist) (CLS)		<a href="#">Child Life Specialist</a>			63.0	0.0
9	TOTAL PRE-SERV CLINICAL LABOR TIME	L042A	RN/LPN	3.0	0.0		
10	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L042A	RN/LPN	62.0	3.0		
11	TOTAL POST-SERV CLINICAL LABOR TIME	L042A	RN/LPN	0.0	0.0		
12	TOTAL PRE-SERV CLINICAL LABOR TIME	L051A	RN			3.0	0.0
13	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN			70.0	0.0
14	TOTAL POST-SERV CLINICAL LABOR TIME	L051A	RN			3.0	0.0
15	TOTAL PRE-SERV CLINICAL LABOR TIME		CLS			3.0	0.0
16	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		CLS			60.0	0.0
17	TOTAL POST-SERV CLINICAL LABOR TIME		CLS			0.0	0.0
18	<b>PRE-SERVICE</b>						
19	Start: Following visit when decision for surgery or procedure made						
20	Complete pre-service diagnostic & referral forms						
21	Coordinate pre-surgery services	L042A	RN/LPN	3		3	
22	Schedule space and equipment in facility						
23	Provide pre-service education/obtain consent						
24	Follow-up phone calls & prescriptions						
25	Other Clinical Activity (RN) (Please see NF PE SoR):	L051A	RN			0	
26	End: When patient enters office/facility for surgery/procedure						
27	<b>SERVICE PERIOD</b>						
28	Start: When patient enters office/facility for surgery/procedure:						
29	Greet patient, provide gowning, ensure appropriate medical records are available						
30	Obtain vital signs						
31	Provide pre-service education/obtain consent	L042A	RN/LPN	5			
32	Prepare room, equipment, supplies	L051A	RN	3			
33	Setup scope (non facility setting only)	L051A	RN				
34	Prepare and position patient/ monitor patient/ set up IV	L051A	RN			2	
35	Sedate/apply anesthesia						



	A	B	C	D	E	F	G
1	<b>NOTE: Cell C8 contains a hyperlink with a reference costing source</b>			<b>JANUARY 2004 PEAC-APPROVED INPUTS</b>			
2	<b>FINAL 10-6-12</b>			<b>99170</b>		<b>99170</b>	
3	<b>Meeting Date: October 2012</b> <b>CPT Code/Tracking Code/RUC Tab: 99170/A1/Tab 13</b> <b>Specialty: American Academy of Pediatrics (AAP)</b>	<b>CMS Code</b>	<b>Staff Type</b>	Anogenital examination with colposcopic in childhood for suspected trauma		Anogenital examination with colposcopic or other similar magnification in childhood for suspected trauma	
4	<b>LOCATION</b>			<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>
5	<b>GLOBAL PERIOD</b>						
36	Intra-service						
37	<b>Assist patient in gowning and positioning</b>	L051A	RN			5	
38	<b>Assist physician in performing procedure</b>	L051A	RN	50		50	
39	<b>Other Clinical Activity (CLS) (Please see NF PE SoR)</b>		CLS			60	
40	Post-Service						
41	Monitor pt. following service/check tubes, monitors, drains						
42	<b>Clean room/equipment by physician staff</b>	L051A	RN	1		3	
43	<b>Clean scope</b>	L051A	RN			10	
44	Clean Surgical Instrument Package						
45	Complete diagnostic forms, lab & X-ray requisitions						
46	Review/read X-ray, lab, and pathology reports						
47	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
48	Other Clinical Activity - <i>specify</i> :						
49	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			n/a		n/a	
50	Dischrg mgmt (1.0 x 99238) (enter 12 min)			n/a		n/a	
51	Dischrg mgmt (1.0 x 99239) (enter 15 min)			n/a		n/a	
52	<b>Other Clinical Activity (please specify): Phone call to child protective services/law enforcement authorities</b>	L042A	RN/LPN	3	3		
53	End: Patient leaves office						
54	<b>POST-SERVICE Period</b>						
55	Start: Patient leaves office/facility						
56	Conduct phone calls/call in prescriptions						
57	<b>Office visits: List Number and Level of Office Visits</b>			<b># visits</b>	<b># visits</b>	<b># visits</b>	<b># visits</b>
58	99211 16 minutes		16				
59	99212 27 minutes		27				
60	99213 36 minutes		36				
61	99214 53 minutes		53				
62	99215 63 minutes		63				
63	Total Office Visit Time			0.0	0.0	0.0	0.0
64	<b>Other Clinical Activity (RN) (Please see NF PE SoR):</b>	L051A	RN			3	
65	End: with last office visit before end of global period						

	A	B	C	D	E	F	G
1	<b>NOTE: Cell C8 contains a hyperlink with a reference costing source</b>			<b>JANUARY 2004 PEAC-APPROVED INPUTS</b>			
2	<b>FINAL 10-6-12</b>			<b>99170</b>		<b>99170</b>	
3	Meeting Date: October 2012 CPT Code/Tracking Code/RUC Tab: 99170/A1/Tab 13 Specialty: American Academy of Pediatrics (AAP)	CMS Code	Staff Type	Anogenital examination with coloscopic in childhood for suspected trauma		Anogenital examination with colposcopic or other similar magnification in childhood for suspected trauma	
4	LOCATION			Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD						
66	<b>MEDICAL SUPPLIES</b>	<b>CODE</b>	<b>UNIT</b>				
67	pack, minimum multi-specialty visit	SA048	pack			1	0
68	drape, non-sterile, sheet 40in x 60in	SB006		1		1	0
69	applicator, cotton-tipped, non-sterile 6in	SG008		2		2	0
70	tubed culture media	SL146				2	0
71	gloves, non-sterile (Note: Two pairs are included in minimum multi-specialty visit pack but a third pair is required for this service.)	SB022		1		1	0
72	film, type 667 Polaroid (per exposure)	SK032		4 exp			
73	spectual, vaginal	SD118				1	0
74	cup, sterile, 8 oz	SL157				1	0
75	lubricating jelly (Surgilube)	SJ033				1	0
76	<b>EQUIPMENT</b>	<b>CODE</b>					
77	table, power	EF031		50 min		60	
78	colposcope	ES004		50 min		67	
79	light, fiberoptic headlight w-source	EQ170		50 min		60	
80	camera, digital system, 12 megapixel (medical grade)	ED005		50 min		60	
81	computer, desktop, w-monitor	ED021				0	
82	mayo stand	EF015				60	
83	video camera (patient monitor)	ED045				50 min	
84	stirrups (for table)	ER062				50 min	
85	<a href="#">Physician's examination chair</a>					50 min	

## AMA/Specialty Society RVS Update Committee Summary of Recommendations

October 2012

### **Interprofessional Telephone Consultative Services**

In June 2010, the CPT Editorial Panel created the Telephone Consultative Services Workgroup to address a proposal to create codes describing telephone/internet consultative services. The workgroup was charged with the following: Clarify use by non-physicians; Review the appropriateness of time increments for physician to patient calls; Clarify the typical patient/service descriptions based upon literature supplied; Consider appropriate use of term “consultation”; and Consider time interval for non-reporting as being distinct from a patient call (ie, if a face to face service occurs the next week or if co-management is in progress and the patient is seen every month, but more than 7 days previously, is the service reported). In May 2012, the CPT Editorial Panel approved a new Evaluation and Management subsection, guidelines and four codes to describe and report telephone/internet consultative services.

An interprofessional telephone/internet consultation is an assessment and management service in which a patient’s treating (eg, attending or primary) physician or other qualified health care professional requests the opinion and/or treatment advice of a physician with specific specialty expertise (the consultant) to assist the treating physician/qualified health care professional in the diagnosis and/or management of the patient’s problem without the need for the patient’s face to face contact with the consulting physician.

These services are typically provided in complex and/or urgent situations where a timely face to face service with the consultant may not be feasible (eg, geographic distance). These codes should not be reported by a consultant who has agreed to accept transfer of care before the telephone/internet assessment, but are appropriate to report if the decision to accept transfer of care cannot be made until after the initial interprofessional telephone/Internet consultation.

The patient for whom the interprofessional telephone/internet consultation is requested may be either a new patient to the consulting physician or an established patient with a new problem or an exacerbation of an existing problem. However, the consultant should not have seen the patient in a face to face encounter within the last 14 days. When the telephone/internet consultation leads to an immediate transfer of care or other face-to-face service (eg, a surgery, hospital visit or a scheduled office evaluation of the patient) within the next 14 days or next available appointment date by the consultative physician, these codes are not reported.

**99446 Interprofessional telephone/internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician/qualified healthcare professional; 5-10 minutes of medical consultative discussion and review**

The RUC reviewed the survey results from 48 multi-specialty physicians and determined that the survey respondents overestimated physician work. The specialty societies proposed and the RUC accepted modifications to the survey times to more accurately reflect the CPT descriptor: 3 minutes for pre-service; 8 minutes for intra service; and 5 minutes for post service. The RUC reviewed key reference service, CPT code 99441 *Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion* (work RVU=0.25) and agreed that 99446 is a more intense procedure. Typically, the patient is unknown to the consulting physician, the service is provided in a complex/urgent situation and the medical decision-making required is more intense than the key reference service. In order to maintain the proper rank order in relation to 99447 (described below), the RUC used magnitude estimation and determined that a work RVU between the survey 25<sup>th</sup> percentile (0.50) and the work RVU of 99441 (0.25) is appropriate. The RUC also compared 99446 to 99281 *Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor* (work RVU = 0.45) and determined that 99281 is a more intense service and should be valued higher. **The RUC recommends a work RVU of 0.35 for CPT code 99446.**

**99447 Interprofessional telephone/internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician/qualified healthcare professional; 11-20 minutes of medical consultative discussion and review**

The RUC reviewed the survey results from 31 multi-specialty physicians and determined that the survey respondents overestimated physician work. The specialty societies proposed and the RUC accepted modifications to the survey times to more accurately reflect the CPT descriptor: 3 minutes of pre-service; 15 minutes of intra service; and 5 minutes of post service. The RUC reviewed key reference service, 99442 *Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion* (work RVU=0.50) and agreed that 99447 is a more intense procedure. Typically, the patient is unknown to the consulting physician, the service is provided in a complex/urgent situation and the medical decision-making required is more intense than the key reference service. In order to maintain the proper rank order within the family of services, the specialty society indicated and the RUC agreed that a work of 0.70, lower than the survey 25<sup>th</sup> percentile is appropriate. The 0.35 increment increase in work RVU is similar to that within the telephone evaluation and management services, 99441-99443. The RUC also reviewed CPT code 99241 *Office consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and*

*Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family (work RVU = 0.64 and 15 minutes of intra-service time) and agreed that 99447 should be valued higher since it is typically provided in a complex/urgent situation. The RUC recommends a work RVU of 0.70 for CPT code 99447.*

**99448 Interprofessional telephone/internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician/qualified healthcare professional; 21-30 minutes of medical consultative discussion and review**

The RUC reviewed the survey results from 31 multi-specialty physicians and determined that the survey respondents overestimated physician work. The specialty societies proposed and the RUC accepted modifications to the survey times to more accurately reflect the CPT descriptor: 5 minutes for pre-service; 25 minutes for intra service; and 5 minutes of post service. The RUC reviewed CPT code 99443 *Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion* (work RVU=0.75) and agreed that 99448 is a more intense procedure. Typically, the patient is unknown to the consulting physician, the service is provided in a complex/urgent situation and the medical decision-making required is more intense than the key reference service. In order to maintain the proper rank order within this family of services, the RUC used magnitude estimation and determined that a work RVU of 1.05 is appropriate (99447 work RVU of 0.70 + 0.35 = 1.05). The RUC compared 99448 to 99374 *Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker* (work RVU = 1.10) and determined that 99374 is a more intense service and should be valued higher. **The RUC recommends a work RVU of 1.05 for CPT code 99448.**

**99449 Interprofessional telephone/internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician/qualified healthcare professional; 31 minutes or more of medical consultative discussion and review**

The RUC reviewed the survey results from 26 multi-specialty physicians and determined that the survey respondents overestimated physician work. The RUC noted that 99449 will typically be utilized by behavioral/mental health professionals as there is a perceived need with access to care. The specialty societies proposed and the RUC accepted modifications to the survey times to more accurately reflect the CPT descriptor: 9 minutes for pre-service; 31 minutes for intra service; and 10 minutes for post service. The RUC reviewed CPT codes 92014 *Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established*

patient, 1 or more visits (work RVU=1.42) and 99304 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 25 minutes at the bedside and on the patient's facility floor or unit. (work RVU=1.64) and agreed that both services require less intra-service time and are more intense than 99449. **The RUC recommends a work RVU of 1.40 for CPT code 99449.**

### New Technology

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

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<p>An on-line electronic medical evaluation is a non-face-to-face evaluation and management (E/M) service by a physician to a patient using Internet resources in response to a patient's on-line inquiry. Reportable services involve the physician's personal timely response to the patient's inquiry and must involve permanent storage (electronic or hard copy) of the encounter. This service is reported only once for the same episode of care during a seven-day period, although multiple physicians could report their exchange with the same patient. If the on-line medical evaluation refers to an E/M service previously performed and reported by the physician within the previous seven days (either physician requested or unsolicited patient follow-up) or within the postoperative period of the previously completed procedure, then the service(s) are considered covered by the previous E/M service or procedure. A reportable service encompasses the sum of communication (eg, related telephone calls, prescription provision, laboratory orders) pertaining to the on-line patient encounter.</p> <p>(For an on-line medical evaluation provided by a qualified nonphysician health care professional, use 98969)</p>				

99444

Online evaluation and management service provided by a physician to an established patient, or guardian not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network

(Do not report 99444 when using 99339-99340, 99374-99380 for the same communication[s])

(Do not report 99444 for anticoagulation management when reporting 99363, 99364)

(Do not report 99444 with 99446-99449)

### **Interprofessional Telephone/Internet Consultations**

The consultant should use the following codes to report interprofessional telephone/internet consultations. An interprofessional telephone/internet consultation is an assessment and management service in which a patient's treating (eg, attending or primary) physician or other qualified health care professional requests the opinion and/or treatment advice of a physician with specific specialty expertise (the consultant) to assist the treating physician/qualified health care professional in the diagnosis and/or management of the patient's problem without the need for the patient's face to face contact with the consulting physician.

These services are typically provided in complex and/or urgent situations where a timely face to face service with the consultant may not be feasible (eg, geographic distance). These codes should not be reported by a consultant who has agreed to accept transfer of care before the telephone/internet assessment, but are appropriate to report if the decision to accept transfer of care cannot be made until after the initial interprofessional telephone/internet consultation.

The patient for whom the interprofessional telephone/internet consultation is requested may be either a new patient to the consulting physician or an established patient with a new problem or an exacerbation of an existing problem. However the consultant should not have seen the patient in a face to face encounter within the last 14 days. When the telephone/internet consultation leads to an immediate transfer of care or other face-to-face service (eg, a surgery, hospital visit or a scheduled office evaluation of the patient) within the next 14 days or next available appointment date by the consultative physician, these codes are not reported.

Review of pertinent medical records, laboratory studies, imaging studies, medication profile, pathology specimens, etc may be required and transmitted electronically, by fax or by mail immediately before the telephone/internet consultation or following the consultation.

The review of this data is included in the telephone/internet consultation service and should not be reported separately. The majority of the service time reported (greater than 50%) must be devoted to the medical consultative verbal/**Internet** discussion. This service should not be reported more than once within a seven day interval.

If more than one telephone/internet contact(s) is required to complete the consultation request (eg, discussion of test results), the entirety of the service and the cumulative discussion and information review time should be reported with a single code.

The written or verbal request for telephone/internet advice by the treating/requesting physician/qualified healthcare professional should be documented in the patient's medical record, including the reason for the request, and concludes with a verbal opinion report and written report from the consulting physician to the treating/requesting physician/qualified healthcare professional.

Telephone/internet consultations of less than 5 minutes should not be reported. Consultant communications with the patient and/or family may be reported using 99441-99444, 98966-98969) and the time related to these services is not used in reporting 99446-99449.

When the sole purpose of the telephone/internet communication is to arrange a transfer of care or other face-to-face service these codes are not reported.

The treating/requesting physician/qualified healthcare professional may report the prolonged service codes 99354-99357 for the time spent on the inter-professional telephone/internet discussion with the consulting (eg, specialist) physician if the time **exceeds 30 minutes** beyond the typical time of the appropriate E/M service performed and the patient is present (onsite) and accessible to the treating/requesting physician/qualified healthcare professional. If the interprofessional telephone/internet assessment and management service occurs when the patient is not present or on-site, and the discussion time exceeds 30 minutes beyond the typical time of the appropriate E/M service performed, then the non face-to-face prolonged service codes 99358-99359 may be reported by the treating/requesting physician/qualified healthcare professional.

(For telephone services provided by a physician to a patient, see 99441-99443)

(For telephone services provided by a qualified healthcare professional to a patient, see 98966-98968)

(For an on-line medical evaluation provided by a physician to a patient, use 99444)



(For an on-line assessment and management service provided by a qualified healthcare professional to a patient, use 98969)				
●99446	E1	Interprofessional telephone/internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician/qualified healthcare professional; 5-10 minutes of medical consultative discussion and review	XXX	0.35
●99447	E2	11-20 minutes of medical consultative discussion and review	XXX	0.70
●99448	E3	21-30 minutes of medical consultative discussion and review	XXX	1.05
●99449	E4	31 minutes or more of medical consultative discussion and review	XXX	1.40
<b>Medicine</b> <b>Non-Face-To-Face Services</b> <b>On-line Medical Evaluation</b> <p>An on-line electronic medical evaluation is a non-face-to-face assessment and management service by a qualified health care professional to a patient using Internet resources in response to a patient's on-line inquiry. Reportable services involve the qualified health care professional's personal timely response to the patient's inquiry and must involve permanent storage (electronic or hard copy) of the encounter. This service is reported only once for the same episode of care during a seven-day period, although multiple qualified healthcare professionals could report their exchange with the same patient. If the on-line medical evaluation refers to an assessment and management service previously performed and reported by the qualified health care professional within the previous seven days (either qualified health care professional requested or unsolicited patient follow-up) or within the postoperative period of the previously completed procedure, then the service(s) are considered covered by the previous assessment and management office service or procedure. A reportable service encompasses the sum of communication (eg, related telephone calls, prescription provision, laboratory orders) pertaining to the on-line patient encounter.</p> <p>(For an on-line medical evaluation provided by a physician, use 99444)</p>				

98969	<p>Online evaluation and management service provided by a qualified nonphysician health care professional to an established patient or guardian not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network (2/12 Panel Action)</p> <p>(Do not report 98969 when using 99339-99340, 99374-99380 for the same communication[s])</p> <p>(Do not report 98969 for anticoagulation management when reporting 99363, 99364)</p>
-------	--

## AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 99446	Tracking Number E1	Original Specialty Recommended RVU: <b>0.50</b>
		Presented Recommended RVU: <b>0.35</b>
Global Period: XXX		RUC Recommended RVU: <b>0.35</b>

CPT Descriptor: Interprofessional telephone/internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician/qualified healthcare professional; 5-10 minutes of medical consultative discussion and review

### CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A two day old hospitalized newborn develops poor feeding and tachypnea and is diagnosed with group B streptococcal bacteremia. The patient's primary care physician telephones an infectious disease specialist located several hours away for treatment advice.

Percentage of Survey Respondents who found Vignette to be Typical: 65%

#### Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

#### Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Confirms that patient, parent, or legal guardian has been informed in advance of the telephone consultation and has agreed. Decide on appropriate timing to fit call into existing daily schedule. Review any data or relevant information sent to consultant in advance of call.

Description of Intra-Service Work: Clarify from the requesting physician the nature of the patient's problem to be discussed. Obtain from the requesting physician all relevant history, physical examination, lab data, imaging. Present to requesting physician an analysis of the patient's problem, including likely diagnosis and suggested management. Provide to requesting physician alternative diagnoses and management approaches, including pluses and minuses of each. Respond to questions from the requesting physician to clarify diagnostic and treatment approach. Relay to requesting physician all relevant scientific background on the disease at issue needed to understand the consultant's recommendations or to respond to requesting physician's questions. Outline suggestions for long-term handling of the patient's problem.

Description of Post-Service Work: Review all relevant lab tests and other data not previously made available to consultant. Complete any literature review in response to issues raised during the phone call. Prepare a written response to the requesting physician.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	10/2012				
<b>Presenter(s):</b>	Steve Krug, MD, FAAP and Dennis Murray, MD, FAAP (AAP); Kevin Kerber, MD (AAN); Alfonso Bello, MD (ACR); Allan Glass, MD (TES); Howard Lando, MD (AAE)				
<b>Specialty(s):</b>	American Academy of Neurology, American Academy of Pediatrics, American Association of Clinical Endocrinologists, American College of Rheumatology, The Endocrine Society				
<b>CPT Code:</b>	99446				
<b>Sample Size:</b>	1738	<b>Resp N:</b>	48	<b>Response:</b> 2.7 %	
<b>Description of Sample:</b>	A survey was sent to 300 randomly selected AAN members; 1, 021 AAP members, 128 ACRh members, 150 TES members and 18 TES Advisors, 100 AACE members 21 members of of the Socioeconomics and Member Advocacy Committee				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	4.25	<b>22.50</b>	50.00	1000.00
<b>Survey RVW:</b>	0.25	0.50	<b>0.64</b>	1.03	49.99
<b>Pre-Service Evaluation Time:</b>			<b>5.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>0.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>0.00</b>		
<b>Intra-Service Time:</b>	2.00	5.00	<b>10.00</b>	15.00	90.00
<b>Immediate Post Service-Time:</b>	<b>5.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

<b>CPT Code:</b>	99446	<b>Recommended Physician Work RVU: 0.35</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>3.00</b>	<b>0.00</b>	<b>3.00</b>
<b>Pre-Service Positioning Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>8.00</b>		
<b>Immediate Post Service-Time:</b>	<b>5.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		

<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? Yes

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99441	XXX	0.25	RUC Time

CPT Descriptor Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99212	XXX	0.48	RUC Time	18,400,000

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
65205	000	0.71	RUC Time	28,100

CPT Descriptor 2 Removal of foreign body, external eye; conjunctival superficial

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99442	XXX	0.50	RUC Time

CPT Descriptor Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code:** 15      **% of respondents:** 31.2 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 99446</b>	<b>Key Reference CPT Code: 99441</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	3.00	1.00	
Median Intra-Service Time	8.00	8.00	

Median Immediate Post-service Time	5.00	4.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>16.00</b>	<b>13.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)**(of those that selected Key  
Reference code)**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.87	3.53
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.73	3.60
--	------	------

Urgency of medical decision making	4.13	3.60
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.13	3.00
--------------------------	------	------

Physical effort required	2.13	2.33
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.87	3.53
---	------	------

Outcome depends on the skill and judgment of physician	4.07	3.67
--	------	------

Estimated risk of malpractice suit with poor outcome	3.33	3.33
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.33	2.27
----------------------------------	------	------

Intra-Service intensity/complexity	3.47	3.40
------------------------------------	------	------

Post-Service intensity/complexity	2.67	2.60
-----------------------------------	------	------

## Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An expert panel was constituted from RUC advisors representing the surveying specialty societies. This expert panel reviewed the survey results in detail and conferred by telephone conference call on several occasions, together with specialty society staff members. As the four codes are linked and ordered by increasing time intervals for the duration of the telephone consultation, initial discussion focused on establishing 99446 as the anchor for the family. Based on survey results and comparison with other codes, the panel recommends the 25th percentile of the survey results (0.50 work RVUs) for 99446. Based on similar considerations, the panel recommends the 25th percentile of the survey results (0.75 work RVUs) for 99447.

The physician work survey results for 99448 were virtually identical to those of 99447, thus leading to a rank order anomaly if the 25th percentile were used. The panel recommends that the median physician work from the survey (1.00) should be used to avoid this rank order anomaly. In addition, this recommendation also maintains the same increment between 99446 and 99447 as between 99447 and 99448.

For 99449, the panel recommends a physician work value of 1.25, just slightly over the survey 25th percentile. This recommendation maintains the same interval between 99449 and 99448 as between 99448 and 99447 or between 99447 and 99446.

After comparison of the survey times with the times from various comparator codes, the panel recommends the median survey times for all four codes as there didn't appear to be substantial reason for modifying the survey results.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) This service was not previously reported.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pediatrics How often? Commonly

Specialty Neurology/Endocrinology/Rheumatology How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 112497

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Expert panel estimation

Specialty Pediatrics Frequency 83081 Percentage 73.85 %

Specialty Neurology/Endocrinology/Rheumatology Frequency 29416 Percentage 26.14 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

24,691 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Expert panel estimation

Specialty Pediatrics Frequency 0 Percentage 0.00 %

Specialty Neurology/Endocrinology/Rheumatology Frequency 24691 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 99462



## AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 99447	Tracking Number E2	Original Specialty Recommended RVU: <b>0.75</b>
		Presented Recommended RVU: <b>0.70</b>
Global Period: XXX		RUC Recommended RVU: <b>0.70</b>

CPT Descriptor: Interprofessional telephone/internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician/qualified healthcare professional; 11-20 minutes of medical consultative discussion and review

### CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66 year old male on levothyroxine and cortisone is admitted to an ICU for chest pain. The hospitalist contacts the patient's endocrinologist to obtain additional information regarding the illness(es) being treated, the dosage of the prescribed medications, any recent laboratory data and additional treatment and management options that should be considered during the hospitalization.

Percentage of Survey Respondents who found Vignette to be Typical: 74%

### Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

### Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Confirms that patient, parent, or legal guardian has been informed in advance of the telephone consultation and has agreed. Decide on appropriate timing to fit call into existing daily schedule. Review any data or relevant information sent to consultant in advance of call.

Description of Intra-Service Work: Clarify from the requesting physician the nature of the patient's problem to be discussed. Obtain from the requesting physician all relevant history, physical examination, lab data, imaging. Present to requesting physician an analysis of the patient's problem, including likely diagnosis and suggested management. Provide to requesting physician alternative diagnoses and management approaches, including pluses and minuses of each. Respond to questions from the requesting physician to clarify diagnostic and treatment approach. Relay to requesting physician all relevant scientific background on the disease at issue needed to understand the consultant's recommendations or to respond to requesting physician's questions. Outline suggestions for long-term handling of the patient's problem.

Description of Post-Service Work: Review all relevant lab tests and other data not previously made available to consultant. Complete any literature review in response to issues raised during the phone call. Prepare a written response to the requesting physician.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	10/2012				
<b>Presenter(s):</b>	Steve Krug, MD, FAAP and Dennis Murray, MD, FAAP (AAP); Kevin Kerber, MD (AAN); Alfonso Bello, MD (ACR); Allan Glass, MD (TES); Howard Lando, MD (AAE)				
<b>Specialty(s):</b>	American Academy of Neurology, American Academy of Pediatrics, American Association of Clinical Endocrinologists, American College of Rheumatology, The Endocrine Society				
<b>CPT Code:</b>	99447				
<b>Sample Size:</b>	1738	<b>Resp N:</b>	31	<b>Response:</b> 1.7 %	
<b>Description of Sample:</b>	A survey was sent to 300 randomly selected AAN members; 1, 021 AAP members, 128 ACRh members, 150 TES members and 18 TES Advisors, 100 AACE members 21 members of of the Socioeconomics and Member Advocacy Committee				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	0.00	<b>5.00</b>	20.00	100.00
<b>Survey RVW:</b>	0.30	0.75	<b>0.95</b>	1.03	45.00
<b>Pre-Service Evaluation Time:</b>			<b>5.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>0.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>0.00</b>		
<b>Intra-Service Time:</b>	5.00	11.50	<b>15.00</b>	20.00	80.00
<b>Immediate Post Service-Time:</b>	<b>5.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

<b>CPT Code:</b>	99447	<b>Recommended Physician Work RVU: 0.70</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>3.00</b>	<b>0.00</b>	<b>3.00</b>
<b>Pre-Service Positioning Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>15.00</b>		
<b>Immediate Post Service-Time:</b>	<b>5.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		

<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? Yes

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99442	XXX	0.50	RUC Time

CPT Descriptor Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99213	XXX	0.97	RUC Time	99,960,000

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
65205	000	0.71	RUC Time	28,100

CPT Descriptor 2 Removal of foreign body, external eye; conjunctival superficial

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99241	XXX	0.64	RUC Time

CPT Descriptor Office consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code:** 9      **% of respondents:** 29.0 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 99447</b>	<b>Key Reference CPT Code: 99442</b>
Median Pre-Service Time	3.00	1.00
Median Intra-Service Time	15.00	15.00
Median Immediate Post-service Time	5.00	5.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>23.00</b>	<b>21.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)**

(of those that selected Key  
Reference code)

**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.11	3.67
Urgency of medical decision making	4.22	3.67

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.44	3.44
--------------------------	------	------

Physical effort required	2.67	2.56
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.22	4.11
Outcome depends on the skill and judgment of physician	4.44	4.44
Estimated risk of malpractice suit with poor outcome	3.78	3.89

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**

**Reference  
Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	2.78	2.78
----------------------------------	------	------

Intra-Service intensity/complexity	3.89	3.67
------------------------------------	------	------

Post-Service intensity/complexity	3.00	2.78
-----------------------------------	------	------

---

### Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An expert panel was constituted from RUC advisors representing the surveying specialty societies. This expert panel reviewed the survey results in detail and conferred by telephone conference call on several occasions, together with specialty society staff members. As the four codes are linked and ordered by increasing time intervals for the duration of the telephone consultation, initial discussion focused on establishing 99446 as the anchor for the family. Based on survey results and comparison with other codes, the panel recommends the 25th percentile of the survey results (0.50 work RVUs) for 99446. Based on similar considerations, the panel recommends the 25th percentile of the survey results (0.75 work RVUs) for 99447.

The physician work survey results for 99448 were virtually identical to those of 99447, thus leading to a rank order anomaly if the 25th percentile were used. The panel recommends that the median physician work from the survey (1.00) should be used to avoid this rank order anomaly. In addition, this recommendation also maintains the same increment between 99446 and 99447 as between 99447 and 99448.

For 99449, the panel recommends a physician work value of 1.25, just slightly over the survey 25th percentile. This recommendation maintains the same interval between 99449 and 99448 as between 99448 and 99447 or between 99447 and 99446.

After comparison of the survey times with the times from various comparator codes, the panel recommends the median survey times for all four codes as there didn't appear to be substantial reason for modifying the survey results.

---

### SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) This service was not previously reported.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pediatrics How often? Commonly

Specialty Neurology/Endocrinology/Rheumatology How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 99801

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Expert panel estimation

Specialty Pediatrics Frequency 75133 Percentage 75.28 %

Specialty Neurology/Endocrinology/Rheumatology Frequency 24668 Percentage 24.71 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

23,129 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Please explain the rationale for this estimate. Expert panel estimation

Specialty Pediatrics Frequency 0 Percentage 0.00 %

Specialty Neurology/Endocrinology/Rheumatology Frequency 23129 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

**Professional Liability Insurance Information (PLI)**

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 99462

## AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 99448	Tracking Number E3	Original Specialty Recommended RVU: <b>1.00</b>
		Presented Recommended RVU: <b>1.05</b>
Global Period: XXX		RUC Recommended RVU: <b>1.05</b>

CPT Descriptor: Interprofessional telephone/internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician/qualified healthcare professional; 21-30 minutes of medical consultative discussion and review

### CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 57 year old woman was sent for a CT exam by her primary care physician for recurrent severe headaches during which a thyroid nodule is incidentally identified. The primary care physician contacts an endocrinologist to discuss the appropriate diagnostic evaluation.

Percentage of Survey Respondents who found Vignette to be Typical: 74%

#### Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

#### Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Confirms that patient, parent, or legal guardian has been informed in advance of the telephone consultation and has agreed. Decide on appropriate timing to fit call into existing daily schedule. Review any data or relevant information sent to consultant in advance of call.

Description of Intra-Service Work: Clarify from the requesting physician the nature of the patient's problem to be discussed. Obtain from the requesting physician all relevant history, physical examination, lab data, imaging. Present to requesting physician an analysis of the patient's problem, including likely diagnosis and suggested management. Provide to requesting physician alternative diagnoses and management approaches, including pluses and minuses of each. Respond to questions from the requesting physician to clarify diagnostic and treatment approach. Relay to requesting physician all relevant scientific background on the disease at issue needed to understand the consultant's recommendations or to respond to requesting physician's questions. Outline suggestions for long-term handling of the patient's problem.

Description of Post-Service Work: Review all relevant lab tests and other data not previously made available to consultant. Complete any literature review in response to issues raised during the phone call. Prepare a written response to the requesting physician.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	10/2012				
<b>Presenter(s):</b>	Steve Krug, MD, FAAP and Dennis Murray, MD, FAAP (AAP); Kevin Kerber, MD (AAN); Alfonso Bello, MD (ACR); Allan Glass, MD (TES); Howard Lando, MD (ACE)				
<b>Specialty(s):</b>	American Academy of Neurology, American Academy of Pediatrics, American Association of Clinical Endocrinologists, American College of Rheumatology, The Endocrine Society				
<b>CPT Code:</b>	99448				
<b>Sample Size:</b>	1738	<b>Resp N:</b>	31	<b>Response:</b> 1.7 %	
<b>Description of Sample:</b>	A survey was sent to 300 randomly selected AAN members; 1,021 AAP members, 128 ACRh members, 150 TES members and 18 TES Advisors, 100 ACE members 21 members of the Socioeconomics and Member Advocacy Committee				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	0.00	4.00	25.00	100.00
<b>Survey RVW:</b>	0.50	0.75	1.00	1.50	45.00
<b>Pre-Service Evaluation Time:</b>			5.00		
<b>Pre-Service Positioning Time:</b>			0.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.00		
<b>Intra-Service Time:</b>	5.00	15.00	20.00	25.00	60.00
<b>Immediate Post Service-Time:</b>	<u>5.00</u>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

<b>CPT Code:</b>	99448	<b>Recommended Physician Work RVU: 1.05</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		5.00	0.00	5.00
<b>Pre-Service Positioning Time:</b>		0.00	0.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	0.00	0.00
<b>Intra-Service Time:</b>		25.00		
<b>Immediate Post Service-Time:</b>	<u>5.00</u>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		



<b>Prolonged Services:</b>	<u><b>0.00</b></u>	99354x <b>0.00</b>	55x <b>0.00</b>	56x <b>0.00</b>	57x <b>0.00</b>
<b>Sub Obs Care:</b>	<u><b>0.00</b></u>	99224x <b>0.00</b>	99225x <b>0.00</b>	99226x <b>0.00</b>	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? Yes

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99443	XXX	0.75	RUC Time

CPT Descriptor Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99213	XXX	0.97	RUC Time	99,960,000

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
-----------------------	---------------	-----------------	--------------------	---

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99242	XXX	1.34	RUC Time

CPT Descriptor Office consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code:** 11      **% of respondents:** 35.4 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 99448</b>	<b>Key Reference CPT Code: 99443</b>
Median Pre-Service Time	5.00	1.00
Median Intra-Service Time	25.00	20.00
Median Immediate Post-service Time	5.00	10.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>35.00</b>	<b>31.00</b>
<b>Other time if appropriate</b>		

Source of Time  
RUC Time**INTENSITY/COMPLEXITY MEASURES (Mean)**(of those that selected Key  
Reference code)**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.09	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.18	3.91
Urgency of medical decision making	4.18	3.91

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.27	3.18
--------------------------	------	------

Physical effort required	2.73	2.64
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.09	3.82
Outcome depends on the skill and judgment of physician	4.27	4.18
Estimated risk of malpractice suit with poor outcome	3.82	3.91

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.73	2.64
----------------------------------	------	------

Intra-Service intensity/complexity	4.18	3.82
------------------------------------	------	------

Post-Service intensity/complexity	2.82	2.64
-----------------------------------	------	------

---

### Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An expert panel was constituted from RUC advisors representing the surveying specialty societies. This expert panel reviewed the survey results in detail and conferred by telephone conference call on several occasions, together with specialty society staff members. As the four codes are linked and ordered by increasing time intervals for the duration of the telephone consultation, initial discussion focused on establishing 99446 as the anchor for the family. Based on survey results and comparison with other codes, the panel recommends the 25th percentile of the survey results (0.50 work RVUs) for 99446. Based on similar considerations, the panel recommends the 25th percentile of the survey results (0.75 work RVUs) for 99447.

The physician work survey results for 99448 were virtually identical to those of 99447, thus leading to a rank order anomaly if the 25th percentile were used. The panel recommends that the median physician work from the survey (1.00) should be used to avoid this rank order anomaly. In addition, this recommendation also maintains the same increment between 99446 and 99447 as between 99447 and 99448.

For 99449, the panel recommends a physician work value of 1.25, just slightly over the survey 25th percentile. This recommendation maintains the same interval between 99449 and 99448 as between 99448 and 99447 or between 99447 and 99446.

After comparison of the survey times with the times from various comparator codes, the panel recommends the median survey times for all four codes as there didn't appear to be substantial reason for modifying the survey results.

---

### SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) This service was not previously reported.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pediatrics How often? Commonly

Specialty Neurology/Endocrinology/Rheumatology How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 94626

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Expert panel estimation

Specialty Pediatrics Frequency 72212 Percentage 76.31 %

Specialty Neurology/Endocrinology/Rheumatology Frequency 22414 Percentage 23.68 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

21,464 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Expert panel estimation

Specialty Pediatrics Frequency 0 Percentage 0.00 %

Specialty Neurology/Endocrinology/Rheumatology Frequency 21464 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

**Professional Liability Insurance Information (PLI)**

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 99462

## AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 99449	Tracking Number E4	Original Specialty Recommended RVU: <b>1.25</b>
		Presented Recommended RVU: <b>1.40</b>
Global Period: XXX		RUC Recommended RVU: <b>1.40</b>

CPT Descriptor: Interprofessional telephone/internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician/qualified healthcare professional; 31 minutes or more of medical consultative discussion and review

### CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 10 year old boy with attention deficit disorder has become increasingly aggressive at home and school. The child's pediatrician arranges a telephone consultation with a child and adolescent psychiatrist and forwards historical records on the child prior to the telephone consultation.

Percentage of Survey Respondents who found Vignette to be Typical: 62%

#### Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

#### Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Confirms that patient, parent, or legal guardian has been informed in advance of the telephone consultation and has agreed. Decide on appropriate timing to fit call into existing daily schedule. Review any data or relevant information sent to consultant in advance of call.

Description of Intra-Service Work: Clarify from the requesting physician the nature of the patient's problem to be discussed. Obtain from the requesting physician all relevant history, physical examination, lab data, imaging. Present to requesting physician an analysis of the patient's problem, including likely diagnosis and suggested management. Provide to requesting physician alternative diagnoses and management approaches, including pluses and minuses of each. Respond to questions from the requesting physician to clarify diagnostic and treatment approach. Relay to requesting physician all relevant scientific background on the disease at issue needed to understand the consultant's recommendations or to respond to requesting physician's questions. Outline suggestions for long-term handling of the patient's problem.

Description of Post-Service Work: Review all relevant lab tests and other data not previously made available to consultant. Complete any literature review in response to issues raised during the phone call. Prepare a written response to the requesting physician.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	10/2012				
<b>Presenter(s):</b>	Steve Krug, MD, FAAP and Dennis Murray, MD, FAAP (AAP); Kevin Kerber, MD (AAN); Alfonso Bello, MD (ACR); Allan Glass, MD (TES); Howard Lando, MD (ACE)				
<b>Specialty(s):</b>	American Academy of Neurology, American Academy of Pediatrics, American Association of Clinical Endocrinologists, American College of Rheumatology, The Endocrine Society				
<b>CPT Code:</b>	99449				
<b>Sample Size:</b>	1738	<b>Resp N:</b>	26	<b>Response:</b> 1.4 %	
<b>Description of Sample:</b>	A survey was sent to 300 randomly selected AAN members; 1, 021 AAP members, 128 ACRh members, 150 TES members and 18 TES Advisors, 100 ACE members 21 members of of the Socioeconomics and Member Advocacy Committee				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	0.00	<b>5.00</b>	10.00	140.00
<b>Survey RVW:</b>	0.50	1.14	<b>1.80</b>	1.90	45.00
<b>Pre-Service Evaluation Time:</b>			<b>9.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>0.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>0.00</b>		
<b>Intra-Service Time:</b>	10.00	20.00	<b>30.00</b>	31.00	60.00
<b>Immediate Post Service-Time:</b>	<b>10.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

<b>CPT Code:</b>	99449	<b>Recommended Physician Work RVU: 1.40</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>9.00</b>	<b>0.00</b>	<b>9.00</b>
<b>Pre-Service Positioning Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>31.00</b>		
<b>Immediate Post Service-Time:</b>	<b>10.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		

<b>Prolonged Services:</b>	<b><u>0.00</u></b>	99354x <b>0.00</b>	55x <b>0.00</b>	56x <b>0.00</b>	57x <b>0.00</b>
<b>Sub Obs Care:</b>	<b><u>0.00</u></b>	99224x <b>0.00</b>	99225x <b>0.00</b>	99226x <b>0.00</b>	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? Yes

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99243	XXX	1.88	RUC Time

CPT Descriptor Office consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99238	XXX	1.28	RUC Time	4,800,000

CPT Descriptor 1 Hospital discharge day management; 30 minutes or less

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99242	XXX	1.34	RUC Time

CPT Descriptor Office consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 10      % of respondents: 38.4 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 99449</b>	<b>Key Reference CPT Code: 99243</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	9.00	5.00	
Median Intra-Service Time	31.00	28.00	

Median Immediate Post-service Time	10.00	7.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>50.00</b>	<b>40.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)**(of those that selected Key  
Reference code)**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.60	4.30
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.60	4.40
--	------	------

Urgency of medical decision making	4.50	4.20
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.90	4.10
--------------------------	------	------

Physical effort required	2.70	3.50
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.50	4.30
---	------	------

Outcome depends on the skill and judgment of physician	4.60	4.40
--	------	------

Estimated risk of malpractice suit with poor outcome	4.40	4.10
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.40	3.80
----------------------------------	------	------

Intra-Service intensity/complexity	4.60	4.40
------------------------------------	------	------

Post-Service intensity/complexity	3.60	4.00
-----------------------------------	------	------



## Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUR analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An expert panel was constituted from RUC advisors representing the surveying specialty societies. This expert panel reviewed the survey results in detail and conferred by telephone conference call on several occasions, together with specialty society staff members. As the four codes are linked and ordered by increasing time intervals for the duration of the telephone consultation, initial discussion focused on establishing 99446 as the anchor for the family. Based on survey results and comparison with other codes, the panel recommends the 25th percentile of the survey results (0.50 work RVUs) for 99446. Based on similar considerations, the panel recommends the 25th percentile of the survey results (0.75 work RVUs) for 99447.

The physician work survey results for 99448 were virtually identical to those of 99447, thus leading to a rank order anomaly if the 25th percentile were used. The panel recommends that the median physician work from the survey (1.00) should be used to avoid this rank order anomaly. In addition, this recommendation also maintains the same increment between 99446 and 99447 as between 99447 and 99448.

For 99449, the panel recommends a physician work value of 1.25, just slightly over the survey 25th percentile. This recommendation maintains the same interval between 99449 and 99448 as between 99448 and 99447 or between 99447 and 99446.

After comparison of the survey times with the times from various comparator codes, the panel recommends the median survey times for all four codes as there didn't appear to be substantial reason for modifying the survey results.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) This service was not previously reported.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pediatrics How often? Commonly

Specialty Neurology/Endocrinology/Rheumatology How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 79666

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Expert panel estimation

Specialty Pediatrics Frequency 60214 Percentage 75.58 %

Specialty Neurology/Endocrinology/Rheumatology Frequency 17452 Percentage 21.90 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

18,694 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Expert panel estimation

Specialty Pediatrics Frequency 0 Percentage 0.00 %

Specialty Neurology/Endocrinology/Rheumatology Frequency 18694 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 99462

## SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN	
1	ISSUE: Interprofessional telephone/internet consultative services																																								
2	TAB: 14																																								
3						RVW				Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day					FAC-obs				Office					Prolonged							
4	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	
5	REF	99441	Telephone evaluation and management service provided by a physician to an established patient		0.017			0.25			13	1					8			4																					
6	CURRENT				#DIV/0!						0																														
7	SVY	99446	Interprofessional telephone/internet assessment and management service provided by a consultative physician; 5-10 minutes	48	0.042	0.25	0.50	0.64	1.03	49.99	20	5			2	5	10	15	90	5																					
8	REC	99446	Interprofessional telephone/internet assessment and management service provided by a consultative physician; 5-10 minutes		0.028	0.50					20	5					10			5																					
9																																									
10						RVW				Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day					FAC-obs				Office					Prolonged							
11	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	
12	REF	99442	Telephone evaluation and management service provided by a physician to an established patient		0.024			0.50			21	1					15			5																					
13	CURRENT				#DIV/0!						0																														
14	SVY	99447	Interprofessional telephone/internet assessment and management service provided by a consultative physician; 11-20 minutes	31	0.048	0.30	0.75	0.95	1.03	45.00	25	5			5	####	15	20	80	5																					
15	REC	99447	Interprofessional telephone/internet assessment and management service provided by a consultative physician; 11-20 minutes		0.035	0.75					25	5					15			5																					
16																																									

[illegible]

# American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



September 11, 2012

141 Northwest Point Blvd  
Elk Grove Village, IL 60007-1019  
Phone: 847/434-4000  
Fax: 847/434-8000  
E-mail: kidsdocs@aap.org  
www.aap.org

## Executive Committee

### President

Robert W. Block, MD, FAAP

### President-Elect

Thomas K. McNerny, MD, FAAP

### Immediate Past President

O. Marion Burton, MD, FAAP

### Executive Director/CEO

Errol R. Alden, MD, FAAP

## Board of Directors

### District I

Carole E. Allen, MD, FAAP  
Arlington, MA

### District II

Danielle Laraque, MD, FAAP  
Brooklyn, NY

### District III

Sandra Gibson Hassink, MD, FAAP  
Wilmington, DE

### District IV

Francis E. Rushton, Jr, MD, FAAP  
Beaufort, SC

### District V

Marilyn J. Bull, MD, FAAP  
Indianapolis, IN

### District VI

Michael V. Severson, MD, FAAP  
Shakopee, MN

### District VII

Kenneth E. Matthews, MD, FAAP  
College Station, TX

### District VIII

Kyle Yasuda, MD, FAAP  
Seattle, WA

### District IX

Myles B. Abbott, MD, FAAP  
Berkeley, CA

### District X

Sara H. Goza, MD, FAAP  
Fayetteville, GA

Barbara Levy, MD

Chair, AMA/Specialty Society RVS Update Committee

American Medical Association

Department of Physician Payment Policy and Systems

515 North State Street

Chicago, IL 60610

Re: Direct Practice Expense Inputs for Interprofessional Telephone/Internet Consultative Services (994XX1-994XX4; Tracking Codes E1-E4; Tab 14)

Dear Dr Levy:

Codes 994XX1-994XX4 (*Interprofessional telephone/internet assessment and management service provided by a consultative physician*) are among the codes being considered during the October 2012 RUC meeting.

The American Academy of Pediatrics (AAP), the American Academy of Neurology (AAN), the American College of Rheumatology (ACR), The Endocrine Society (TES), and the American Association of Clinical Endocrinologists (AACE) have conducted physician work surveys for codes 994XX1-994XX4 and developed work RVU recommendations based on the survey results.

However, we recommend no direct practice expense inputs for codes 994XX1-994XX4.

If you have any questions, please contact Linda Walsh, AAP staff, at 800/433-9016 ext 7931 or [lwalsh@aap.org](mailto:lwalsh@aap.org). Thank you.

Sincerely,

Alfonso Bello, MD  
ACR RUC Advisor

Howard Milton Lando, MD  
AACE RUC Advisor

Steve Krug, MD  
AAP RUC Advisor

Allan Glass, MD  
TES RUC Advisor

Kevin Kerber, MD  
AAN RUC Advisor



## AMA/Specialty Society RVS Update Committee Summary of Recommendations

January 2013

### **Total Body and Selective Head Hypothermia**

In October 2012, the CPT Editorial Panel created CPT codes 99481 and 99482 to replace CPT Category III codes, 0260T and 0261T, which describe services for hypothermia in a critically ill neonate per day. These services are no longer experimental and are part of the standard of care in neonatal intensive care units and as such are being valued in as CPT Category I codes.

CPT codes 99481 *Total body systemic hypothermia in a critically ill neonate per day (List separately in addition for code for primary procedure)* and 99482 *Selective head hypothermia in a critically ill neonate per day (List separately in addition for code for primary procedure)* were surveyed for the January 2013 RUC meeting. The RUC reviewed the survey results from 52 neonatologists and noted the low performance rate for this service with a median of 6 performed per year for 99481 and a median of 0 performed per year for 99482. The RUC was concerned that an add-on code that can be billed once per day rather than time based may overlap with other neonate critical care services. The RUC was also concerned with how the survey respondent arrived at 60 minutes of intra-service time for this service in the midst of the other services they are providing to a critically ill neonate throughout the day. The specialty explained that the Sarnat score, which measures six basic components of neurological function, must be taken every 4 hours, requiring 5-10 minutes for each evaluation. This, plus the assessment of continuous amplitude EEG monitoring, will result in at least 60 minutes of intra-service time.

The RUC determined that because of the low performance rate the survey data could not be considered reliable. Furthermore, there was concern that these services overlapped with the critical care services. For these reasons, the RUC decided that these codes should be carrier priced. The RUC recommends that the specialty work with the Research Subcommittee to determine an appropriate method to survey these services for the October 2013 RUC meeting. **The RUC recommends carrier pricing for CPT code 99481 and 99482.**

#### **Practice Expense:**

This service is primarily performed in a facility and does not have direct practice expense inputs associated with it.

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
D0260T		Total body systemic hypothermia, per day, in the neonate 28 days of age or younger	YYY	N/A
D0261T		Selective head hypothermia, per day, in the neonate 28 days of age or younger  (0260T, 0261T have been deleted. To report, see 99481, 99482)	YYY	N/A
<b>Category I</b> <b>Evaluation and Management</b> <b>Inpatient Neonatal Intensive Care Services and Pediatric and Neonatal Critical Care Services</b> <b>Pediatric Critical Care Patient Transport</b> <p>The following codes (99466, 99467) are used to report the physical attendance and direct face-to-face care by a physician during the interfacility transport of a critically ill or critically injured pediatric patient 24 months of age or younger. For the purpose of reporting codes 99466 and 99467, face-to-face care begins when the physician assumes primary responsibility of the pediatric patient at the referring hospital/facility, and ends when the receiving hospital/facility accepts responsibility for the pediatric patient's care. Only the time the physician spends in direct face-to-face contact with the patient during the transport should be reported. Pediatric patient transport services involving less than 30 minutes of face-to-face physician care should not be reported using codes 99466, 99467.</p>				



Procedure(s) or service(s) performed by other members of the transporting team may not be reported by the supervising physician.

For the definition of the critically injured pediatric patient, see the **Neonatal and Pediatric Critical Care Services** section.

The direction of emergency care to transporting staff by a physician located in a hospital or other facility by two-way communication is not considered direct face-to-face care and should not be reported with 99466, 99467. Physician-directed emergency care through outside voice communication to transporting staff personnel is reported with 99288.

Emergency department services (99281- 99285), initial hospital care (99221- 99223), critical care (99291, 99292), initial date neonatal intensive (99477) or critical care (99468) are only reported after the patient has been admitted to the emergency department, the inpatient floor, or the critical care unit of the receiving facility. If inpatient critical care services are reported in the referring facility prior to transfer to the receiving hospital, use the critical care codes (99291, 99292).

The following services are included when performed during the pediatric patient transport by the physician providing critical care and may not be reported separately: routine monitoring evaluations (eg, heart rate, respiratory rate, blood pressure, and pulse oximetry), the interpretation of cardiac output measurements (93562), chest X-rays (71010, 71015, 71020), pulse oximetry (94760, 94761, 94762), blood gases and information data stored in computers (eg, ECGs, blood pressures, hematologic data) ( 99090), gastric intubation (43752, 43753), temporary transcutaneous pacing (92953), ventilatory management (94002, 94003, 94660, 94662) and vascular access procedures (36000, 36400, 36405, 36406, 36415, 36591, 36600). Any services performed which are not listed above should be reported separately.

Code 99466 is used to report the first 30 to 74 minutes of direct face-to-face time with the transport pediatric patient and should be reported only once on a given date. Code 99467 is used to report each additional 30 minutes provided on a given date. Face-to-face services of less than 30 minutes should not be reported with these codes.

(For total body cooling of neonates, see 99481, 99482 ~~0260T, 0261T~~)

✚●99481	K1	Total body systemic hypothermia in a critically ill neonate per day (List separately in addition for code for primary procedure) <u>(Use 99481 in conjunction with 99291, 99292, 99468, 99469)</u>	ZZZ	Carrier Price Resurvey for October 2013
---------	----	--	-----	---

<div> <div>+</div> <div>●</div> <div>99482</div> </div>	K2	Selective head hypothermia in a critically ill neonate per day (List separately in addition for code for primary procedure) <u>(Use 99482 in conjunction with 99291, 99292, 99468, 99469)</u> <u>(Services by the professional during either cooling approach includes radiographic confirmation of core temperature probe (code), assessment of continuous amplitude EEG monitoring and interpretation of cooling related laboratory evaluations)</u>	ZZZ	Carrier Price Resurvey for October 2013
---	----	--	-----	---

# American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



141 Northwest Point Blvd  
Elk Grove Village, IL 60007-1019  
Phone: 847/434-4000  
Fax: 847/434-8000  
E-mail: kidsdocs@aap.org  
www.aap.org

January 2, 2013

## Executive Committee

### President

Thomas K. McInerney, MD, FAAP

### President-Elect

James M. Perrin, MD, FAAP

### Immediate Past President

Robert W. Block, MD, FAAP

### Executive Director/CEO

Errol R. Alden, MD, FAAP

## Board of Directors

### District I

Carole E. Allen, MD, FAAP  
Arlington, MA

### District II

Danielle Laraque, MD, FAAP  
Brooklyn, NY

### District III

David I. Bromberg, MD, FAAP  
Frederick, MD

### District IV

Francis E. Rushton, Jr, MD, FAAP  
Beaufort, SC

### District V

Marilyn J. Bull, MD, FAAP  
Indianapolis, IN

### District VI

Pamela K. Shaw, MD, FAAP  
Kansas City, KS

### District VII

Kenneth E. Matthews, MD, FAAP  
College Station, TX

### District VIII

Kyle Yasuda, MD, FAAP  
Seattle, WA

### District IX

Stuart A. Cohen, MD, MPH, FAAP  
San Diego, CA

### District X

Sara H. Goza, MD, FAAP  
Fayetteville, GA

Barbara Levy, MD  
Chair, AMA/Specialty Society RVS Update Committee  
American Medical Association  
Department of Physician Payment Policy and Systems  
515 North State Street  
Chicago, IL 60610

Re: Direct Practice Expense Inputs for Neonatal Hypothermia Services (99481-99482;  
Tracking Codes K1-K2; Tab 18)

Dear Dr Levy:

Codes 99481-99482 (*Total body systemic/selective head hypothermia in a critically ill neonate per day*) are among the codes being considered during the January 2013 RUC meeting.

The American Academy of Pediatrics (AAP) has conducted physician work surveys for codes 99481-99482 and developed work RVU recommendations based on the survey results.

However, we recommend no direct practice expense inputs for codes 99481-99482.

If you have any questions, please contact Linda Walsh, AAP staff, at 800/433-9016 ext 7931 or [lwalsh@aap.org](mailto:lwalsh@aap.org). Thank you.

Sincerely,

A handwritten signature in black ink, appearing to read "Steve Krug".

Steven E. Krug, MD, FAAP  
AAP RUC Advisor



AMA/Specialty Society RVS Update Committee Summary of Recommendations  
*CMS High Expenditure Procedural Codes Screen*

April 2013

**Destruction of Premalignant Lesions**

CPT code 17004 was identified through the CMS High Expenditure Procedural Codes screen. The RUC recommended to survey for physician work and review practice expense for this family of services at the January 2013 RUC meeting. In January 2013, the RUC reviewed the survey results for these services and agreed with the specialty society that there may have been confusion among the survey respondents. Specifically, for CPT code 17004, the surveyed time may not have accurately reflected the physician work to treat the typical number of lesions (15 or more). The RUC recommended that the specialty society consider adding a question to the survey instrument to determine the typical number of lesions for this code. The specialty society submitted a request to withdraw the issue and resurvey for the April 2013 RUC meeting which was approved.

**17000, Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion**

The RUC reviewed survey results from 232 dermatologists and determined that a work RVU of 0.61, less than the survey 25<sup>th</sup> percentile appropriately accounts for the physician work to perform this service. The RUC noted that 17000 is reported with 17003, *Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); second through 14 lesions, each (List separately in addition to code for first lesion)* 72% of the time. Therefore, multiple lesions are typically treated. The RUC questioned whether or not an office visit was typically reported within the global period for this procedure. The specialty society noted that the survey instrument was revised to confirm whether or not an office visit was performed specifically in the 010-day global period. The survey respondents indicated that 70% of the time, an office visit is indeed performed. The specialty societies determined, and the RUC agreed, that the current work RVU of 0.65 overstated physician work, especially since this procedure is typically reported with an Evaluation and Management (E/M) service on the same date. In addition, the day of procedure time was reduced in this survey to 7 minutes from 9 minutes in the 2005 RUC survey. The specialty society appropriately reduced the work RVU to 0.61 to account for this difference using magnitude estimation. The RUC compared this service to similar service, 88302 *Level II - Surgical pathology, gross and microscopic examination Appendix, incidental Fallopian tube, sterilization Fingers/toes, amputation, traumatic Foreskin, newborn Hernia sac, any location Hydrocele sac Nerve Skin, plastic repair Sympathetic ganglion Testis, castration Vaginal mucosa, incidental Vas deferens, sterilization* (work RVU=0.13 and 11 minutes intra-service time) and 73140 *Radiologic examination, finger(s), minimum of 2 views* (work RVU=0.13 and 4 minutes intra-service time) and added the typical 99212 office visit (work RVU=0.48) that is included in the global period, which results in a work RVU of 0.61. For additional support, the RUC also reviewed service 95018 *Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with drugs or biologicals, immediate type reaction, including test interpretation and report, specify number of tests*

(work RVU=0.14 and intra time=2 minutes,) and added a 99212 office visit (work RVU=0.48) resulting in a work RVU of 0.62. **Therefore, the RUC recommends a work RVU of 0.61 for CPT code 17000.**

**17003, Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); second through 14 lesions, each (List separately in addition to code for first lesion)**

The RUC reviewed survey results from 232 dermatologists and determined that a work RVU of 0.04, less than the survey 25<sup>th</sup> percentile appropriately accounts for the physician work for this procedure. The RUC noted that 17000 is reported with 17003 72% of the time. In addition, this service is typically reported with an Evaluation and Management (E/M) service. The RUC noted that the current intra-service time for this service is 2 minutes. The survey respondents indicated a median intra-service time of 1 minute. Since there was a 50% reduction in time, the RUC recommended reducing the work. Therefore, a 50% reduction in work RVU from current value of 0.07 equals 0.04. To further support this value, the RUC reviewed CPT code 95017 *Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intra-dermal), sequential and incremental, with venoms, immediate type reaction, including test interpretation and report, specify number of tests* (work RVU=0.07 and total time =1.86 minutes) which equates to 0.038 RVU per 1 minute. **The RUC recommends a work RVU of 0.04 for CPT code 17003.**

**17004, Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions**

The RUC reviewed survey results from 232 dermatologists and determined that a work RVU of 1.37, a direct cross walk to CPT code 17270 *Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less* (work RVU=1.37) appropriately accounts for the physician work required to perform this service. Although, CPT code 17004 requires less pre service time compared to 17270, the RUC agreed this was acceptable since 17004 is typically reported with an Evaluation and Management (E/M) service. Additionally, the results of the survey from the specialty society suggested that the typical number of lesions treated is 20. Treating 20 lesions using the values for 17000 and 17003 would result in  $0.61 + (0.04 \times 19) = 1.37$ . The RUC also compared 17004 to key reference code 17282 *Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm* (work RVU=2.09) and agreed that the treatment of malignant lesions is a more intense service requiring more physician work and therefore, should be valued higher. **The RUC recommends a work RVU of 1.37 for CPT code 17004.**

**Work Neutrality**

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

**Practice Expense:**

The RUC confirmed that the use of a camera is typical in this procedure and reaffirmed the practice expense inputs reviewed at the January RUC meeting.

<b>CPT Code (•New)</b>	<b>CPT Descriptor</b>	<b>Global Period</b>	<b>Work RVU Recommendation</b>
17000	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion	010	0.61
17003	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); second through 14 lesions, each (List separately in addition to code for first lesion)	ZZZ	0.04
17004	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions	010	1.37

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 17000	Tracking Number	Original Specialty Recommended RVU: <b>0.61</b>
		Presented Recommended RVU: <b>0.61</b>
Global Period: 010		RUC Recommended RVU: <b>0.61</b>

CPT Descriptor: Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A woman presents with a rough, scaly lesion on her face. The lesion is compatible with the diagnosis of an actinic keratosis.

Percentage of Survey Respondents who found Vignette to be Typical: 80%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

**Description of Pre-Service Work:**

The exact location of the lesion is measured and documented in the medical record and a photograph of the treatment site is taken for future assessment of response to treatment. The necessary materials are arranged. The patient is placed on the examination table and positioned for access.

**Description of Intra-Service Work:** The lesion is inspected and palpated for size and depth. Cryosurgery commences with the chosen modality until an ice ball with a 1 to 2 mm margin is achieved. The application of liquid nitrogen is timed (based on the thickness of the lesion) so that once the ice ball forms it has a thaw time of 20 to 40 seconds. After the lesion has completely thawed, cryosurgery is repeated until a second ice ball with a 1 to 2 mm margin is formed to achieve a second thaw time of 20 to 40 seconds.

Treatment can be administered either via directed spray from a Cry-Ac unit or via touch application of cotton tipped applicators. If cotton tipped applicators are used, liquid nitrogen is obtained from the central dispenser and poured into a disposable transfer cup. Small cotton tip applicators are used to apply the liquid nitrogen directly to the skin. Guidance via a neoprene cone or use of a protective shield may be required. Although cryodestruction is typical, for larger, keratotic lesions, other modalities such as electrosurgical destruction and curettage may be performed.

**Description of Post-Service Work:** Appropriate ointment and dressings are applied to the treatment site. The patient is instructed on wound care. A follow-up post-surgical visit is arranged. A procedure report is dictated and appropriate communication with family and referring physician is done.



**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Brett Coldiron, M.D., Michael Bigby, M.D., Bruce Deitchman, M.D., Mark Kaufman, M.D., Mollie MacCormack, M.D.				
<b>Specialty(s):</b>	American Academy of Dermatology				
<b>CPT Code:</b>	17000				
<b>Sample Size:</b>	1000	<b>Resp N:</b>	232	<b>Response:</b> 23.2 %	
<b>Description of Sample:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	20.00	400.00	<b>900.00</b>	1763.00	10000.00
<b>Survey RVW:</b>	0.40	0.90	<b>0.95</b>	1.00	3.00
<b>Pre-Service Evaluation Time:</b>			<b>5.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>2.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>0.00</b>		
<b>Intra-Service Time:</b>	1.00	1.00	<b>3.00</b>	5.00	15.00
<b>Immediate Post Service-Time:</b>	<b>3.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x <b>0.00</b> 99292x <b>0.00</b>			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x <b>0.00</b> 99232x <b>0.00</b> 99233x <b>0.00</b>			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x <b>0.00</b> 99239x <b>0.00</b> 99217x <b>0.00</b>			
<b>Office time/visit(s):</b>	<b>16.00</b>	99211x <b>0.00</b> 12x <b>1.00</b> 13x <b>0.00</b> 14x <b>0.00</b> 15x <b>0.00</b>			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x <b>0.00</b> 55x <b>0.00</b> 56x <b>0.00</b> 57x <b>0.00</b>			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x <b>0.00</b> 99225x <b>0.00</b> 99226x <b>0.00</b>			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

5 - NF Procedure without sedation/anesthesia care

<b>CPT Code:</b>	17000	<b>Recommended Physician Work RVU: 0.61</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>1.00</b>	<b>7.00</b>	<b>-6.00</b>
<b>Pre-Service Positioning Time:</b>		<b>1.00</b>	<b>0.00</b>	<b>1.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>3.00</b>		
<b>Immediate Post Service-Time:</b>	<b>2.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x <b>0.00</b> 99292x <b>0.00</b>		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x <b>0.00</b> 99232x <b>0.00</b> 99233x <b>0.00</b>		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x <b>0.0</b> 99239x <b>0.0</b> 99217x <b>0.00</b>		
<b>Office time/visit(s):</b>	<b>16.00</b>	99211x <b>0.00</b> 12x <b>1.00</b> 13x <b>0.00</b> 14x <b>0.00</b> 15x <b>0.00</b>		
<b>Prolonged Services:</b>	<b>0.00</b>	99354x <b>0.00</b> 55x <b>0.00</b> 56x <b>0.00</b> 57x <b>0.00</b>		

Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00
---------------	-------------	-------------	-------------	-------------

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
17260	010	0.96	RUC Time

CPT Descriptor Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 0.5 cm or less

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
	000		RUC Time	

CPT Descriptor 1 There are no MPC codes in the range with a 010 global.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
11200	010	0.82	RUC Time

CPT Descriptor Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code:** 142 **% of respondents:** 61.2 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 17000</b>	<b>Key Reference CPT Code: 17260</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	2.00	9.00	
Median Intra-Service Time	3.00	16.00	
Median Immediate Post-service Time	2.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	16.0	16.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>23.00</b>	<b>46.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.69	3.40
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.90	3.04
--	------	------

Urgency of medical decision making	3.00	3.12
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.58	3.56
--------------------------	------	------

Physical effort required	2.78	2.99
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.28	3.32
---	------	------

Outcome depends on the skill and judgment of physician	3.80	3.68
--	------	------

Estimated risk of malpractice suit with poor outcome	3.19	3.30
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.28	3.32
----------------------------------	------	------

Intra-Service intensity/complexity	3.09	3.25
------------------------------------	------	------

Post-Service intensity/complexity	2.72	2.88
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Academy of Dermatology (AAD) surveyed Destruction of Premalignant Lesions codes 17000, 17003 and 17004. These codes were valued by the RUC in 2005, where the RUC determined cryotherapy was the typical modality. A year later, the definition of the codes changed from destruction of all lesions to destruction of pre-malignant lesions. The AAD surveyed the code for presentation at the January 2013 RUC meeting. The results of the survey and SOR were pre-facilitated. The pre-facilitation committee recommended and the RUC agreed that the AAD should re-survey the code family. The AAD expert panel has incorporated the results of the new survey and the recommendations of the pre-facilitation committee in the current SOR. These codes are typically done with an E&M service, and cryotherapy is the predominant treatment method although the CPT definitions describe other treatment modalities.

17000 is typically performed with an E&M service and with the ZZZ add on 17003.

#### Pre-service time:

Because these procedures are typically performed with an E&M service, and in keeping with the recent RUC directions, the expert panel has removed most of the pre-service time. The median survey pre service time is 7 minutes (5 minutes pre and 2 minutes positioning) and the selected pre-time package 5 is 7 minutes. The expert panel recommends reducing it by 5 minutes and is requesting 1 minute of pre-evaluation time and 1 minute of positioning time for this procedure.

As indicated in the 2011 Medicare 5% claims data, 72% of the time code 17000 is billed with varying numbers of the zzz add-on code 17003, hence multiple lesions are typically being treated. The expert panel believes that 1 minute of positioning is more appropriate than the survey median of 2 minutes. The total 2 minutes of pre-time the expert panel is requesting is less than the existing pre-time for code 17000, which is 4 minutes.

#### Intra-service time:

The expert panel recommends the median intra-service time of 3 minutes, which is the current time.

#### Post-Service time

The expert panel believes the survey median post-service time of 3 minutes is most likely accurate but suggests a 2 minute time. 2 minutes is the existing post service time.

#### Relative Value Units:

The expert panel recommends 0.61 RVUs for this procedure. The removal of the 2 minutes pre service time reduces the current 0.65 by 0.044 RVU for a recommended RVU of 0.61. This is below the 25% value of the survey. Since code 17000 has the lowest 010 global value, it is difficult to find comparator codes or crosswalks.

In summary, the expert panel recommends 0.61 RVUs, 2 minutes of pre-service time, 3 minutes for intra-service time and 2 minutes of post-time for code 17000.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.

- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☒ Other reason (please explain) Billed with Office E/M (code 99212) 76% of the time.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 17000

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Dermatology                      How often? Commonly

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 14966508

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The overall number of services described by code 17000 provided nationally in a one year period is estimated to be 14,966,508.

Specialty Dermatology                      Frequency 12209677                      Percentage 81.57 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 4,910,363 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2012 Medicare Claims' data estimates that CPT code was billed approximately 5,000,000 times for Medicare patients nationally in one-year period.

Specialty Dermatology                      Frequency 3997526                      Percentage 81.40 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

## Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 17000

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 17003	Tracking Number	Original Specialty Recommended RVU: <b>0.05</b>
		Presented Recommended RVU: <b>0.04</b>
Global Period: ZZZ		RUC Recommended RVU: <b>0.04</b>

CPT Descriptor: Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); second through 14 lesions, each (List separately in addition to code for first lesion)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A woman presents with several scattered rough and scaly lesions located on her face. The lesions are compatible with the diagnoses of actinic keratoses.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: There is no pre service time as this is a ZZZ global period code.

Description of Intra-Service Work: The additional lesions are inspected and palpated for size and depth. Cryosurgery commences with the chosen modality until an ice ball with a 1 to 2 mm margin is achieved for each additional lesion. The application of liquid nitrogen is timed (based on the thickness of the lesion) so that once the ice ball forms it has a thaw time of 20-40 seconds. After each additional lesion has completely thawed, cryosurgery is repeated until a second ice ball with a 1 to 2 mm margin is formed to achieve a second thaw time of 20 to 40 seconds.

Treatment can be administered either via directed spray from a Cry-Ac unit or via touch application of cotton tipped applicators, with guidance via a neoprene cone or use of a protective shield when necessary. Although cryodestruction is typical, for larger, keratotic lesions, other modalities such as electrosurgical destruction and curettage may be performed.

Description of Post-Service Work: Appropriate ointment and dressings are applied to the treatment sites.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Brett Coldiron, M.D., Michael Bigby, M.D., Bruce Deitchman, M.D., Mark Kaufman, M.D., Mollie MacCormack, M.D.				
<b>Specialty(s):</b>	American Academy of Dermatology				
<b>CPT Code:</b>	17003				
<b>Sample Size:</b>	1000	<b>Resp N:</b>	232	<b>Response:</b> 23.2 %	
<b>Description of Sample:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	5.00	400.00	1000.00	2225.00	10000.00
<b>Survey RVW:</b>	0.05	0.20	0.34	0.41	3.00
<b>Pre-Service Evaluation Time:</b>			0.00		
<b>Pre-Service Positioning Time:</b>			0.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.00		
<b>Intra-Service Time:</b>	1.00	1.00	1.00	2.00	10.00
<b>Immediate Post Service-Time:</b>	0.00				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	0.00	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

ZZZ Global Code

<b>CPT Code:</b>	17003	<b>Recommended Physician Work RVU: 0.04</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		0.00	0.00	0.00
<b>Pre-Service Positioning Time:</b>		0.00	0.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	0.00	0.00
<b>Intra-Service Time:</b>		1.00		
<b>Immediate Post Service-Time:</b>	0.00			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	0.00	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	0.00	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	0.00	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		



Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00
---------------	-------------	-------------	-------------	-------------

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
11101	ZZZ	0.41	RUC Time

CPT Descriptor Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; each separate/additional lesion (List separately in addition to code for primary procedure)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
-----------------------	---------------	-----------------	--------------------	---

CPT Descriptor 1 There are no MPC codes in the range with a ZZZ global.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
-----------------------	---------------	-----------------	--------------------	---

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
11201	ZZZ	0.29	RUC Time

CPT Descriptor Removal of skin tags, multiple fibrocutaneous tags, any area; each additional 10 lesions, or part thereof (List separately in addition to code for primary procedure))

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code:** 115 **% of respondents:** 49.5 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 17003</b>	<b>Key Reference CPT Code: 11101</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	1.00	10.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>1.00</b>	<b>10.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.50	3.00
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.82	2.71
--	------	------

Urgency of medical decision making	2.92	2.70
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.47	3.14
--------------------------	------	------

Physical effort required	2.80	2.81
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.31	2.99
---	------	------

Outcome depends on the skill and judgment of physician	3.62	3.15
--	------	------

Estimated risk of malpractice suit with poor outcome	3.19	2.90
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity		
----------------------------------	--	--

Intra-Service intensity/complexity	3.11	2.97
------------------------------------	------	------

Post-Service intensity/complexity		
-----------------------------------	--	--

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Academy of Dermatology (AAD) surveyed Destruction of Premalignant Lesions codes 17000, 17003 and 17004. These codes were valued by the RUC in 2005, where the RUC determined cryotherapy was the typical modality. A year later, the definition of the codes changed from destruction of all lesions to destruction of pre-malignant lesions. The AAD surveyed the code for presentation at the January 2013 RUC meeting. The results of the survey and SOR were pre-facilitated. The pre-facilitation committee recommended and the RUC agreed that the AAD should re-survey the code family. The AAD expert panel has incorporated the results of the new survey and the recommendations of the pre-facilitation committee in the current SOR. These codes are typically done with an E&M service, and cryotherapy is the predominant treatment method although the CPT definitions describe other treatment modalities. Since 17003 is a zzz code there are multiple lesions that are being treated.

17003 is the lowest zzz in the RUC database. As such, it proved difficult for the surveyees to value. There is no appropriate crosswalk, and the suggested values are based on comparative explanations.

*Intra-service time:*

The expert panel recommends the median survey intra-service time of 1 minute. This figure takes into account the multitasking that occurs when multiple lesions are treated.

*Relative Value Units:*

The current RVU is 0.07. The 25% RVU in the survey was 0.20. The expert panel recommends 0.05 RVU for 17003. This recommendation is based on 2 arguments. First, 0.05 is the minimum RVU in our survey. That value is lower than the current RVU. In addition, the median time in the survey for 17004 is 13 minutes. On a purely proportional basis that is 65% of the current IS time for 17004, which is 20 minutes. And if applied as a time measurement to 17003 65% allows for 0.05 RVU.

Although this is not usual methodology, the multitasking involved in treating multiple lesions increases the intensity, and even though the time is halved, 0.05 takes into account the increased intensity, the time factor, and maintains rank order and intensity across the family. One minute is the lowest multiple in time, and 17003 is the lowest valued zzz code.

In summary, the expert panel recommends 0.05 RVUs and 1 minute for intra-service time for code 17003.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 17003

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Dermatology                      How often? Commonly

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 47055162

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The overall number of services described by code 17003 provided nationally in a one year period is estimated to be 47,055,162.

Specialty Dermatology                      Frequency 40392151                      Percentage 85.83 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 15,449,279 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. According to Medicare Claims' data, code 17003 was reported 15,685,054 times nationally in one year for Medicare patients.

Specialty Dermatology                      Frequency 13261661                      Percentage 85.83 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 17003

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

## AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 17004	Tracking Number	Original Specialty Recommended RVU: <b>1.43</b>
		Presented Recommended RVU: <b>1.37</b>
Global Period: 010		RUC Recommended RVU: <b>1.37</b>

CPT Descriptor: Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions

### CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A man presents with 15 or more rough, scaly lesions scattered over the face, ears, upper torso, and extremities. The lesions are compatible with the diagnosis of multiple actinic keratoses.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

### Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

### Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The exact locations of the lesions are measured and documented in the medical record and photographs of the treatment sites are taken for future assessment of response to treatment. The necessary materials are arranged. The patient is placed on the examination table and positioned for access to all areas.

Description of Intra-Service Work: The lesions are inspected and palpated for size and depth. Cryosurgery commences with the chosen modality until an ice ball with a 1 to 2 mm margin is achieved for each lesion. The application of liquid nitrogen is timed (based on the thickness of the lesion) so that once the ice ball forms, it has a thaw time of 20 to 40 seconds. After each lesion has completely thawed, cryosurgery is repeated until a second ice ball with a 1 to 2 mm margin is formed to achieve a second thaw time of 20 to 40 seconds.

Treatment can be administered either via directed spray from a Cry-Ac unit or via touch application of cotton tipped applicators. If cotton tipped applicators are used, liquid nitrogen is obtained from the central dispenser and poured into a disposable transfer cup. Small cotton tip applicators are used to apply the liquid nitrogen directly to the skin. Guidance via a neoprene cone or use of a protective shield may be required. Although cryodestruction is typical, for larger, keratotic lesions, other modalities such as electrosurgical destruction and curettage may be performed.

Description of Post-Service Work: Appropriate ointment and dressings are applied to the treatment sites. The patient is instructed on wound care. A follow-up post-surgical visit is arranged. A procedure report is dictated and appropriate communication with family and referring physician is done.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Brett Coldiron, M.D., Michael Bigby, M.D., Bruce Deitchman, M.D., Mark Kaufman, M.D., Mollie MacCormack, M.D.				
<b>Specialty(s):</b>	American Academy of Dermatology				
<b>CPT Code:</b>	17004				
<b>Sample Size:</b>	1000	<b>Resp N:</b>	232	<b>Response:</b> 23.2 %	
<b>Description of Sample:</b>	Random				
	<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75<sup>th</sup> pctl</u>	<u>High</u>
<b>Service Performance Rate</b>	5.00	51.00	200.00	500.00	10000.00
<b>Survey RVW:</b>	0.80	1.85	2.25	3.00	10.00
<b>Pre-Service Evaluation Time:</b>			7.00		
<b>Pre-Service Positioning Time:</b>			3.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.00		
<b>Intra-Service Time:</b>	5.00	9.00	13.00	20.00	40.00
<b>Immediate Post Service-Time:</b>	<u>4.00</u>				
<b>Post Operative Visits</b>	<u>Total Min**</u>	<u>CPT Code and Number of Visits</u>			
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<u>16.00</u>	99211x 0.00 12x 1.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

5 - NF Procedure without sedation/anesthesia care

<b>CPT Code:</b>	17004	<b>Recommended Physician Work RVU: 1.37</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		1.00	7.00	-6.00
<b>Pre-Service Positioning Time:</b>		1.00	0.00	1.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	0.00	0.00
<b>Intra-Service Time:</b>		13.00		
<b>Immediate Post Service-Time:</b>	<u>4.00</u>			
<b>Post Operative Visits</b>	<u>Total Min**</u>	<u>CPT Code and Number of Visits</u>		
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<u>16.00</u>	99211x 0.00 12x 1.00 13x 0.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00
---------------	-------------	-------------	-------------	-------------

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
17282	010	2.09	RUC Time

CPT Descriptor Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
-----------------------	---------------	-----------------	--------------------	---

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
17111	010	0.97	RUC Time

CPT Descriptor Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 57      % of respondents: 24.5 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 17004</b>	<b>Key Reference CPT Code: 17282</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	2.00	9.00	
Median Intra-Service Time	13.00	25.00	
Median Immediate Post-service Time	4.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	16.0	16.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>35.00</b>	<b>55.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.86	3.59
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.19	3.24
--	------	------

Urgency of medical decision making	3.22	3.25
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.75	3.71
--------------------------	------	------

Physical effort required	3.31	3.26
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.56	3.56
---	------	------

Outcome depends on the skill and judgment of physician	3.88	3.78
--	------	------

Estimated risk of malpractice suit with poor outcome	3.41	3.43
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.56	3.50
----------------------------------	------	------

Intra-Service intensity/complexity	3.62	3.60
------------------------------------	------	------

Post-Service intensity/complexity	3.12	3.19
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*



The American Academy of Dermatology (AAD) surveyed Destruction of Premalignant Lesions codes 17000, 17003 and 17004. These codes were valued by the RUC in 2005, where the RUC determined cryotherapy was the typical modality. A year later, the definition of the codes changed from destruction of all lesions to destruction of pre-malignant lesions. The AAD surveyed the code for presentation at the January 2013 RUC meeting. The results of the survey and SOR were pre-facilitated. The pre-facilitation committee recommended and the RUC agreed that the AAD should re-survey the code family. The AAD expert panel has incorporated the results of the new survey and the recommendations of the pre-facilitation committee in the current SOR. These codes are typically done with an E&M service, and cryotherapy is the predominant treatment method although the CPT definitions describe other treatment modalities. 17004 is treatment of 15 or more premalignant lesions, and the survey 25% and median numbers indicated that 20 lesions are typically treated at a time.

#### *Pre-Service time*

The survey median of total pre time is 10 minutes, and the appropriate pre-time package (5) has 7 minutes of pre-time. Because these procedures are typically performed with an E&M service, and in keeping with recent RUC direction, the expert panel has removed most of the pre-service time. We recommend 1 minute of pre-service evaluation time and 1 minute of positioning time, for a total of 2 minutes of pre-service time. Typically 20 lesions will involve multiple anatomic sites.

The total 2 minutes of pre-time requested is less than the current pre time for code 17004, which is 5 minutes.

#### *Intra-Service time*

Although the expert panel is concerned that the survey underestimates the time for 17004, it recommends the median survey intra time of 13 minutes. The 13 minutes indicated by our surveyees incorporates all possible economies of scale in performing multiple repetitive procedures, and assumes significant efficiencies including the presumption of working on 2 lesions at the same time. The current RUC database time is 20 minutes, and the expert panel believes that this time difference is a result of both the redefinition of this code and the assumption that the predominant treatment modality is cryotherapy. The survey shows that the typical number of lesions treated for 17004 is 20, both at the 25% and median. With the economies of scale of multitasking, we believe 13 minutes of intra-service time for 17004 is appropriate, and consistent with a 17000 intra-service time of 3 and multiple additives of 17003 intra-service times of 1 minute.

#### *Post-Service time*

The expert panel recommends the survey median post-service time of 4 minutes for 17004. That is 1 minute less than the current post service time of 5 minutes.

#### *Relative Value Units*

The expert panel recommends 1.43 RVUs for 17004. We offer this recommendation having taken into account the direction provided by the January 2013 pre-facilitation committee and the difficulty in establishing an appropriate value based upon crosswalk and magnitude estimation.

We are recommending removing 3 minutes of the existing 5 minutes of pre-time and are recommending a reduction from current post-service time from 5 minutes to 4 minutes for a total reduction of 4 minutes, resulting in a reduction of 0.09 RVU. As the existing RVU is 1.85, reducing it by 0.09 RVUs brings it to 1.76 RVUs. This RVU is less than the 25th percentile of the survey value (1.85). However, with the marked decrease in Intra-Service (IS) time for 17004 from 20 minutes to 13 minutes, an RVU of 1.76 is too high for 17004.

Looking at the intra-service (IS) time alone, after the adjustments made to pre and post times, if we back out the visit and pre and post time we arrive at  $1.76 - 0.48 - (6 \times .0224 = .13) = 1.15$  wRVU for IS time. Even though such an analogy is not RUC methodology, by pure time considerations alone (current IS 20 minutes, median survey IS 13 minutes), the 1.15 wRVU for IS time would translate into  $13/20 \times 1.15 = 0.75$ . This calculation does not take into account the increased intensity in performing 20 lesion destructions using multiple modalities in a shorter time interval. The above math would determine 17004 having an RVU of  $.75 + .48 + .13 = 1.36$

Using the recommended RVU of 0.05 for 17003, and a building block methodology,  $19 \times 0.05 = 0.95 + 17000 (0.61)$  plus 2 minutes extra in 17004 post time (0.044) would yield a value of 1.60. To ensure that there are no rank order issues, we looked at the additive value of 15 lesions  $17000 (0.61) + 14 \times 17003 (14 \times 0.05 = 0.70)$ , which gives 1.31.

The expert panel believes the value lies between 1.36 and 1.60. Using a lower number of lesions treated (e.g. 18 lesions) and building block, we arrive at a value of 1.51, preserve rank order and produce a proportional decrease in the value of the code of almost 20%. Adding back in the fact that 17004 has 2 minutes extra of pre and post time than 17000, this brings the value to between 1.51 and 1.55.

However, because of lack of a suitable crosswalk we need to rely on magnitude estimation and building block. For that reason, we chose 16 to 17 as the number of additional lesions ( $0.8 + 0.61 = 1.41$ ,  $0.85 + 0.61 = 1.46$ ) for an average of 1.43. This number does not include the 2 minutes extra of pre and post time in 17004 as compared to 17000, but we believe it is correct, given the difficulty with a crosswalk.

Although the techniques used to arrive at that number are not RUC sanctioned, we believe it is the correct RVU. This can be verified by crosswalk and magnitude estimation as the RUC did the last time these codes were valued, using 17111 (*Destruction of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions.*)

Below is the rationale that was used to value the code when reviewed in 2005.

“Due to the clarification of descriptors, description of intra-service time and adjusted intra-service work, the RUC felt that the specialty society recommended 1.80 work RVUs, half way between the 25th and median survey percentile for 17004, was appropriate. In addition, the RUC noted that the surveyed code 17004 requires greater mental effort and judgment, technical skill, intensity and time in comparison to the reference code 17111 (Work RVU=0.92) and felt that the value of 1.80 work RVUs appropriately values the surveyed code in relation to the reference code. Furthermore, the RUC agreed that 17004 indeed had slightly less work associated with it than 11750 Excision of nail and nail matrix, partial or complete, (eg, ingrown or deformed nail) for permanent removal; (Work RVU=1.86) with 10 minutes pre-service time, 15 minutes of intra-service time, 10 minutes of post service time and 2-99213 office visits. The RUC believed the median number of lesions for 17004 is 22 and the RUC recommends 1.80 work RVUs for 17004.” The current values for codes 17111 and 17004 have changed slightly since 2005 (current 17111, 0.97 and 17004, 1.85).

Utilizing the same crosswalks that the RUC used, taking into account the reduced IS and pre and post time, the comparisons to code 17111 are still valid, and using a new RVU of 1.43, we offer that crosswalk adjusted for time.

In comparison, the selected key reference code (17282 -*Destruction, malignant lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0cm*), has an RVU of 2.09, and the expert panel believes that it is not the most accurate comparator to the survey code. It has a higher RVU, and we acknowledge that the treatment of malignant lesions requires greater mental effort and judgment, technical skill, intensity and time (intra-service time for 17282 is 25 minutes, and 13 minutes for 17004). That is why we are comfortable altering the survey median value of 1.85.

In summary, the expert panel recommends 1.43 RVUs, 2 minutes of pre-service time, 13 minutes for intra-service time and 4 minutes of post-service time for code 17004.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.

☒ Other reason (please explain) Code 17004 is billed with E/M (code 99212) 76% of the time.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 17004

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Dermatology                      How often? Commonly

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 2272000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The overall number of services described by code 17004 provided nationally in a one-year period is estimated to be 2,272,000.

Specialty Dermatology                      Frequency 1987772                      Percentage 87.48 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 757,250 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. According to Medicare Claims' data, code 17004 was reported 757,250 times nationally in one year for Medicare patients.

Specialty Dermatology                      Frequency 662518                      Percentage 87.48 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

## Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 17004

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.



## SS Rec Summary

	A	B	C					D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	AF	AG	AH	AI	AJ	AO	AP	AQ	AR	AS
3	ISSUE: Destruction of Premalignant Lesions																																	
4	TAB: 17																																	
5						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	Office					SURVEY EXPERIENCE								
6	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	15	14	13	12	11	MIN	25th	MED	75th	MAX				
7	REF	17260	Destruction, malignant lesion, trunk, arms or legs; lesion diameter 0.5 cm or less	142	0.0122			0.96			46	7		2			16			5				1										
8	CURRENT	17000	Destruction, premalignant lesions (eg, actinic keratoses); first lesion		0.0119			0.65			25	4					3			2				1										
9	SVY	17000	Destruction, premalignant lesions (eg, actinic keratoses); first lesion	232	0.0820	0.40	0.90	0.95	1.00	3.00	29	5	2		1	1	3	5	15	3				1		20	400	900	1763	10000				
10	REC	17000	Destruction, premalignant lesions (eg, actinic keratoses); first lesion		0.0135	0.61					23	1	1				3			2				1										
11																																		
12																																		
13																																		
14						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	Office					SURVEY EXPERIENCE								
15	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	15	14	13	12	11	MIN	25th	MED	75th	MAX				
16	REF	11101	Biopsy of skin, subcutaneous tissue and/or muscle, not otherwise specified	115	0.0410			0.41			10						10																	
17	CURRENT	17003	Destruction, premalignant lesions (eg, actinic keratoses); second through 14 lesions, each		0.0350			0.07			2						2																	
18	SVY	17003	Destruction, premalignant lesions (eg, actinic keratoses); second through 14 lesions, each	232	0.3400	0.05	0.20	0.34	0.41	3.00	1				1	1	1	2	10						5	400	1000	2225	10000					
19	REC	17003	Destruction, premalignant lesions (eg, actinic keratoses); second through 14 lesions, each		0.0400	0.04					1						1																	
20																																		
21																																		
22																																		
23						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	Office					SURVEY EXPERIENCE								
24	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	15	14	13	12	11	MIN	25th	MED	75th	MAX				
25	REF	17282	Destruction, malignant lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less	57	0.0530			2.09			55	7		2			25			5				1										
26	CURRENT	17004	Destruction, premalignant lesions (eg, actinic keratoses); 15 or more lesions		0.0573			1.85			46	5					20			5				1										
27	SVY	17004	Destruction, premalignant lesions (eg, actinic keratoses); 15 or more lesions	232	0.1120	0.80	1.85	2.25	3.00	10.00	43	7	3		5	9	13	20	40	4				1		5	51	200	500	10000				
28	REC	17004	Destruction, premalignant lesions (eg, actinic keratoses); 15 or more lesions		0.0581	1.37					35	1	1				13			4				1										
29																																		

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

**CPT Long Descriptor: 17000 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettage), premalignant lesions (eg, actinic keratoses); first lesion**

**Global Period: 010 Meeting Date: Jan 2013**

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

**The AAD RBRVS Committee assigned review of the current PE direct inputs to a Task Force which reviewed the values and compared them to current practice environments and have recommended a limited number of specific changes to reflect changes in equipment and supply requirements.**

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

**AAD PE Task Force used the current PE direct inputs for 17000 as approved at the Jan 2002 PEAC meeting.**

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:

**AAD PE Task Force is recommending less time for this code with values reduced to reflect current RUC Clinical labor time standards.**

4. Please describe in detail the clinical activities of your staff:

**Pre-Service Clinical Labor Activities:**

**There are no pre-service clinical labor activities.**

**Intra-Service Clinical Labor Activities:**

**Clinical staff prepares liquid nitrogen with transfer to appropriate delivery device (Cry-Ac unit or insulated container with cotton tipped applicator) from large storage unit. If hyperkeratotic lesions are to be treated with curettage or electrosurgery, the necessary equipment and materials are arranged. Staff assists patient onto the examination table and helps position for access. Staff assists physician with prep of local anesthesia and destruction modality equipment and related supplies.**

**Post-Service Clinical Labor Activities:**

**Assist with application of dressing. Assist with instruction on post-operative care and scheduling of follow-up care.**

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

**CPT Long Descriptor: 17003 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); second through 14 lesions; each**

**Global Period: ZZZ Meeting Date: Jan 2013**

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

**The AAD RBRVS Committee assigned review of the current PE direct inputs to a Task Force which reviewed the values and compared them to current practice environments and have recommended a limited number of specific changes to reflect changes in equipment and supply requirements.**

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

**AAD PE Task Force used the current PE direct inputs for 17003 as approved at the Jan 2002 PEAC meeting.**

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:

**AAD PE Task Force is recommending the same time for this code.**

4. Please describe in detail the clinical activities of your staff:

**Pre-Service Clinical Labor Activities:**

**There are no pre-service clinical labor activities.**

**Intra-Service Clinical Labor Activities:**

**Staff assists physician with prep of local anesthesia, patient positioning and destruction modality equipment and related supplies.**

**Post-Service Clinical Labor Activities:**

**There are no post-service clinical labor activities.**

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

**CPT Long Descriptor: 17004 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettage), premalignant lesions (eg, actinic keratoses), 15 or more lesions**

**Global Period: 010 Meeting Date: Jan 2013**

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

**The AAD RBRVS Committee assigned review of the current PE direct inputs to a Task Force which reviewed the values and compared them to current practice environments and have recommended a limited number of specific changes to reflect changes in equipment and supply requirements.**

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

**AAD PE Task Force used the current PE direct inputs for 17000 as approved at the Jan 2002 PEAC meeting.**

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:

**AAD PE Task Force is recommending less time for this code with values reduced to reflect current RUC Clinical labor time standards.**

4. Please describe in detail the clinical activities of your staff:

**Pre-Service Clinical Labor Activities:**

**There are no pre-service clinical labor activities.**

**Intra-Service Clinical Labor Activities:**

**Clinical staff prepares liquid nitrogen with transfer to appropriate delivery device (Cry-Ac unit or insulated container with cotton tipped applicator) from large storage unit. If hyperkeratotic lesions are to be treated with curettage or electrosurgery, the necessary equipment and materials are arranged. Staff assists patient onto the examination table and helps position for access. Staff assists physician with prep of local anesthesia and destruction modality equipment and related supplies.**

**Post-Service Clinical Labor Activities:**

**Assist with application of dressing. Assist with instruction on post-operative care and scheduling of follow-up care.**



	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	Revised at RUC 1-24-2013			Current 17000 (PEAC Jan 2002)		Current 17003 (PEAC Jan 2002)		Current 17004 (PEAC Jan 2002)							
2	<b>Note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.</b>			17000	17000	17003	17003	17004	17004						
3	Meeting Date: January 2013 Tab: 19 Specialty: Dermatology/AAD	CMS Code	Staff Type	Destruction (eg, laser surgery, electrosurgery, cryosurgery, surgical curettement), premalignant	Destruction (eg, laser surgery, electrosurgery, cryosurgery, surgical	Destruction (eg, laser surgery, electrosurgery, cryosurgery, surgical	Destruction (eg, laser surgery, electrosurgery, cryosurgery, surgical	Destruction (eg, laser surgery, electrosurgery, cryosurgery, surgical	Destruction (eg, laser surgery, electrosurgery, cryosurgery, surgical	Destruction (eg, laser surgery, electrosurgery, cryosurgery, surgical	Destruction (eg, laser surgery, electrosurgery, cryosurgery, surgical	Destruction (eg, laser surgery, electrosurgery, cryosurgery, surgical	Destruction (eg, laser surgery, electrosurgery, cryosurgery, surgical	Destruction (eg, laser surgery, electrosurgery, cryosurgery, surgical	Destruction (eg, laser surgery, electrosurgery, cryosurgery, surgical
4	LOCATION			Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac
5	GLOBAL PERIOD			010	010	010	010	ZZZ	ZZZ	ZZZ	ZZZ	010	010	010	010
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	55.0	33.0	39.0	27.0	2.0	0.0	1.0	0.0	79.0	33.0	46.0	27.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			28.0	6.0	12.0	0.0	2.0	0.0	1.0	0.0	52.0	6.0	19.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			27.0	27.0	27.0	27.0	0.0	0.0	0.0	0.0	27.0	27.0	27.0	27.0
10	PRE-SERVICE														
11	Start: Following visit when decision for surgery or procedure made														
12	Complete pre-service diagnostic & referral forms														
13	Coordinate pre-surgery services														
14	Schedule space and equipment in facility														
15	Provide pre-service education/obtain consent														
16	Follow-up phone calls & prescriptions														
17	Other Clinical Activity - <i>specify:</i>														
18	End: When patient enters office/facility for surgery/procedure														
19	SERVICE PERIOD														
20	Start: When patient enters office/facility for surgery/procedure:														
21	Greet patient, provide gowning, ensure appropriate medical records are available														
22	Obtain vital signs														
23	Provide pre-service education/obtain consent					0								0	
24	Prepare room, equipment, supplies					2								2	
25	Setup scope (non facility setting only)														
26	Prepare and position patient/ monitor patient/ set up IV			3		2						3		2	
27	Sedate/apply anesthesia														
28	Intra-service														
29	Assist physician in performing procedure		2/3 MD Time			2				1				9	
30	Post-Service														
31	Monitor pt. following service/check tubes, monitors, drains														
32	Clean room/equipment by physician staff					3								3	
33	Clean Scope														
34	Clean Surgical Instrument Package														
35	Complete diagnostic forms, lab & X-ray requisitions														
36	Review/read X-ray, lab, and pathology reports														
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions					3								3	
38	Other Clinical Activity - <i>specify:</i>														
39	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			n/a		n/a		n/a		n/a		n/a		n/a	
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)			n/a		n/a		n/a		n/a		n/a		n/a	
41	Dischrg mgmt (1.0 x 99239) (enter 15 min)			n/a		n/a		n/a		n/a		n/a		n/a	
42	End: Patient leaves office														
43	POST-SERVICE Period														
44	Start: Patient leaves office/facility														
45	Conduct phone calls/call in prescriptions														
46	Office visits: List Number and Level of Office Visits			# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits
47	99211 16 minutes		16												
48	99212 27 minutes		27	1		1	1					1		1	1
49	99213 36 minutes		36												
50	99214 53 minutes		53												
51	99215 63 minutes		63												
52	Total Office Visit Time			27.0	0.0	27.0	27.0	0.0	0.0	0.0	0.0	27.0	0.0	27.0	27.0
53	Other Clinical Activity - <i>specify:</i>														
54	End: with last office visit before end of global period														

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	Revised at RUC 1-24-2013			Current 17000 (PEAC Jan 2002)				Current 17003 (PEAC Jan 2002)				Current 17004 (PEAC Jan 2002)			
2	<b>Note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.</b>			17000		17000		17003		17003		17004		17004	
3	Meeting Date: January 2013 Tab: 19 Specialty: Dermatology/AAD	CMS Code	Staff Type	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant		Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical		Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical		Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical		Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical		Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical	
4	LOCATION			Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac	Non Fac	Fac
5	GLOBAL PERIOD			010	010	010	010	ZZZ	ZZZ	ZZZ	ZZZ	010	010	010	010
55	MEDICAL SUPPLIES	CODE	UNIT												
56	pack, minimum multi-specialty visit	SA048	pack	2		2	1					2		2	1
57	gown, drape	SB027	item	1		0						1		0	
58	mask, surgical	SB033	item	2		1						2		1	
59	gloves, sterile	SB024	pair	2		0						2		0	
60	swab-pad, alcohol	SJ053	item			2		1		2		6		6	
61	gauze, sterile 3in x 3in	SG054	item	10		0		10		0		10		0	
62	povidone soln (Betadine)	SJ041	ml	10		0		1		0		24		0	
63	hydrogen peroxide	SJ028	ml	20		0		3		0		62		0	
64	tape, surgical paper 1in (Micropore)	SG079	inch	12		0		12		0		42		0	
65	bacitracin oint (15gm uou)	SJ008	15 gm uou	1		1						1		1	
66	gas, liquid nitrogen	SD082	ml	8		8		8		8 ml		90		90 ml	
67	skin marking pen, sterile (Skin Skribe)	SK075	1			0								0	
68	map, Moh's surgery (per sheet)	SK047	1			0								0	
69	eye shield, splash protection	SM016				0								0	
70	LMX 4% anesthetic cream	SH092	grams			5 gr				3 gr				15 gr	
71	EQUIPMENT	CODE	minutes of use												
72	table, power	EF031	1	55		40	27	2		1		79	27	57	27
73	light, exam	EQ168	1	55		40	27	2		1		47	27	57	27
74	cryosurgery equipment (for liquid nitrogen)	EQ093		28		13		2		1		52		30	
75	gloves, cryoresistant	invoice	pair			0								0	
76	apron, cryoresistant	invoice	1			0								0	
77	face shield	invoice				0								0	
78	warning sign, liquid nitrogen use	invoice	2	55		0		2		0		52		0	
79	camera, digital (6 mexapixel)	ED004		28		13						52		30	

AMA/Specialty Society RVS Update Committee Summary of Recommendations  
*CMS High Expenditure Procedural Codes Screen*

April 2013

**Mohs Surgery**

CPT codes 17311 and 17312 were identified through the CMS High Expenditure Procedural Codes screen. In January 2012, the RUC recommended the specialty society survey physician work and review practice expense for this family of services at the April 2013 RUC meeting.

The RUC reviewed the Mohs surgery CPT codes 17311-17315 survey results and noted that the survey 25<sup>th</sup> percentile work RVUs were all above the current work RVU. The specialty society indicated and the RUC agreed that there was not compelling evidence to increase these services at this time. Therefore, the RUC recommends maintaining the current work RVU for each code in this family of services.

The specialty society's presenters indicated that they typically see 2 to 4 Mohs patients per day. The survey respondents provided an annual service performance rate from 475 to 880 per year (which is the interquartile range of the survey responses). Given differing case mixes and practice patterns the case numbers will vary widely, with one patient coming in after another and staggering care. The physician time included in these services does not count the time a patient may be waiting for the physician or waiting for the histologic tissue processing.

**17311 Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks**

The RUC reviewed the survey results from 249 dermatologists (mohs surgeons) and determined that the current work RVU of 6.20 appropriately accounts for the physician work required to perform this service. The RUC noted that the survey intra-service time is the same as the current time. The RUC recommends maintaining the current physician time with a reallocation of the pre-time to 14 minutes pre-evaluation, 1 minute positioning and 5 minutes scrub/dress/wait pre-service time to align more to the pre-time packages. The RUC noted that in preparation of the reference service list, the specialty society was allowed to place 010 and 090-day global period codes adjusted with the post-operative visits removed in order to provide reference services with relative work RVUs for the survey respondents. Otherwise the 000-day and ZZZ global period codes would not provide adequate comparisons and would skew the survey results.

The RUC compared 17311 to key reference code 15260 *Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less* (global adjusted work RVU = 6.79 and 100 minutes intra-service time) and similar service 11646 *Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter over 4.0 cm* (global adjusted work RVU= 5.29 and 65 minutes intra-service time) and determined that maintaining the current work RVU of 6.20 for 17311 maintains the appropriate relativity among other services. CPT code 15260 requires slightly less intra-service, 100 minutes versus 115 minutes, respectively, but is more intense and complex to perform. **The RUC recommends a work RVU of 6.20 for CPT code 17311.**

**17312 Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure)**

The RUC reviewed the survey results from 249 dermatologists (mohs surgeons) and determined that the current work RVU of 3.30 appropriately accounts for the physician work required to perform this service. The RUC noted that the survey intra-service time is the same as the current time. The RUC recommends maintaining the current physician time with reallocation of the pre-time to 2 minutes pre-evaluation, 1 minute positioning and 5 minutes scrub/dress/wait pre-service time. The RUC confirmed the additional 8 minutes of pre-time is appropriate for this add-on service because the patient must go back and undress again, be re-gowned, prepped, draped, re-anesthetized and given the pathology results. Subsequently, there is additional direct practice expense time where the clinical staff must account for additional cleaning.

The RUC compared 17312 to key reference code 14302 *Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 3.73 and 40 minutes intra-service time) and determined that the key reference code requires 10 more minutes of physician work and is therefore appropriately valued higher. **The RUC recommends a work RVU 3.30 for CPT code 17312.**

**17313 Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; first stage, up to 5 tissue blocks**

The RUC reviewed the survey results from 249 dermatologists (mohs surgeons) and determined that the current work RVU of 5.56 appropriately accounts for the physician work required to perform this service. The RUC noted that the survey intra-service time is the same as the current time. The RUC recommends maintaining the current physician time with a reallocation of the pre-time to 14 minutes pre-evaluation, 1 minute positioning and 5 minutes scrub/dress/wait pre-service time to align closer to the pre-time package

The RUC compared 17313 to key reference code 15260 *Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less* (global adjusted work RVU = 6.79 and 100 minutes intra-service time) and similar service 11646 *Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter over 4.0 cm* (global adjusted work RVU= 5.29 and 65 minutes intra-service time) and determined that maintaining the current work RVU of 5.56 for 17313 maintains the appropriate relativity among other services. CPT code 15260 requires the same intra-service time of 100 minutes as the surveyed code, but is more intense and complex to perform. Additionally, the RUC noted that this mohs surgery service is appropriately less, relative to code 17311, mohs surgery to the face, which is a more intense service and requires slightly more time. **The RUC recommends a work RVU of 5.56 for CPT code 17313.**

**17314 Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure)**

The RUC reviewed the survey results from 249 dermatologists (mohs surgeons) and determined that the current work RVU of 3.06 appropriately accounts for the physician work required to perform this service. The RUC noted that the survey intra-service time is the same as the current time. The RUC recommends maintaining the current physician time with reallocation of the pre-time to 2 minutes pre-evaluation, 1 minute positioning and 5 minutes scrub/dress/wait pre-service time. The RUC confirmed the additional 8 minutes of pre-time is appropriate for this add-on service because the patient must go back and undress again, be re-gowned, prepped, draped, re-anesthetized and given the pathology results. Subsequently, there is additional direct practice expense time where the clinical staff must account for additional cleaning.

The RUC compared 17314 to reference code 14302 *Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 3.73 and 40 minutes intra-service time) and determined that the key reference code requires 10 more minutes of physician work, and is therefore appropriately valued higher. The RUC also noted that this mohs surgery service is appropriately less, relative to code 17312, mohs surgery to the face, which is a more intense service and requires slightly more time. **The RUC recommends a work RVU 3.06 for CPT code 17314.**

**17315 Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), each additional block after the first 5 tissue blocks, any stage (List separately in addition to code for primary procedure)**

The RUC reviewed the survey results from 249 dermatologists (mohs surgeons) and determined that the current work RVU of 0.87 appropriately accounts for the physician work required to perform this service. The RUC noted that the survey intra-service time is the same as the current time. The RUC confirmed the intra-service time of 30 minutes is appropriate as the patient typically has a large lesion, requiring not only a pathology block, but also a surgical component. This service is rare, as 1 in 100 mohs surgery cases require it to be performed.

The RUC compared 17315 to key reference code 13102 *Repair, complex, trunk; each additional 5 cm or less (List separately in addition to code for primary procedure)* (work RVU = 1.24) and determined that these services require the same time, but 13102 is more intense and complex. Therefore, maintaining the current work RVU of 0.87 for 17315 appropriately places this service relative to other similar services. **The RUC recommends a work RVU of 0.87 for CPT code 17315.**

### Practice Expense

The RUC noted that there was an error in the prior direct practice expense inputs and therefore compelling evidence existed to increase the clinical staff time by 15 minutes in codes 17311-17314 and 2 minutes in code 17215 for the Histotechnologist (L037B) to clean (line 49). Additionally supply input *slide, microscope* (SL122) has been replaced with a new type of slide, *Slide, charged*, that currently is not listed as a 2013 CMS direct PE input. An invoice is included in this submission. The RUC recommends the direct practice expense inputs with modifications as approved by the Practice Expense Subcommittee.

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
17311	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks	000	6.20 (No Change)
17312	each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure)  (Use 17312 in conjunction with 17311)	ZZZ	3.30 (No Change)
17313	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; first stage, up to 5 tissue blocks	000	5.56 (No Change)

17314	each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure)  (Use 17314 in conjunction with 17313)	ZZZ	3.06  (No Change)
17315	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), each additional block after the first 5 tissue blocks, any stage (List separately in addition to code for primary procedure)  (Use 17315 in conjunction with 17311- 17314 )	ZZZ	0.87  (No Change)

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 17311      Tracking Number

Original Specialty Recommended RVU: **6.20**Presented Recommended RVU: **6.20**

Global Period: 000

RUC Recommended RVU: **6.20**

CPT Descriptor: Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: An adult with extensive sun damage presents with a poorly defined infiltrative basal cell carcinoma of the right nose and cheek.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 2%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 6%

Description of Pre-Service Work: The patient is taken to the surgical room, and gowned. The benefits, risks and alternatives to removal are explained. Sun exposure discussed. The procedure is explained, and the healing period with restrictions is reviewed. A fresh history of medications taken, including aspirin, vitamin E, and/or other blood thinners is reviewed along with a review of pertinent problems that may have arisen since the scheduling visit. The patient is placed on the surgical table and positioned for access. Under surgical lighting and magnification, the clinically obvious extent of the tumor is outlined. The area is cleansed with betadine, a sterile surgical marker is used to delineate the extent of the planned excision. Lidocaine is injected. The patient is re-prepped and draped, lights are positioned.

Description of Intra-Service Work: A scalpel is used to incise along the planned borders of the excision. The visible cancer is removed first (debulking) without attempting to remove a margin of normal tissue. Hemostasis is achieved with electrocoagulation. After the bulk of the tissue is removed, the first layer or stage is excised as a thin continuous wafer of tissue typically 1-3 mm thick around the sides and base of the wound. Prior to removing the specimen, hatch marks are then incised from the margin of the specimen into the surrounding adjacent normal skin to maintain orientation of the specimen to the defect. Hemostasis is achieved with electrocoagulation and the patient bandaged and discharged to the waiting room. This thin cup or saucer shaped wafer of tissue is flattened by cutting it into pieces (blocks) or making radial incisions to flatten the tissue. The smallest number of tissue blocks are created that will allow the performance of sectioning in the cryostat. The edges of the tissue are color coded with dyes that persist through histologic tissue processing. Once the wafer is cut into pieces and color-coded, a drawing or map of this tissue and its pieces is made so that



it corresponds to the surgical wound. These tissue pieces, disassembled like a puzzle, are processed by frozen section pathology. Each flattened piece (or tissue block) is mounted, frozen, sectioned horizontally and then stained. These frozen sections create an image of 100 percent of the peripheral and deep surgical margin including tissue dyes and hatch marks. Microscopic examination of this image allows the Mohs surgeon who also functions as the pathologist to identify the location(s) of any remaining tumor. The surgeon examines serial sections of the tissue to evaluate the status of the surgical margin. Residual tumor location(s) as seen through the microscope is marked on the map of the surgical wound. Following review of the pathology, the patient is returned to the operating room, and outcome of the review is discussed with the patient. After all required Mohs layers have been taken and a tumor free plane is reached the temporary dressing is removed. The wound is re-anesthetized and hemostasis is obtained as needed and the defect is evaluated for wound management. A final dressing is applied.

Description of Post-Service Work: Wound care is reviewed, as well as instructions for problems such as bleeding or pain, and restrictions on motion and activities. Prescriptions for pain and antibiotics, if needed, are given. Arrangements are made for postoperative follow-up.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Brett Coldiron, MD, John Zitelli, MD, Glenn Goldman, MD, Bruce Deitchman, MD				
<b>Specialty(s):</b>	American Academy of Dermatology				
<b>CPT Code:</b>	17311				
<b>Sample Size:</b>	747	<b>Resp N:</b>	249	<b>Response:</b> 33.3 %	
<b>Description of Sample:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	100.00	476.00	636.00	881.00	2455.00
<b>Survey RVW:</b>	3.73	6.80	7.50	8.00	12.00
<b>Pre-Service Evaluation Time:</b>			20.00		
<b>Pre-Service Positioning Time:</b>			5.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			5.00		
<b>Intra-Service Time:</b>	10.00	75.00	110.00	120.00	240.00
<b>Immediate Post Service-Time:</b>	<b>25.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

6 - NF Procedure with sedation/anesthesia care

<b>CPT Code:</b>	17311	<b>Recommended Physician Work RVU: 6.20</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		14.00	17.00	-3.00
<b>Pre-Service Positioning Time:</b>		1.00	1.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00
<b>Intra-Service Time:</b>		110.00		
<b>Immediate Post Service-Time:</b>	<b>8.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
15260	090	11.64	RUC Time

CPT Descriptor Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1 There are no MPC codes in the range of a 000 global.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
14301	090	12.65	RUC Time

CPT Descriptor adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code:** 200      **% of respondents:** 80.3 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 17311</b>	<b>Key Reference CPT Code: 15260</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	20.00	28.00	
Median Intra-Service Time	110.00	100.00	
Median Immediate Post-service Time	8.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	115.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

<b>Median Total Time</b>	<b>138.00</b>	<b>273.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.56	3.79
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.46	3.53
Urgency of medical decision making	4.28	3.63

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.85	4.23
Physical effort required	4.37	3.99

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.59	3.97
Outcome depends on the skill and judgment of physician	4.85	4.23
Estimated risk of malpractice suit with poor outcome	4.54	3.85

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.12	3.64
Intra-Service intensity/complexity	4.75	4.13
Post-Service intensity/complexity	4.02	3.65

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Additional Rationale for Valuing of Mohs codes**

The American Academy of Dermatology (AAD) surveyed a random sample of members who perform Mohs surgery. These codes were thoroughly and exhaustively reviewed last at the April 2006 RUC and multiple approaches were used at that time to value these codes. Since that time, the Mohs procedure has not undergone any technical changes.

The survey data collected has been reviewed by an expert panel. Median survey values support selection of the non-facility pre-time package six (N/F 6), an intra-service time of 110 minutes as well as the survey median for post-service times of 25 minutes.

**These codes require the physician to act in two roles: Surgeon and Pathologist. Thus, the codes encompass both surgical work and pathology work.**

**Reference Service List (RSL)** – We compiled a list of procedure all Mohs surgeons are familiar with, and with Research Subcommittee approval we adjusted services on the RSL to represent Day of Service work. The RSL indicated the day of procedure time and RVUs associated with the day of procedure.

For CPT 17311, surveyees consistently selected reference code 15260 with a 090 day global period. As there is no compelling evidence to increase the value of this code, the specialty society recommends the current RVU value of 6.20. The calculated IWPUT for 17311 is 0.047.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Same code

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Dermatology

How often? Sometimes

Specialty

How often?

Specialty

How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1644000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The overall number of services described by code 17311 provided nationally in a one year period is estimated to be 1,644,000.

Specialty Dermatology	Frequency 1595068	Percentage 97.02 %
-----------------------	-------------------	--------------------

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

547,315 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2011 Medicare claims data estimates that CPT code was billed approximately 500,000 times for Medicare patients nationally in a one-year period.

Specialty Dermatology	Frequency 531560	Percentage 97.12 %
-----------------------	------------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 17311

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

## AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 17312	Tracking Number	Original Specialty Recommended RVU: <b>3.30</b>
		Presented Recommended RVU: <b>3.30</b>
Global Period: ZZZ		RUC Recommended RVU: <b>3.30</b>

CPT Descriptor: Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure)

### CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An adult with extensive sun damage presents with tumor positive margins following the first stage of Mohs surgery for a poorly defined infiltrative basal cell carcinoma of the right nose and cheek

Percentage of Survey Respondents who found Vignette to be Typical: 94%

#### Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

#### Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 2%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 6%

Description of Pre-Service Work: The patient is returned to the surgical room, and gowned. The stage two Mohs procedure is explained. The method and healing period with restrictions is reviewed. The patient is placed on the surgical table and positioned for access. First stage dressing is removed. The area of histologically positive tumor margin and proposed excision area are marked with a sterile surgical marker to delineate the extent of the planned second stage. The area is cleansed and Lidocaine is injected. The patient is re-prepped and draped, lights are positioned.

Description of Intra-Service Work: Hemostasis is obtained. A scalpel is used to incise along the planned area of the excision. The second layer or stage is excised as a thin continuous wafer of tissue typically 1-3 mm thick around the sides and base of the wound. Prior to removing the specimen, hatch marks are then incised from the margin of the specimen into the surrounding adjacent normal skin, to maintain orientation of the specimen to the defect. Hemostasis is achieved with electrocoagulation and the patient bandaged and discharged to the waiting room. This thin cup or saucer shaped wafer of tissue is flattened by cutting it into pieces (blocks) or making radial incisions to flatten the tissue. The smallest number of tissue blocks are created that will allow the performance of sectioning in the cryostat. The edges of the tissue are color coded with dyes that persist through histologic tissue processing. Once the wafer is cut into pieces and color-coded, a drawing or map of this tissue and its pieces is made so that it corresponds to the surgical wound. These tissue pieces, disassembled like a puzzle, are processed by frozen section pathology. Each flattened piece (or tissue block) is mounted, frozen, sectioned horizontally and then stained. The Mohs surgeon also acts as pathologist. These frozen sections create an image of 100 percent of the new surgical margin including tissue dyes and hatch marks. Microscopic examination of this image allows the Mohs surgeon who also functions as the pathologist to identify the location(s) of any remaining tumor.

The surgeon looks at serial sections of the tissue to evaluate the status of the surgical margin. Residual tumor location(s) as seen through the microscope is marked on the map of the surgical wound.

Description of Post-Service Work: Wound care is reviewed, as well as instructions for problems such as bleeding or pain, and restrictions on motion and activities. Prescriptions for pain and antibiotics, if needed, are given. Arrangements are made for postoperative follow-up.



**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Brett Coldiron, MD, John Zitelli, MD, Glenn Goldman, MD, Bruce Deitchman, MD				
<b>Specialty(s):</b>	American Academy of Dermatology				
<b>CPT Code:</b>	17312				
<b>Sample Size:</b>	747	<b>Resp N:</b>	249	<b>Response:</b> 33.3 %	
<b>Description of Sample:</b>	random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	20.00	280.00	<b>388.00</b>	600.00	2000.00
<b>Survey RVW:</b>	1.22	3.75	<b>4.10</b>	4.50	13.00
<b>Pre-Service Evaluation Time:</b>			<b>10.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>5.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>5.00</b>		
<b>Intra-Service Time:</b>	10.00	60.00	<b>65.00</b>	75.00	180.00
<b>Immediate Post Service-Time:</b>	<b>20.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

6 - NF Procedure with sedation/anesthesia care

<b>CPT Code:</b>	17312	<b>Recommended Physician Work RVU: 3.30</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>2.00</b>	<b>17.00</b>	<b>-15.00</b>
<b>Pre-Service Positioning Time:</b>		<b>1.00</b>	<b>1.00</b>	<b>0.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>5.00</b>	<b>5.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>65.00</b>		
<b>Immediate Post Service-Time:</b>	<b>0.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
14302	ZZZ	3.73	RUC Time

CPT Descriptor Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1 There are no MPC codes in the range with a ZZZ global.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
11606	010	5.02	RUC Time

CPT Descriptor Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter over 4.0 cm

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code:** 111      **% of respondents:** 44.5 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 17312</b>	<b>Key Reference CPT Code: 14302</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	8.00	0.00	
Median Intra-Service Time	65.00	40.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

<b>Median Total Time</b>	<b>73.00</b>	<b>40.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.23	3.79
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.09	3.46
Urgency of medical decision making	4.12	3.73

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.63	4.31
--------------------------	------	------

Physical effort required	4.04	4.06
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.34	4.18
Outcome depends on the skill and judgment of physician	4.61	4.25
Estimated risk of malpractice suit with poor outcome	4.34	3.94

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.80	3.62
Intra-Service intensity/complexity	4.43	4.09
Post-Service intensity/complexity	3.84	3.68

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Additional Rationale for Valuing of Mohs codes**

The American Academy of Dermatology (AAD) surveyed a random sample of members who perform Mohs surgery. These codes were thoroughly and exhaustively reviewed last at the April 2006 RUC and multiple approaches were used at that time to value these codes. Since that time, the Mohs procedure has not undergone any technical changes.

The survey data collected has been reviewed by an expert panel. Median survey values support selection of the non-facility pre-time package six (N/F 6). However, we are requesting 2 minutes for pre-evaluation, 1 minute positioning, and 5 minutes of scrub/dress/wait time. The survey median for post-service time is 20 minutes, however, we recommend 5 minutes as appropriate. The survey median supports an intra-service time of 65 minutes.

**These codes require the physician to act in two roles: Surgeon and Pathologist. Thus, the codes encompass both surgical work and pathology work.**

**Reference Service List (RSL)** – We compiled a list of procedures that all Mohs surgeons are familiar with, and with Research Subcommittee approval we adjusted services on the RSL to represent Day of Service work. The RSL indicated the day of procedure time and RVUs associated with the day of procedure.

For CPT 17312, surveyees consistently selected reference code 14302 with a ZZZ day global period. As there is no compelling evidence to increase the value of this code, the specialty society recommends the current RVU value of 3.30. The calculated IWPOT for 17312 is 0.047.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 17312

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Dermatology                      How often? Sometimes

Specialty                      How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1248000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Extrapolated from Medicare claims data

Specialty Dermatology	Frequency 1185600	Percentage 95.00 %
-----------------------	-------------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

415,936 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare claims data

Specialty Dermatology	Frequency 403520	Percentage 97.00 %
-----------------------	------------------	--------------------

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 17312

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 17313      Tracking Number

Original Specialty Recommended RVU: **5.56**Presented Recommended RVU: **5.56**

Global Period: 000

RUC Recommended RVU: **5.56**

CPT Descriptor: Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; first stage, up to 5 tissue blocks

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: An adult with extensive sun exposure presents with an ill-defined invasive squamous cell carcinoma of the forearm.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 2%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 6%

Description of Pre-Service Work: The patient is taken to the surgical room, and gowned. The benefits, risks and alternatives to removal are explained. Sun exposure discussed. The procedure is explained, and the healing period with restrictions is reviewed. A fresh history of medications taken, including aspirin, vitamin E, and/or other blood thinners is reviewed along with a review of pertinent problems that may have arisen since the scheduling visit. The patient is placed on the surgical table and positioned for access. Under surgical lighting and magnification, the clinically obvious extent of the tumor is outlined. The area is cleansed with betadine, and a sterile surgical marker is used to delineate the extent of the planned excision. Lidocaine is injected. The patient is re-prepped and draped, lights are positioned.

Description of Intra-Service Work: A scalpel is used to incise along the planned borders of the excision. The visible cancer is removed first (debulking) without attempting to remove a margin of normal tissue. Hemostasis is achieved with electrocoagulation. After the bulk of the tissue is removed, the first layer or stage is excised as a thin continuous wafer of tissue typically 1-3 mm thick around the sides and base of the wound. Prior to removing the specimen, hatch marks are then incised from the margin of the specimen into the surrounding adjacent normal skin, to maintain orientation of the specimen to the defect. Hemostasis is achieved with electrocoagulation and the patient bandaged and discharged to the waiting room. This thin cup or saucer shaped wafer of tissue is flattened by cutting it into pieces (blocks) or making radial incisions to flatten the tissue. The smallest number of tissue blocks are created that will allow the performance of sectioning in the cryostat. The edges of the tissue are color coded with dyes that persist through histologic tissue processing. Once the wafer is cut into pieces and color-coded, a drawing or map of this tissue and its pieces is made so that it corresponds to the surgical wound. These tissue pieces, disassembled like a puzzle, are processed by frozen section pathology. Each flattened piece (or tissue block) is mounted, frozen, sectioned horizontally and then stained. The Mohs

surgeon also acts as pathologist. These frozen sections create an image of 100 percent of the peripheral and deep surgical margin including tissue dyes and hatch marks. Microscopic examination of this image allows the Mohs surgeon who also functions as the pathologist to identify the location(s) of any remaining tumor. The surgeon looks at the serial sections of the tissue to evaluate the status of the surgical margin. Residual tumor location(s) as seen through the microscope is marked on the map of the surgical wound. Following review of the pathology, the patient is returned to the operating room, and outcome of the review is discussed with the patient. After all required Mohs layers have been taken and a tumor free plane is reached, the temporary dressing is removed. The wound is re-anesthetized and hemostasis is obtained as needed, and the defect is evaluated for wound management. A final dressing is applied.

Description of Post-Service Work: Wound care is reviewed, as well as instructions for problems such as bleeding or pain, and restrictions on motion and activities. Prescriptions for pain and antibiotics, if needed, are given. Arrangements are made for post-operative follow-up.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Brett Coldiron, MD, John Zitelli, MD, Glenn Goldman, MD, Bruce Deitchman, MD				
<b>Specialty(s):</b>	American Academy of Dermatology				
<b>CPT Code:</b>	17313				
<b>Sample Size:</b>	747	<b>Resp N:</b>	249	<b>Response:</b> 33.3 %	
<b>Description of Sample:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	10.00	79.00	150.00	300.00	1200.00
<b>Survey RVW:</b>	2.10	5.80	6.20	6.50	12.00
<b>Pre-Service Evaluation Time:</b>			20.00		
<b>Pre-Service Positioning Time:</b>			5.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			5.00		
<b>Intra-Service Time:</b>	15.00	70.00	100.00	120.00	240.00
<b>Immediate Post Service-Time:</b>	<b>25.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

6 - NF Procedure with sedation/anesthesia care

<b>CPT Code:</b>	17313	<b>Recommended Physician Work RVU: 5.56</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		14.00	17.00	-3.00
<b>Pre-Service Positioning Time:</b>		1.00	1.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00
<b>Intra-Service Time:</b>		100.00		
<b>Immediate Post Service-Time:</b>	<b>8.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00



**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
15260	090	11.64	RUC Time

CPT Descriptor Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1 There are no MPC codes in the range with a 000 global.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
11646	010	0.00	RUC Time

CPT Descriptor Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter over 4.0 cm

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code:** 165      **% of respondents:** 66.2 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 17313</b>	<b>Key Reference CPT Code: 15260</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	20.00	28.00	
Median Intra-Service Time	100.00	100.00	
Median Immediate Post-service Time	8.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	115.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

<b>Median Total Time</b>	<b>128.00</b>	<b>273.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.13	3.78
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.03	3.67
--	------	------

Urgency of medical decision making	3.97	3.75
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.42	4.27
--------------------------	------	------

Physical effort required	4.00	4.08
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.08	4.04
---	------	------

Outcome depends on the skill and judgment of physician	4.41	4.23
--	------	------

Estimated risk of malpractice suit with poor outcome	4.01	3.84
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.81	3.75
----------------------------------	------	------

Intra-Service intensity/complexity	4.33	4.19
------------------------------------	------	------

Post-Service intensity/complexity	3.72	3.78
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Additional Rationale for Valuing of Mohs codes**

The American Academy of Dermatology (AAD) surveyed a random sample of members who perform Mohs surgery. These codes were thoroughly and exhaustively reviewed last at the April 2006 RUC and multiple approaches were used at that time to value these codes. Since that time, the Mohs procedure has not undergone any technical changes.

The survey data collected has been reviewed by an expert panel. Median survey values support selection of the non-facility pre-time package six (N/F 6) as well as the survey median for intra-service time of 100 minutes and post-service time of 25 minutes.

**These codes require the physician to act in two roles: Surgeon and Pathologist. Thus, the codes encompass both surgical work and pathology work.**

**Reference Service List (RSL)** – We compiled a list of procedures that all Mohs surgeons are familiar with, and with Research Subcommittee approval we adjusted services on the RSL to represent Day of Service work. The RSL indicated the day of procedure time and RVUs associated with the day of procedure.

For CPT 17313, surveyees consistently selected reference code 15260 with a 090 day global period. As there is no compelling evidence to increase the value of this code, the specialty society recommends the current RVU value of 5.56. The calculated IWPUT for 17313 is 0.046.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 17313

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Dermatology                      How often? Sometimes

Specialty                                      How often?

Specialty                                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 240000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Extrapolated from Medicare claims data

Specialty Dermatology	Frequency 232800	Percentage 97.00 %
-----------------------	------------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

79,616 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Please explain the rationale for this estimate. Medicare claims data

Specialty Dermatology	Frequency 78000	Percentage 97.97 %
-----------------------	-----------------	--------------------

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 17313

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

## AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 17314	Tracking Number	Original Specialty Recommended RVU: <b>3.06</b>
		Presented Recommended RVU: <b>3.06</b>
Global Period: ZZZ		RUC Recommended RVU: <b>3.06</b>

CPT Descriptor: Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure)

### CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An adult with extensive sun exposure presents with tumor positive margins following the first stage of Mohs surgery for an ill-defined invasive squamous cell carcinoma of the forearm.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

#### Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

#### Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 2%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 5%

Description of Pre-Service Work: The patient is returned to the surgical room, and gowned. The stage two Mohs procedure is explained. The method and healing period with restrictions is reviewed. The patient is placed on the surgical table, positioned for access and stage one dressing removed. The area of histologically-positive tumor margin and the proposed excision are marked with a sterile surgical marker to delineate the extent of the planned second stage. The area is cleansed and Lidocaine is injected. The patient is re-prepped and draped, lights are positioned.

Description of Intra-Service Work: Hemostasis is obtained. A scalpel is used to incise along the planned area of the excision. The second layer or stage is excised as a thin continuous wafer of tissue typically 1-3 mm thick around the sides and base of the wound. Prior to removing the specimen, hatch marks are then incised from the margin of the specimen into the surrounding adjacent normal skin, to maintain orientation of the specimen to the defect.. Hemostasis is achieved and the patient bandaged and discharged to the waiting room. This thin cup or saucer shaped wafer of tissue is flattened by cutting it into pieces (blocks) or making radial incisions to flatten the tissue. The smallest number of tissue blocks are created that will allow the performance of sectioning in the cryostat. The edges of the tissue are color coded with dyes that persist through histologic tissue processing. Once the wafer is cut into pieces and color-coded, a drawing or map of this tissue and its pieces is made so that it corresponds to the surgical wound. These tissue pieces, disassembled like a puzzle, are processed by frozen section pathology. Each flattened piece (or tissue block) is mounted, frozen, sectioned horizontally and then stained. The Mohs surgeon also acts as pathologist. These frozen sections create an image of 100 percent of the new surgical margin. Microscopic examination of this image allows the Mohs surgeon who also functions as the pathologist to identify the location(s) of any remaining tumor. The surgeon looks at the serial sections of the tissue to

evaluate the status of the surgical margin. Residual tumor location(s) as seen through the microscope is marked on the map of the surgical wound.

Description of Post-Service Work: Wound care is reviewed, as well as instructions for problems such as bleeding or pain, and restrictions on motion and activities. Prescriptions for pain and antibiotics, if needed, are given. Arrangements are made for postoperative follow-up.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Brett Coldiron, MD, John Zitelli, MD, Glenn Goldman, MD, Bruce Deitchman, MD				
<b>Specialty(s):</b>	American Academy of Dermatology				
<b>CPT Code:</b>	17314				
<b>Sample Size:</b>	747	<b>Resp N:</b>	249	<b>Response:</b> 33.3 %	
<b>Description of Sample:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	15.00	40.00	100.00	200.00	1200.00
<b>Survey RVW:</b>	1.00	3.50	4.00	4.40	12.00
<b>Pre-Service Evaluation Time:</b>			10.00		
<b>Pre-Service Positioning Time:</b>			5.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			5.00		
<b>Intra-Service Time:</b>	10.00	60.00	60.00	70.00	180.00
<b>Immediate Post Service-Time:</b>	<b>20.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

6 - NF Procedure with sedation/anesthesia care

<b>CPT Code:</b>	17314	<b>Recommended Physician Work RVU: 3.06</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		2.00	17.00	-15.00
<b>Pre-Service Positioning Time:</b>		1.00	1.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00
<b>Intra-Service Time:</b>		60.00		
<b>Immediate Post Service-Time:</b>	<b>0.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00		

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
11606	010	5.02	RUC Time

CPT Descriptor Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter over 4.0 cm**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1 There are no MPC codes in the range with a ZZZ global.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
14302	ZZZ	3.73	RUC Time

CPT Descriptor Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 171      % of respondents: 68.6 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 17314</b>	<b>Key Reference CPT Code: 11606</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	8.00	30.00	
Median Intra-Service Time	60.00	90.00	
Median Immediate Post-service Time	0.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	23.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
<b>Median Total Time</b>	<b>68.00</b>	<b>153.00</b>	



Other time if appropriate		
---------------------------	--	--

**INTENSITY/COMPLEXITY MEASURES (Mean)**(of those that selected Key  
Reference code)**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.08	3.80
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.02	3.73
--	------	------

Urgency of medical decision making	4.09	3.75
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.42	3.88
--------------------------	------	------

Physical effort required	4.03	3.79
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.17	3.87
---	------	------

Outcome depends on the skill and judgment of physician	4.41	3.98
--	------	------

Estimated risk of malpractice suit with poor outcome	4.12	3.82
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.73	3.61
----------------------------------	------	------

Intra-Service intensity/complexity	4.23	3.86
------------------------------------	------	------

Post-Service intensity/complexity	3.76	3.59
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Additional Rationale for Valuing of Mohs codes**

The American Academy of Dermatology (AAD) surveyed a random sample of members who perform Mohs surgery. These codes were thoroughly and exhaustively reviewed last at the April 2006 RUC and multiple approaches were used at that time to value these codes. Since that time, the Mohs procedure has not undergone any technical changes.

The survey data collected has been reviewed by an expert panel. Median survey values support selection of the non-facility pre-time package six (N/F 6). However, we are requesting 2 minutes for pre-evaluation, 1 minute positioning, and 5 minutes of scrub/dress/wait time. The survey median for post-service time is 20 minutes, however, we recommend 5 minutes as appropriate. The survey median supports an intra-service time of 60 minutes.

**These codes require the physician to act in two roles: Surgeon and Pathologist. Thus, the codes encompass both surgical work and pathology work.**

**Reference Service List (RSL)** – We compiled a list of procedure all Mohs surgeons are familiar with, and with Research Subcommittee approval we adjusted services on the RSL to represent Day of Service work. The RSL indicated the day of procedure time and RVUs associated with the day of procedure.

For CPT 17314, surveyees consistently selected reference code 11606 with a 010 day global period. As there is no compelling evidence to increase the value of this code, the specialty society recommends the current RVU value of 3.06. The calculated IWPUT for 17314 is 0.047.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 17314

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Dermatology                      How often? Sometimes

Specialty                                      How often?

Specialty                                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 130500

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Extrapolated from Medicare claims data

Specialty Dermatology	Frequency 127107	Percentage 97.40 %
-----------------------	------------------	--------------------

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

43,282 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Please explain the rationale for this estimate. Medicare claims data

Specialty Dermatology	Frequency 42369	Percentage 97.89 %
-----------------------	-----------------	--------------------

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 17314

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 17315	Tracking Number	Original Specialty Recommended RVU: <b>0.87</b>
		Presented Recommended RVU: <b>0.87</b>
Global Period: ZZZ		RUC Recommended RVU: <b>0.87</b>

CPT Descriptor: Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), each additional block after the first 5 tissue blocks, any stage (List separately in addition to code for primary procedure)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: An adult with extensive sun damage presents with a large, ill-defined infiltrative basal cell carcinoma of the scalp. The first stage is cut into seven blocks. The initial Mohs stage is reported as 17311. The other two blocks are each reported with CPT code 17315.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: None

Description of Intra-Service Work: The layer or stage is excised as a thin continuous wafer of tissue typically 1-3 mm thick around the sides and base of the wound. Hemostasis is achieved and the patient bandaged and discharged to the waiting room. This thin cup or saucer shaped wafer of tissue is flattened by cutting it into pieces (blocks) or making radial incisions to flatten the tissue. The smallest number of tissue blocks are created that will allow the performance of sectioning in the cryostat. The edges of the tissue are color coded with dyes that persist through histologic tissue processing. Once the wafer is cut into pieces and color-coded, a drawing or map of this tissue and its pieces is made so that it corresponds to the surgical wound. These tissue pieces, disassembled like a puzzle, are processed by frozen section pathology. Each flattened piece (or tissue block) is mounted, frozen, sectioned horizontally and then stained. The Mohs surgeon also acts as pathologist. These frozen sections create an image of 100 percent of the new surgical margin. Microscopic examination of this image allows the Mohs surgeon who also functions as the pathologist to identify the location(s) of any remaining tumor. The surgeon looks at serial sections of the tissue to evaluate the status of the surgical margin. Residual tumor location(s) as seen through the microscope is marked on the map of the surgical wound.

Description of Post-Service Work: None

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Brett Coldiron, MD, John Zitelli, MD, Glenn Goldman, MD, Bruce Deitchman, MD				
<b>Specialty(s):</b>	American Academy of Dermatology				
<b>CPT Code:</b>	17315				
<b>Sample Size:</b>	747	<b>Resp N:</b>	249	<b>Response:</b> 33.3 %	
<b>Description of Sample:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	4.00	20.00	35.00	50.00	470.00
<b>Survey RVW:</b>	0.50	1.00	1.25	1.40	12.00
<b>Pre-Service Evaluation Time:</b>			0.00		
<b>Pre-Service Positioning Time:</b>			0.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.00		
<b>Intra-Service Time:</b>	3.00	30.00	30.00	38.00	120.00
<b>Immediate Post Service-Time:</b>	<b>0.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

ZZZ Global Code

<b>CPT Code:</b>	17315	<b>Recommended Physician Work RVU: 0.87</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		0.00	0.00	0.00
<b>Pre-Service Positioning Time:</b>		0.00	0.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	0.00	0.00
<b>Intra-Service Time:</b>		30.00		
<b>Immediate Post Service-Time:</b>	<b>0.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
13102	ZZZ	1.24	RUC Time

CPT Descriptor Repair, complex, trunk; each additional 5 cm or less (List separately in addition to code for primary procedure)**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1 There are no MPC codes in the range with a ZZZ global.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
13133	ZZZ	2.19	RUC Time

CPT Descriptor Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 133      % of respondents: 53.4 %

**TIME ESTIMATES (Median)**

	CPT Code: 17315	Key Reference CPT Code: 13102	Source of Time RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	30.00	30.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>30.00</b>	<b>30.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)**(of those that selected Key  
Reference code)**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.68	3.32
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.58	3.25
Urgency of medical decision making	3.67	3.32

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.07	3.64
Physical effort required	3.55	3.49

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.75	3.49
Outcome depends on the skill and judgment of physician	4.05	3.62
Estimated risk of malpractice suit with poor outcome	3.79	3.41

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	3.76	3.50
Post-Service intensity/complexity	0.00	0.00

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUR analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

### Additional Rationale for Valuing of Mohs codes

The American Academy of Dermatology (AAD) surveyed a random sample of members who perform Mohs surgery. These codes were thoroughly and exhaustively reviewed last at the April 2006 RUC and multiple approaches were used at that time to value these codes. Since that time, the Mohs procedure has not undergone any technical changes.

The survey data collected has been reviewed by an expert panel. Median survey values support the current intra-service time of 30 minutes.

**These codes require the physician to act in two roles: Surgeon and Pathologist. Thus, the codes encompass both surgical work and pathology work.**

**Reference Service List (RSL)** – We compiled a list of procedure all Mohs surgeons are familiar with, and with Research Subcommittee approval we adjusted services on the RSL to represent Day of Service work. The RSL indicated the day of procedure time and RVUs associated with the day of procedure.

For CPT 17315, surveyees consistently selected reference code 13102 with a ZZZ day global period. As there is no compelling evidence to increase the value of this code, the specialty society recommends the current RVU value of 0.87. The calculated IWPOT for 17315 is 0.029.

### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

### FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 17315

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Dermatology                      How often? Sometimes

Specialty                                      How often?



Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 70500

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Extrapolate from Medicare claims data

Specialty Dermatology	Frequency 68554	Percentage 97.23 %
-----------------------	-----------------	--------------------

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

23,238 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare claims data

Specialty Dermatology	Frequency 22325	Percentage 96.07 %
-----------------------	-----------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 17315

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	AF	AG	AH	AI	AJ	AO	AP	AQ	AR	AS
3	ISSUE: Mohs Microsurgery																													
4	TAB: 18																													
5	Source	CPT	DESC	Resp	IWPUT	RVW					Total Time	PRE-TIME			INTRA-TIME					IMMD POST	Office					SURVEY EXPERIENCE				
6						MIN	25th	MED	75th	MAX		EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX		15	14	13	12	11	MIN	25th	MED	75th	MAX
7	REF	15260	Full thickness graft, nose, ears, eyelids, and/or lips; 20 sq cm or less	200	0.056			11.64			273	17	1	10			100			30	5									
8	CURRENT	17311	Mohs Stage 1, head, neck, hands, feet, genitalia		0.051			6.20			138	8	6	6			110			8										
9	SVY	17311	Mohs Stage 1, head, neck, hands, feet, genitalia	249	0.058	3.73	6.80	7.50	8.00	12.00	165	20	5	5	10	75	110	120	240	25						100	476	636	881	2455
10	REC	17311	Mohs Stage 1, head, neck, hands, feet, genitalia		0.051	6.20					138	14	1	5			110			8										
11																														
12																														
13	Source	CPT	DESC	Resp	IWPUT	RVW					Total Time	PRE-TIME			INTRA-TIME					IMMD POST	Office					SURVEY EXPERIENCE				
14						MIN	25th	MED	75th	MAX		EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX		15	14	13	12	11	MIN	25th	MED	75th	MAX
15	REF	14302	Adjacent tissue transfer, each additional 30.0 sq cm.	111	0.093			3.73			40						40													
16	CURRENT	17312	Mohs additional stage, head, neck, hands, feet, genitalia		0.048			3.30			73	8					65													
17	SVY	17312	Mohs additional stage, head, neck, hands, feet, genitalia	249	0.050	1.22	3.75	4.10	4.50	13.00	105	10	5	5			65			20						20	280	388	600	2000
18	REC	17312	Mohs additional stage, head, neck, hands, feet, genitalia		0.049	3.30					73	2	1	5			65			0										
19																														
20																														
21	Source	CPT	DESC	Resp	IWPUT	RVW					Total Time	PRE-TIME			INTRA-TIME					IMMD POST	Office					SURVEY EXPERIENCE				
22						MIN	25th	MED	75th	MAX		EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX		15	14	13	12	11	MIN	25th	MED	75th	MAX
23	REF	15260	Full thickness graft, nose, ears, eyelids, and/or lips; 20 sq cm or less	165	0.056			11.64			273	17	1	10			100			30	5									
24	CURRENT	17313	Mohs Stage 1 trunk, arms or legs		0.050			5.56			128	8	6	6			100			8										
25	SVY	17313	Mohs Stage 1 trunk, arms or legs	249	0.050	2.10	5.80	6.20	6.50	12.00	155	20	5	5			100			25						10	79	150	300	1200
26	REC	17313	Mohs Stage 1 trunk, arms or legs		0.050	5.56					128	14	1	5			100			8										
27																														
28																														
29	Source	CPT	DESC	Resp	IWPUT	RVW					Total Time	PRE-TIME			INTRA-TIME					IMMD POST	Office					SURVEY EXPERIENCE				
30						MIN	25th	MED	75th	MAX		EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX		15	14	13	12	11	MIN	25th	MED	75th	MAX
31	REF	11606	Excision, trunk, arms, or legs over 4.0 cm	171	0.036			5.02			153	20	5	5			90			10	1									
32	CURRENT	17314	Mohs additional stage, trunk, arms, or legs		0.048			3.06			68	8					60													
33	SVY	17314	Mohs additional stage, trunk, arms, or legs	249	0.053	1.00	3.50	4.00	4.40	12.00	100	10	5	5			60			20						15	40	100	200	1200
34	REC	17314	Mohs additional stage, trunk, arms, or legs		0.049	3.06					68	2	1	5			60			0										
35																														
36																														
37	Source	CPT	DESC	Resp	IWPUT	RVW					Total Time	PRE-TIME			INTRA-TIME					IMMD POST	Office					SURVEY EXPERIENCE				
38						MIN	25th	MED	75th	MAX		EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX		15	14	13	12	11	MIN	25th	MED	75th	MAX
39	REF	13102	Complex repair, trunk 5cm of less	133	0.040			1.21			30						30													
40	CURRENT	17315	Mohs surgery additional block		0.029			0.87			30						30													
41	SVY	17315	Mohs surgery additional block	249	0.042	0.50	1.00	1.25	1.40	12.00	30						30									4	20	35	50	470
42	REC	17315	Mohs surgery additional block		0.029	0.87					30						30													

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor(s):

**17311-** (000) Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks

**17312-** (ZZZ) Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure)

**17313-** (000) Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; first stage, up to 5 tissue blocks

**17314-** (ZZZ) Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure)

**17315-** (ZZZ) Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), each additional block after the first 5 tissue blocks, any stage (List separately in addition to code for primary procedure)

Global Period(s): **000 & ZZZ**

Meeting Date: **April 2013**

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

These values have been reviewed by the Mohs PE Task Force, a sub group appointed by and reporting to the AAD RBRVS Committee. This group is comprised of general dermatologists, dermatopathologists as well as Mohs surgeons.

The Task Force was charged with reviewing the current direct inputs to ensure the accuracy of the clinical labor, supplies and equipment and recommending additions or deletions to reflect current procedural requirements.

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes.

**Reference Code Rationale:** The practice expense recommendations are based on the current pe direct input values for the Mohs codes contained in the AMA RUC database. These values were reviewed by the PERC at the Feb 2006 meeting.

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:

All clinical labor times proposed are at or below current PE Subcommittee standards.

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:

All clinical labor times proposed are at or below current PE Subcommittee standards. However, clinical labor time has been added for those functions which have always been included in the staff work for these procedures but had not been previously broken out by the PE Subcommittee and associated/recognized with a particular function.

5. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Clinical staff completes pre-service diagnostic & referral forms, coordinates pre-surgery services, and provides pre-service education/obtain consent. The benefits, risks and alternatives to removal are explained. Sun exposure discussed. The procedure is explained, and the healing period with restrictions is reviewed. A fresh history of medications taken, including aspirin, vitamin E, and/or other blood thinners is reviewed along with a review of pertinent problems that may have arisen since the scheduling visit.

Intra-Service Clinical Labor Activities:

Clinical staff greets patient, provides gowning, ensures appropriate medical records are available and obtains vital signs. Staff prepares room, equipment, supplies. Staff prepares and positions patient and monitor patient during the procedure.

Clinical staff members assist as surgeon performs a lamellar excision of the tumor, carefully excising a thin layer of tissue around the surgical wound created by the previous procedures. The intensity of this lamellar excision is high since the typical malignancy is located at highly sensitive areas of the face, ears, eyes, nose and lips where risk of loss of substantial tissue mass and nerve function is high. Tissue excised may include epidermis, dermis, subcutaneous fat, muscle, cartilage and bone. The lamellar excision, to ensure the pathologic examination that immediately follows, must be perfectly flat, uniform of thickness and contain no holes in the layer of excised tissue. The

tissue excised is cut and divided into four or five sections for smaller tissue excisions and substantially more sections for larger tissue excisions. The number of divisions varies according to the shape and pliability of the tissue excised. In addition the tissue must be sized to allow the specimen(s) to fit on a tissue object disk for subsequent processing to allow sectioning for placement on a slide.

Clinical staff members assist the surgeon to maintain the orientation of the excised tissue to the patient's wound, the excised tissue is marked with color dyes to permit accurate orientation of excised tissue. The surgeon will manipulate the specimen to make sure it lies flat in a two-dimensional plane for precise orientation to the patient. Photos may be taken to further insure proper orientation of specimens to wound site.

The surgeon hands over the excised tissue specimens to the histologic technician and provides any special instructions necessary for proper preparation of the tissue specimens for the surgeon's subsequent examination. Typically, the surgeon plays an active role in mapping and grossing the specimen to assure precise orientation to allow localization of any areas in need of further excision.

The histotechnician prepares tissue block(s) 1 block = 2-4 sides (10, 6, 6, 1), embedding, flattening and freezing tissue labeling slides, mounting tissue on slides, staining tissue, cover slipping slides, transporting slides to microscope cleaning slide prep area, filing and storing slides.

Post-Service Clinical Labor Activities:

Clinical staff monitors the patient following service. Staff clean room/equipment used by physician staff cleans Surgical Instrument Package, completes diagnostic forms, lab requisitions. Checks dressings & wound/ home care instructions / prescriptions.

# AMA Specialty Society Recommendation

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W
1				17311- Feb 05				17312- Feb 05				17313 - Feb 05				17314- Feb 05				17315- Feb 05			
2	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.			17311		17311		17312		17312		17313		17313		17314		17314		17315		17315	
3	Meeting Date: April 2013 Tab: 18 Specialty: American Academy of Dermatology	CMS Code	Staff Type	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens		Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens		each additional stage after the first stage, up to 5 blocks (list separately in addition to code for primary		each additional stage after the first stage, up to 5 blocks (list separately in addition to code for primary		each additional stage after the first stage, up to 5 blocks (list separately in addition to code for primary		each additional stage after the first stage, up to 5 blocks (list separately in addition to code for primary		each additional stage after the first stage, up to 5 blocks (list separately in addition to code for primary procedure)		each additional stage after the first stage, up to 5 blocks (list separately in addition to code for primary procedure)		Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens		Mohs micrographic tech-nique, including removal of all gross tumor, surgical excision of tissue specimens	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	ZZZ	ZZZ	ZZZ	ZZZ	000	000	000	000	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ
6	TOTAL CLINICAL LABOR TIME			229.0	0.0	223.0	0.0	152.0	0.0	130.0	0.0	199.0	0.0	219.0	0.0	126.0	0.0	130.0	0.0	34.0	0.0	36.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/PN/MTA	15.0	0.0	15.0	0.0	0.0	0.0	0.0	0.0	15.0	0.0	15.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/PN/MTA	117.0	0.0	99.0	0.0	97.0	0.0	60.0	0.0	87.0	0.0	95.0	0.0	71.0	0.0	60.0	0.0	15.0	0.0	15.0	0.0
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037B	Histotech	94.0		109.0		55.0		70.0		94.0		109.0		55.0		70.0		19.0		21.0	
10	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/PN/MTA	3.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
11	PRE-SERVICE																						
12	Start: Following visit when decision for surgery or procedure made																						
13	Complete pre-service diagnostic & referral forms	L037D	RN/PN/MTA	5		5						5		5									
14	Coordinate pre-surgery services	L037D	RN/PN/MTA	3		3						3		3									
15	Schedule space and equipment in facility																						
16	Provide pre-service education/obtain consent	L037D	RN/PN/MTA	7		7						7		7									
17	Follow-up phone calls & prescriptions																						
18	*Other Clinical Activity - specify:																						
19	End: When patient enters office/facility for surgery/procedure																						
20	SERVICE PERIOD																						
21	Start: When patient enters office/facility for surgery/procedure:																						
22	Review charts	L037D	RN/PN/MTA	2								2											
23	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/PN/MTA	3		2		3		2		3		2		3		2					
24	Obtain vital signs	L037D	RN/PN/MTA	5		3		3		3		5		3		3		3					
25	Provide pre-service education/obtain consent															2		2					
26	Prepare room, equipment, supplies	L037D	RN/PN/MTA	2		2		2		2		2		2									
27	Setup scope (non facility setting only)																						
28	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/PN/MTA	2		2		2		2		2		2		2		2					
29	Sedate/apply anesthesia																						
30	*Other Clinical Activity - specify:																						
31	Intra-service																						
32	Assist physician in performing procedure	L037D	RN/PN/MTA	73		60		66		30		43		56		40		30		15		15	
33	Post-Service																						
34	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/PN/MTA	3		3		3		3		3		3		3		3					
35	Clean room/equipment by physician staff	L037D	RN/PN/MTA	3		3		3		3		3		3		3		3					
36	Clean Scope																						
37	Clean Surgical Instrument Package	L037D	RN/PN/MTA	15		15		15		15		15		15		15		15					
38	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/PN/MTA	2		2						2		2									
39	Review/read X-ray, lab, and pathology reports	L037D	RN/PN/MTA	2		2						2		2									
40	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/PN/MTA	5		5						5		5									
41	*Other Clinical Activity - specify: Histotechnician	L037B	Histotech																				
42																							
43	Embedding, flattening and freezing tissue	L037B	Histotech	18		18		12		12		18		18		12		12		4		4	
44	Labeling slides	L037B	Histotech	10		10		4		4		10		10		4		4		1		1	
45	Mounting tissue on slides	L037B	Histotech	43		43		23		23		43		43		23		23		8		8	
46	Staining tissue	L037B	Histotech	12		12		9		9		12		12		9		9		3		3	

AMA Specialty Society Recommendation

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W
1				17311- Feb 05				17312- Feb 05				17313 - Feb 05				17314- Feb 05				17315- Feb 05			
2	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.			17311		17311		17312		17312		17313		17313		17314		17314		17315		17315	
3	Meeting Date: April 2013 Tab: 18 Specialty: American Academy of Dermatology	CMS Code	Staff Type	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens		Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens		each additional stage after the first stage, up to 5 blocks (list separately in addition to code for primary		each additional stage after the first stage, up to 5 blocks (list separately in addition to code for primary		each additional stage after the first stage, up to 5 blocks (list separately in addition to code for primary		each additional stage after the first stage, up to 5 blocks (list separately in addition to code for primary		each additional stage after the first stage, up to 5 blocks (list separately in addition to code for primary procedure)		each additional stage after the first stage, up to 5 blocks (list separately in addition to code for primary procedure)		Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens		Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	ZZZ	ZZZ	ZZZ	ZZZ	000	000	000	000	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ
47	Cover slipping slides	L037B	Histotech	5		5		3		3		5		5		3		3		1		1	



# AMA Specialty Society Recommendation

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W
1				17311- Feb 05				17312- Feb 05				17313 - Feb 05				17314- Feb 05				17315- Feb 05			
2	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.			17311		17311		17312		17312		17313		17313		17314		17314		17315		17315	
3	Meeting Date: April 2013 Tab: 18 Specialty: American Academy of Dermatology	CMS Code	Staff Type	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens	each additional stage after the first stage, up to 5 blocks (list separately in addition to code for primary	each additional stage after the first stage, up to 5 blocks (list separately in addition to code for primary	each additional stage after the first stage, up to 5 blocks (list separately in addition to code for primary	each additional stage after the first stage, up to 5 blocks (list separately in addition to code for primary	each additional stage after the first stage, up to 5 blocks (list separately in addition to code for primary procedure)	each additional stage after the first stage, up to 5 blocks (list separately in addition to code for primary procedure)	each additional stage after the first stage, up to 5 blocks (list separately in addition to code for primary procedure)	each additional stage after the first stage, up to 5 blocks (list separately in addition to code for primary procedure)	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens								
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	ZZZ	ZZZ	ZZZ	ZZZ	000	000	000	000	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ
48	Transporting slides to microscope	L037B	Histotech	1		1		1		1		1		1		1		1		1		1	
49	Cleaning	L037B	Histotech			15				15				15				15				2	
50	Filing and storing slides	L037B	Histotech	5		5		3		3		5		5		3		3		1		1	
51	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a	
52	Dischrg mgmt (1.0 x 99238) (enter 12 min)			n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a	
53	Dischrg mgmt (1.0 x 99239) (enter 15 min)			n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a	
54	End: Patient leaves office																						
55	POST-SERVICE Period																						
56	Start: Patient leaves office/facility																						
57	Conduct phone calls/call in prescriptions	L037D	RN/PN/MTA	3								3											
58	Office visits: List Number and Level of Office Visits			# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits
59	99211 16 minutes		16																				
60	99212 27 minutes		27																				
61	99213 36 minutes		36																				
62	99214 53 minutes		53																				
63	99215 63 minutes		63																				
64	Total Office Visit Time			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
65	*Other Clinical Activity - specify:																						
66	End: with last office visit before end of global period																						
67	MEDICAL SUPPLIES**	CODE	UNIT																				
68	pack, minimum multi-specialty visit	SA048	pack	1		1		1		1		1		1		1		1					
69	needle, 18-27 g	SC029	item	2		2		2		2		2		2		2		2					
70	syringe, 10-12 ml	SC051	item	2		2		2		2		2		2		2		2					
71	cautery, monopolar, pencil-handpiece	SF020	item	1		1		1		1		1		1		1		1					
72	cautery, patient ground pad w/ cord	SF021	item	1		1		1		1		1		1		1		1					
73	suture, vicryl, 3-0 to 6-0, p, ps	SF040	item	1		1		1		1		1		1		1		1					
74	pack, cleaning, surgical instruments	SA043	item	1		1		1		1		1		1		1		1					
75	cap, surgical	SB001	item	4		4		3		3		4		4		3		3					
76	drape, sterile for Mayo stand	SB012	item	1		1		1		1		1		1		1		1					
77	drape-towel, sterile 18 X 26	SB019	item	1		1		1		1		1		1		1		1					
78	drape-towel, fenestrated 16X29	SB011	item	1		1		1		1		1		1		1		1					
79	gown, staff, impervious	SB027	item	3		3		2		2		3		3		2		2					
80	mask, surgical, with face shield	SB034	item	3		3		2		2		3		3		2		2					
81	gloves, sterile	SB024	item	2		2		2		2		2		2		2		2					
82	gloves, non-sterile (histotech)	SB022	item	1		1		1		1		1		1		1		1					
83	underpad 2X3 (chux)	SB044	item	1		1		1		1		1		1		1		1					
84	blade, microtome	SF044	item	1		1						1		1									
85	needle, 30g	SC031	item	2		2		2		2		2		2		2		2					
86	dressing 3X4 (Telfa, release)	SG035	item	1		1		1		1		1		1		1		1					
87	blade, surgical hair clipper	SF010	item	1		1						1		1									
88	curette, dermal	SF024	item	1		1						1		1									
89	lidocane, 1% w-ep inj (Xylocaine with epi)	SH046	ml	20		20		20		20		20		20		20		20					
90	dressing, eye pad (Opticlude)	SG043	item	2		2		2		2													
91	tape, surgical occlusive 1 in (Blenderm)	SG078	inch	60		60		60		60		60		60		60		60					
92	tape, foam, elastic 2 in (mircofoam)	SG088	inch	8		8		8		8		10		10		8		8					
93	povidone surgical scrub (Betadine)	SJ042	ml	10		10		10		10		10		10		10		10					
94	scrub brush (impregnated)	SM023	item	1		2		1		2		1		2		1		2					
95	skin marking pen, sterile	SK075	item	1		1		1		1		1		1		1		1					
96	anatomical drawings (for treatment recording)	SK002	item	1		1		1		1		1		1		1		1					
97	measuring tape, paper	SK048	item	1		1		1		1		1		1		1		1					
98	histology freezing spray (Freeze-It)	SL078	oz	1		1		0.6		0.6		1		1		0.6		0.6		0.2		0.2	
99	Slide, charged	INV	item			10				6				10				6				2	
100	slide container (20 microscope slides)	SL120	item	1		1						1		1									



# AMA Specialty Society Recommendation

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W
1				17311- Feb 05				17312- Feb 05				17313 - Feb 05				17314- Feb 05				17315- Feb 05			
2	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.			17311		17311		17312		17312		17313		17313		17314		17314		17315		17315	
3	Meeting Date: April 2013 Tab: 18 Specialty: American Academy of Dermatology	CMS Code	Staff Type	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens		Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens		each additional stage after the first stage, up to 5 blocks (list separately in addition to code for primary		each additional stage after the first stage, up to 5 blocks (list separately in addition to code for primary		each additional stage after the first stage, up to 5 blocks (list separately in addition to code for primary		each additional stage after the first stage, up to 5 blocks (list separately in addition to code for primary		each additional stage after the first stage, up to 5 blocks (list separately in addition to code for primary procedure)		each additional stage after the first stage, up to 5 blocks (list separately in addition to code for primary procedure)		Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens		Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	ZZZ	ZZZ	ZZZ	ZZZ	000	000	000	000	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ
101	cover slip, glass	SL303	item	10		10		6		6		10		10		6		6		2		2	
102	adhesive liquid (Mastisol) (.67ml)	SG004	item	1		1		1		1		1		1		1		1					
103	tubing, suction, non-latex (6ft) with poole tip	SD133	item	1		1		1		1		1		1		1		1					
104	gas, liquid nitrogen	SD082	ml	20		20		20		20		20		20		20		20		20		20	
105	mounting media (Histomount)	SL095	item	1		1		1		1		1		1		1		1		1		1	
106	OCT Tissue-Tek	SL097	ml	8		8		6		6		8		8		6		6		1		1	
107	slide, microscope, charged	SL122	item	10		0		6		0		8		0		6		0		2		0	
108	stain, frozen section, H&E (1ml per slide)	SL134	ml	10		10		6		6		10		10		6		6		2		2	
109	marking dyes	SL470	ml			12				9				12				9				3	
110	map, Moh's surgery (per sheet)	SK047	item	1		1						1		1									
111	patient education booklet	SK062	item	1		1						1		1									
112	bacitracin ointment (15gm uou)	SJ008	item	1		1		1		1		1		1		1		1					
113	hydrogen peroxide	SJ028	ml	20		20		20		20		20		20		20		20					
114	water, sterile for irrigation (250-1000ml uou)	SH074	item	0.4		0.4		0.4		0.4		0.4		0.4		0.4		0.4					
115	applicator, cotton-tipped, non sterile 6in	SG008	item	30		30		20		20		30		30		20		20					
116	bandage, King, non-sterile 2in	SG017	item	1		1		1		1		1		1		1		1					
117	dressing, 12-7mm (Gelfoam)	SG033	item	1		1		1		1		1		1		1		1					
118	gauze, sterile 4in x 4in	SG055	item	3		3		2		2		3		3		2		2					
119	adhesive remover, liquid (Detachol) (0.67ml uou)	SG005	item	1		1		1		1		1		1		1		1					
120	scalpel, safety, surgical, with blade (#10-20)	SF047	item			3				2				3				2					
121	EQUIPMENT	CODE																					
122	electrosurgical generator	EQ114		60		60		30		30		56		56		30		30		15		15	
123	light, surgical	EF014		60		60		30		30		56		56		30		30		15		15	
124	loupes, surgical, prism	EQ177		60		60		30		30		56		56		30		30		15		15	
125	cryosurgery system, non ophthalmic	EQ094		60		43		30		23		56		43		30		23		15		8	
126	cryostat	EQ092		60		43		30		23		56		43		30		23		15		8	
127	grossing station with heavy duty disposal	EP015		60		18		30		12		56		18		30		12		15		4	
128	hood, fume	EP017		60		43		30		23		56		43		30		23		15		8	
129	table, power	EF031		60		60		30		30		56		56		30		30		15		15	
130	microscope, compound	EP024		60		60		30		30		56		56		30		30		15		15	
131	mayo stand	EF015		60		60		30		30		56		56		30		30		15		15	
132	suction maching (Gomco)	EQ235		60		60		30		30		56		56		30		30		15		15	
133	camera, digital, 12 megapixel	ED005		60		5		30		5		56		5		30		5		15		0	
134	instrument pack, medium	EQ138		60		60		30		30		56		56		30		30		15		15	
135	Smoke Evacuator (tubing, covering, etc) with stand	EQ351				60				30				56				30				15	

AMA/Specialty Society RVS Update Committee Summary of Recommendations  
*High Expenditure Procedural Codes Screen*

April 2013

**Nasal/Sinus Endoscopy**

CPT code 31237 *Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)* was identified through the CMS High Expenditure Procedural Codes screen. The RUC recommended survey of physician work and review of practice expense for this family of services at the April 2013 RUC meeting.

**31237 *Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)***

The RUC reviewed the survey results from 153 otolaryngologists and agreed with the specialty on the following physician time components: 23 minutes of pre-service time, 20 minutes of intra-service time and 5 minutes of immediate post-service time.

The RUC reviewed the survey data and agreed that current work RVU of 2.98 no longer accurately reflects the physician work involved in this service. Specifically, the RUC noted the decrease in intra-service time from the previous survey performed in 1993. Given this, the RUC agreed with the specialty society that the 25<sup>th</sup> percentile survey value of 2.60 accurately accounts for the work to perform 31237. To justify this value, the RUC reviewed MPC code 51102 *Aspiration of bladder; with insertion of suprapubic catheter* (work RVU= 2.70) and noted that both services have identical intra-service time, 20 minutes; however, the reference code has 12 additional minutes of total time and is therefore properly valued slightly higher than the surveyed code. In addition, the RUC compared code 31237 to CPT code 57454 *Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage* (work RVU= 2.33) and agreed that while both procedures have identical intra-service time, the surveyed code should be valued higher due to greater total time and increased intensity compared to 57454. **The RUC recommends a work RVU of 2.60 for CPT code 31237.**

**31238 *Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage***

The RUC reviewed the survey results from 132 otolaryngologists and agreed with the specialty on the following physician time components: 18 minutes of pre-service time, 25 minutes of intra-service time and 10 minutes of immediate post-service time. These recommended pre- and post-service times reflect a reduction of 5 minutes in each category to account for any potential overlap of physician work between the endoscopy service and an Evaluation and Management service that is typically performed on the same date of service.

The RUC reviewed the survey data and agreed that the current work RVU of 3.26 no longer accurately reflects the physician work involved in this service. As with the survey data for 31237, the median intra-service time is lower than the last RUC survey performed in 1993. Given this, the RUC agreed with the specialty society that the 25<sup>th</sup> percentile survey value of 2.74 accurately accounts for the work of 31238. To justify this value,

the RUC reviewed the key reference code 31296 *Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation)* (work RVU= 3.29) and noted that the reference code has 5 additional minutes of intra-service time and greater total time compared to the surveyed code. Therefore, the reference code is accurately valued higher than 31238. In addition, the RUC reviewed codes 57460 *Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix* (work RVU= 2.83) and 52204 *Cystourethroscopy, with biopsy(s)* (work RVU= 2.59) and agreed that since both codes have identical intra-service time, 25 minutes, compared to the surveyed code, 31238 is appropriately valued between these services. **The RUC recommends a work RVU of 2.74 for CPT code 31238.**

### **31239 *Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy***

The RUC reviewed the survey results from 105 otolaryngologists and ophthalmologists and agreed with the specialties on the following physician time components: 46 minutes of pre-service time, 60 minutes of intra-service time and 20 minutes of immediate post-service time. The RUC also agreed with the following post-operative visits for this 010 day global code: one 99213 and one-half day discharge management service, 99238. The RUC noted that while the survey respondents did not indicate a discharge management service was typical, there was consensus that the physician work of detailing to the patient the post-operative care instructions and prescriptions, preparing the operative report and scheduling the follow-up visit is necessary physician work and should be captured in a discharge management code.

The RUC reviewed the survey data and agreed that the current work RVU of 9.33 no longer accurately reflects the physician work involved in this service. The RUC again noted that the surveyed median intra-service time is lower than the last RUC survey performed in 1994, 60 minutes versus 90 minutes. To determine an appropriate value, the RUC compared the surveyed code to CPT code 22523 *Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic* (work RVU= 9.04) and agreed that both codes have almost identical intra-service time, 58 minutes compared to 60 minutes, and similar total time. Therefore, the RUC agreed to directly crosswalk the physician work of 22523 to the surveyed code, 31239. To justify a work RVU of 9.04, the RUC compared the surveyed code to MPC code 22520 *Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; thoracic* (work RVU= 9.22) and agreed that since the reference code has slightly greater total time and is a more intense procedure, it is appropriately valued slightly higher than 31239. Finally, the RUC validated the crosswalk by noting that the recommended post-operative visits contain one less 99213 and the addition of a half-day discharge code compared to the current time for this code. By subtracting out the work of a 99213 (0.97) and adding in the work of a half-day discharge (0.64) to the current work RVU (9.33) the resulting value (9.00) is almost identical to the recommended value of 9.04. **The RUC recommends a work RVU of 9.04 for CPT code 31239.**

**31240 Nasal/sinus endoscopy, surgical; with concha bullosa resection**

The RUC reviewed the survey results from 125 otolaryngologists and agreed with the specialty on the following physician time components: 38 minutes of pre-service time, 20 minutes of intra-service time and 15 minutes of immediate post-service time.

The RUC reviewed the survey respondent's estimated physician work values and agreed that the current work value of 2.61, almost identical to the 25<sup>th</sup> percentile value (2.64), remains appropriate for this code. The RUC noted that the median intra-service time is reduced from the last survey performed in 1993, 20 minutes versus 30 minutes. However, it appears that in 1993 the RUC recommended a much higher value (4.00) for this procedure, but CMS (then HCFA) rejected this recommendation by lowering the value for the services in this family by 33 percent. This arbitrary reduction was justified by the Agency, noting that the intensities would have been too high based on the RUC recommendations at the time. Given how these services were previously considered by the RUC, the RUC agreed that the current value, properly valued relative to the other codes in this family of services, is appropriate. Further justification was gained by comparing the surveyed code to key reference code 31295 *Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa* (work RVU= 2.70). The RUC noted that since both codes have identical intra-service time and analogous total time, the two codes should be valued similarly. Finally, CPT code 36555 *Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age* (work RVU= 2.68) was compared to code 31240 and since both codes have identical intra-service time, they should be valued similarly. **The RUC recommends a work RVU of 2.61 for CPT code 31240.**

**Practice Expense:**

The PE Subcommittee determined that the equipment time needed to be recalculated to comply with the CMS definition of appropriate allocation of equipment time. This resulted in removing 15 minutes of equipment time for each of the three scopes included in this procedure. The RUC noted that the specialty did not agree with this decision, stating that staff observes the patient for recurrent bleeding and if bleeding occurs the scopes need to be available in the room and therefore cannot be used by other patients. However, the RUC agreed that the 15 minutes of patient monitoring should be removed from all the equipment time to comply with CMS standards. The Chair noted that a PE Subcommittee workgroup is going to be established to review monitoring time issues. The RUC reviewed and approved the direct practice expense inputs with modifications as recommended by the Practice Expense Subcommittee.

**Work Neutrality:**

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

<b>CPT Code (•New)</b>	<b>CPT Descriptor</b>	<b>Global Period</b>	<b>Work RVU Recommendation</b>
31237	Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)	000	2.60
31238	with control of nasal hemorrhage	000	2.74
31239	with dacryocystorhinostomy	010	9.04
31240	with concha bullosa resection	000	2.61 (No Change)

AMA/Specialty Society RVS Update Committee Summary of Recommendations  
*High Expenditure Procedural Codes Screen*

April 2013

**Nasal/Sinus Endoscopy**

CPT code 31237 *Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)* was identified through the CMS High Expenditure Procedural Codes screen. The RUC recommended survey of physician work and review of practice expense for this family of services at the April 2013 RUC meeting.

**31237 *Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)***

The RUC reviewed the survey results from 153 otolaryngologists and agreed with the specialty on the following physician time components: 23 minutes of pre-service time, 20 minutes of intra-service time and 5 minutes of immediate post-service time.

The RUC reviewed the survey data and agreed that current work RVU of 2.98 no longer accurately reflects the physician work involved in this service. Specifically, the RUC noted the decrease in intra-service time from the previous survey performed in 1993. Given this, the RUC agreed with the specialty society that the 25<sup>th</sup> percentile survey value of 2.60 accurately accounts for the work to perform 31237. To justify this value, the RUC reviewed MPC code 51102 *Aspiration of bladder; with insertion of suprapubic catheter* (work RVU= 2.70) and noted that both services have identical intra-service time, 20 minutes; however, the reference code has 12 additional minutes of total time and is therefore properly valued slightly higher than the surveyed code. In addition, the RUC compared code 31237 to CPT code 57454 *Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage* (work RVU= 2.33) and agreed that while both procedures have identical intra-service time, the surveyed code should be valued higher due to greater total time and increased intensity compared to 57454. **The RUC recommends a work RVU of 2.60 for CPT code 31237.**

**31238 *Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage***

The RUC reviewed the survey results from 132 otolaryngologists and agreed with the specialty on the following physician time components: 18 minutes of pre-service time, 25 minutes of intra-service time and 10 minutes of immediate post-service time. These recommended pre- and post-service times reflect a reduction of 5 minutes in each category to account for any potential overlap of physician work between the endoscopy service and an Evaluation and Management service that is typically performed on the same date of service.

The RUC reviewed the survey data and agreed that the current work RVU of 3.26 no longer accurately reflects the physician work involved in this service. As with the survey data for 31237, the median intra-service time is lower than the last RUC survey performed in 1993. Given this, the RUC agreed with the specialty society that the 25<sup>th</sup> percentile survey value of 2.74 accurately accounts for the work of 31238. To justify this value,

the RUC reviewed the key reference code 31296 *Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation)* (work RVU= 3.29) and noted that the reference code has 5 additional minutes of intra-service time and greater total time compared to the surveyed code. Therefore, the reference code is accurately valued higher than 31238. In addition, the RUC reviewed codes 57460 *Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix* (work RVU= 2.83) and 52204 *Cystourethroscopy, with biopsy(s)* (work RVU= 2.59) and agreed that since both codes have identical intra-service time, 25 minutes, compared to the surveyed code, 31238 is appropriately valued between these services. **The RUC recommends a work RVU of 2.74 for CPT code 31238.**

### **31239 *Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy***

The RUC reviewed the survey results from 105 otolaryngologists and ophthalmologists and agreed with the specialties on the following physician time components: 46 minutes of pre-service time, 60 minutes of intra-service time and 20 minutes of immediate post-service time. The RUC also agreed with the following post-operative visits for this 010 day global code: one 99213 and one-half day discharge management service, 99238. The RUC noted that while the survey respondents did not indicate a discharge management service was typical, there was consensus that the physician work of detailing to the patient the post-operative care instructions and prescriptions, preparing the operative report and scheduling the follow-up visit is necessary physician work and should be captured in a discharge management code.

The RUC reviewed the survey data and agreed that the current work RVU of 9.33 no longer accurately reflects the physician work involved in this service. The RUC again noted that the surveyed median intra-service time is lower than the last RUC survey performed in 1994, 60 minutes versus 90 minutes. To determine an appropriate value, the RUC compared the surveyed code to CPT code 22523 *Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic* (work RVU= 9.04) and agreed that both codes have almost identical intra-service time, 58 minutes compared to 60 minutes, and similar total time. Therefore, the RUC agreed to directly crosswalk the physician work of 22523 to the surveyed code, 31239. To justify a work RVU of 9.04, the RUC compared the surveyed code to MPC code 22520 *Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; thoracic* (work RVU= 9.22) and agreed that since the reference code has slightly greater total time and is a more intense procedure, it is appropriately valued slightly higher than 31239. Finally, the RUC validated the crosswalk by noting that the recommended post-operative visits contain one less 99213 and the addition of a half-day discharge code compared to the current time for this code. By subtracting out the work of a 99213 (0.97) and adding in the work of a half-day discharge (0.64) to the current work RVU (9.33) the resulting value (9.00) is almost identical to the recommended value of 9.04. **The RUC recommends a work RVU of 9.04 for CPT code 31239.**

**31240 *Nasal/sinus endoscopy, surgical; with concha bullosa resection***

The RUC reviewed the survey results from 125 otolaryngologists and agreed with the specialty on the following physician time components: 38 minutes of pre-service time, 20 minutes of intra-service time and 15 minutes of immediate post-service time.

The RUC reviewed the survey respondent's estimated physician work values and agreed that the current work value of 2.61, almost identical to the 25<sup>th</sup> percentile value (2.64), remains appropriate for this code. The RUC noted that the median intra-service time is reduced from the last survey performed in 1993, 20 minutes versus 30 minutes. However, it appears that in 1993 the RUC recommended a much higher value (4.00) for this procedure, but CMS (then HCFA) rejected this recommendation by lowering the value for the services in this family by 33 percent. This arbitrary reduction was justified by the Agency, noting that the intensities would have been too high based on the RUC recommendations at the time. Given how these services were previously considered by the RUC, the RUC agreed that the current value, properly valued relative to the other codes in this family of services, is appropriate. Further justification was gained by comparing the surveyed code to key reference code 31295 *Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa* (work RVU= 2.70). The RUC noted that since both codes have identical intra-service time and analogous total time, the two codes should be valued similarly. Finally, CPT code 36555 *Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age* (work RVU= 2.68) was compared to code 31240 and since both codes have identical intra-service time, they should be valued similarly. **The RUC recommends a work RVU of 2.61 for CPT code 31240.**

**Practice Expense:**

The PE Subcommittee determined that the equipment time needed to be recalculated to comply with the CMS definition of appropriate allocation of equipment time. This resulted in removing 15 minutes of equipment time for each of the three scopes included in this procedure. The RUC noted that the specialty did not agree with this decision, stating that staff observes the patient for recurrent bleeding and if bleeding occurs the scopes need to be available in the room and therefore cannot be used by other patients. However, the RUC agreed that the 15 minutes of patient monitoring should be removed from all the equipment time to comply with CMS standards. The Chair noted that a PE Subcommittee workgroup is going to be established to review monitoring time issues. The RUC reviewed and approved the direct practice expense inputs with modifications as recommended by the Practice Expense Subcommittee.

**Work Neutrality:**

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



<b>CPT Code (•New)</b>	<b>CPT Descriptor</b>	<b>Global Period</b>	<b>Work RVU Recommendation</b>
31237	Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)	000	2.60
31238	with control of nasal hemorrhage	000	2.74
31239	with dacryocystorhinostomy	010	9.04
31240	with concha bullosa resection	000	2.61 (No Change)

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor:

50360 Renal allotransplantation, implantation of graft; without recipient nephrectomy

Global Period: 090

Meeting Date: April 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: Representatives of the American Society of Transplant Surgeons and the American Urological Surgeons utilized the practice expense details accepted by the RUC and CMS in 2004.
2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale: N/A
3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time: An additional 30 minutes has been added to the typical 60 minutes assigned to 90-day global procedures. All work performed once the patient is admitted to the hospital relevant to the recipient procedure falls under Medicare Part B. this is in sharp contrast to all work performed prior to admission, including evaluation, listing, maintenance on waiting list, up to and including organ offer, which fall under Medicare Part A. While the latter non-physician work is typically performed by hospital staff, the former is typically performed by nurse coordinators involved in the post transplant care and commonly the responsibility of the surgical team. This transition of care is highly regulated and has been and continues to be the topic of OIG investigations and therefore most programs are acutely aware of the need to abide by these regulatory directives.
4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence: N/A
5. Please describe in detail the clinical activities of your staff:

CLINICAL STAFF TYPE: It has previously been accepted that transplant surgeons will have an RN as their typical staff type, therefore, "RN" is indicated for all clinical staff activities.

Pre-Service Clinical Labor Activities:

Standard time of 60 minutes for major surgical procedures (90-day global) is indicated . An additional 30 minutes has been added to the typical 60 minutes assigned to 90-day global procedures. All work performed once the patient is admitted to the hospital relevant to the recipient procedure falls under Medicare Part B. this is in sharp contrast to all work performed prior to admission, including evaluation, listing, maintenance on waiting list, up to and including organ offer, which fall under Medicare Part A. While the latter non-physician work is typically performed by hospital staff, the former is typically performed by nurse coordinators involved in the post transplant care and commonly the responsibility of the surgical team. This transition of care is highly regulated and has been and continues to be the topic of OIG investigations and therefore most programs are acutely aware of the need to abide by these regulatory directives.

Intra-Service Clinical Labor Activities:

The RUC database indicates discharge day management at 99238 level for the living donor procedure codes. The PEAC standard 12 minutes of clinical staff activity for 99238 is shown on the spreadsheet.

Post-Service Clinical Labor Activities:

Standard times for each office visit.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 31238	Tracking Number	Original Specialty Recommended RVU: <b>2.74</b>
		Presented Recommended RVU: <b>2.74</b>
Global Period: 000		RUC Recommended RVU: <b>2.74</b>

CPT Descriptor: Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 68 year old with hypertension presents with refractory left epistaxis which is not controlled by anterior or posterior nasal packing. The patient undergoes endoscopic examination with identification of the bleeding source in the nasal cavity followed by control of hemorrhage.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 49%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 9%

**Description of Pre-Service Work:**

- After the decision is made for the need for nasal endoscopy the patient is moved to a room equipped with the video tower and a protective drape is placed on the patient.
- Vital signs are obtained.
- The physician ensures that the endoscopes, suction, air source for insufflation, cautery, and video recording equipment are available and functioning properly.
- The procedure is explained and consent obtained.
- A time out is performed.
- The physician washes hands and dons proper gloves, mask, and protective eye wear.
- Topical decongestant and anesthetic sprays are applied to the nostrils followed by a wait time for it to take effect.
- The patient is positioned in an upright, seated position.

Description of Intra-Service Work: Complete bilateral nasal endoscopy is performed. Previous packing, crusts, and clots are removed to help identify the bleeding site. The bleeding area is then packed with cotton or pledget soaked with topical decongestant and anesthetic spray followed by a wait time for the anesthetic to take effect. The bleeding region is then infiltrated with local with epinephrine followed by a wait time. The bleeding site(s) is then cauterized with bipolar or suction cautery to achieve control of epistaxis. Absorbable packing, such as fibrillar surgical, is applied to the cautery site and any other bleeding areas.

**Description of Post-Service Work:**

- Monitor patient during recovery period and check for any recurrence of bleeding.

- Home restrictions (i.e. diet, activity), treatment and findings are explained to the patient using the procedure video recording and pointing out areas of normal anatomy and pathology.
- Subsequent evaluation and therapeutic plan are discussed.
- Write prescriptions for medications and supplies needed post-discharge
- Perform medication reconciliation.
- The examination and any still images are saved on the digital recording system.
- The procedure note is dictated and findings communicated to the referring physician.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Wayne Koch, MD; Jane Dillon, MD				
<b>Specialty(s):</b>	AAO-HNS				
<b>CPT Code:</b>	31238				
<b>Sample Size:</b>	1088	<b>Resp N:</b>	132	<b>Response:</b> 12.1 %	
<b>Description of Sample:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	10.00	15.00	30.00	1000.00
<b>Survey RVW:</b>	1.25	2.74	3.35	4.13	15.00
<b>Pre-Service Evaluation Time:</b>			20.00		
<b>Pre-Service Positioning Time:</b>			6.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10.00		
<b>Intra-Service Time:</b>	2.00	15.00	25.00	30.00	90.00
<b>Immediate Post Service-Time:</b>	<u>15.00</u>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

6 - NF Procedure with sedation/anesthesia care

<b>CPT Code:</b>	31238	<b>Recommended Physician Work RVU: 2.74</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		12.00	17.00	-5.00
<b>Pre-Service Positioning Time:</b>		1.00	1.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00
<b>Intra-Service Time:</b>		25.00		
<b>Immediate Post Service-Time:</b>	<u>10.00</u>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31296	000	3.29	RUC Time

CPT Descriptor Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation)**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
51102	000	2.70	RUC Time	14,090

CPT Descriptor 1 Aspiration of bladder; with insertion of suprapubic catheter

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
15002	000	3.65	RUC Time	16,473

CPT Descriptor 2 Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
57460	000	2.83	RUC Time

CPT Descriptor Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 31      % of respondents: 23.4 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 31238</b>	<b>Key Reference CPT Code: <u>31296</u></b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	18.00	43.00	
Median Intra-Service Time	25.00	30.00	
Median Immediate Post-service Time	10.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
<b>Median Total Time</b>	<b>53.00</b>	<b>88.00</b>	

Other time if appropriate		
---------------------------	--	--

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.68	3.32
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.58	3.39
--	------	------

Urgency of medical decision making	4.55	3.13
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.16	3.84
--------------------------	------	------

Physical effort required	3.97	3.65
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.23	3.74
---	------	------

Outcome depends on the skill and judgment of physician	4.16	3.90
--	------	------

Estimated risk of malpractice suit with poor outcome	3.94	3.81
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.90	3.39
----------------------------------	------	------

Intra-Service intensity/complexity	4.10	3.71
------------------------------------	------	------

Post-Service intensity/complexity	3.45	3.13
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Why are these codes being reviewed?**

The nasal/sinus endoscopy code 31237 was identified in the CY 2012 Final Physician Fee Schedule by CMS as a potentially misvalued service. Following submission of an action plan to survey 31237 by the Academy, it was determined that 31237-31240 was a “family” of codes based on their location in the CPT book, and therefore, all four codes were required for survey by the RAW for April 2013.

**Description of Random Survey**

All four codes in this family were surveyed by AAO-HNS. The standard 000 global survey instrument was utilized with two revisions instructing respondents to include time for administering topical anesthetic, where appropriate, in the pre-service time and localized or injected anesthesia, where appropriate, in the intra service time. This change was approved by the Research Subcommittee. The Otolaryngology physician work recommendations were derived by conducting a random survey of our members. Surveys for CPT 31238 were sent to nearly 1100 Otolaryngologists, including the subspecialty of rhinology, as well as to the Academy's leadership and key committees such as the Rhinology Paranasal Sinus Committee which contains clinicians who were most likely to be familiar with the services under review. Of the 1088 surveys distributed for CPT 31238, 132 responses were received, a response rate of 12%.

**Physician Time**

**Pre Time:** Following a review of the pre-time survey data, our expert panel determined that preservice package 6 (Non-Facility procedure with sedation/anesthesia care) was most appropriate. Prepackage 6 assigns 17 minutes for evaluation, 1 minute for positioning, and 5 minutes for scrub, dress, and wait. Our expert panel felt this was the most appropriate package given that service is predominantly provided in a physician's office and topical anesthetic and decongestant is utilized to numb the nose prior to providing an endoscopy procedure. We recognize that the five percent file claims data provided by the AMA RUC staff reflects that 31238 is billed with an E/M code on the same date of service 67% of the time. As a result, our expert panel recommends a reduction to the pre-service package's evaluation time of 9 minutes (the time for the history and exam) to account for the E/M typically billed on the same day. Our expert panel felt, however, that the preservice package's 1 minute allotted for the check/set-up room, supplies and equipment was not sufficient for this type of emergency procedure, and recommends adding 4 minutes for this work, resulting in 5 minutes to set up the room for a total of 12 preservice evaluation minutes. This results in a total pre service time recommendation of 18 minutes.

**Intra Time:** Our expert panel agreed with our surveyees regarding the time for intra service work and are recommending the survey median time of 25 minutes for intra service work.

**Post Time:** Likewise, our experts felt that the survey's post time was an accurate reflection of the post time required for this procedure and are recommending the median post time of 15 minutes. The expert panel did not feel it was necessary to reduce the post time for this service, despite the fact that it is typically billed with an E/M, because with this type of emergency procedure patients frequently stay at the physician office far longer than the survey's reflected 15 minutes of post time to ensure there is no recurrence of bleeding. This results in a request for a total of 58 minutes of physician work time for CPT 31238.

**Physician Work Recommendation**

After concluding the survey, the results were analyzed by an expert panel and it was determined that the survey's median value was too high given that the work for this service has not changed, and no compelling evidence exists to increase the value of the service. As a result, they felt the survey's 25<sup>th</sup> percentile of 2.74 RVUs was more appropriate for CPT 31238.

**Therefore, we recommend an RVU of 2.74, consistent with the survey's 25<sup>th</sup> percentile, for CPT 31238.**

This recommendation is supported by the key reference service (KRS) 31296. While survey said the KRS was lower in intensity and complexity, it contains 30 minutes of additional time as compared to our recommendations for 31238, and therefore, has a higher work RVU of 3.29. Our expert panel also felt CPT 57460 served as an excellent reference code for this service and has a work RVU of 2.83 and a total time of 50 minutes. We are also providing the following reference tables which include recently reviewed services which support our requested values for physician time and work for CPT 31238.

**Comparison to key reference code**

CPT Code	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	Post
31238	2.74	0.0829	58	12	1	5	25	15
31296	3.29	0.0710	88	30	3	10	30	15

**Comparison to MPC codes**

CPT Code	Descriptor	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	Post
51102	Aspiration of bladder; with insertion of suprapubic catheter	2.70	0.0938	60	19	1	5	20	15
31238	Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage	2.74	0.0829	58	12	1	5	25	15
15002	Surgical preparation or creation of	3.65	0.0868	115	45	15	15	20	20



recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children									
--	--	--	--	--	--	--	--	--	--

The table below compares the survey code to other RUC reviewed codes of similar time and work, providing further support that the recommended value for 31238 is appropriate.

<u>RUC Reviewed</u>	<u>CPT Code</u>	<u>Descriptor</u>	<u>RVW</u>	<u>IWPUT</u>	<u>Total Time</u>	<u>Eval</u>	<u>Posit</u>	<u>SDW</u>	<u>INTRA</u>	<u>Post</u>
2006	<b>52204</b>	Cystourethroscopy, with biopsy(s)	2.59	0.0805	54	10	2	5	25	12
2002	<b>57460</b>	Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix	2.83	0.0908	50	15	0	0	25	10
2012	<b>52287</b>	Cystourethroscopy, with injection(s) for chemodenervation of the bladder	3.20	0.1197	58	7	5	10	21	15
1997	<b>58555</b>	Hysteroscopy, diagnostic (separate procedure)	3.33	0.0884	75	30	0	0	25	20
2002	<b>57461</b>	Colposcopy of the cervix including upper/adjacent vagina; with loop electrode conization of the cervix	3.43	0.0985	58	15	0	0	28	15

## SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☒ Other reason (please explain) CPT 31238 is typically billed in conjunction with an E/M office visit.

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. CPT 31238 is billed with one of the following office E/M visits (99212-99215) on the same day 67% of the time per the CMS 5% data file.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 31238

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otolaryngology

How often? Commonly

Specialty Physicians Assistant

How often? Rarely

Specialty Nurse Practitioners

How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 74847

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This is three times the 2011 Medicare volume for this service which we believe accurately estimates the national frequency of this service.

Specialty Otolaryngology	Frequency 72602	Percentage 97.00 %
--------------------------	-----------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 24,949 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is based on the 2011 claims data from the 2013 RUC database.

Specialty Otolaryngology	Frequency 24201	Percentage 97.00 %
--------------------------	-----------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 31238

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 31239	Tracking Number	Original Specialty Recommended RVU: <b>9.33</b>
		Presented Recommended RVU: <b>9.33</b>
Global Period: 010		RUC Recommended RVU: <b>9.04</b>

CPT Descriptor: Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 49 year old presents with constant daily tearing in the right eye over the past six months. The patient has a history of multiple episodes of conjunctivitis and right inner canthal tenderness that have responded to topical and oral antibiotics. The examination confirms a purulent discharge with pressure to the lacrimal sac. Lacrimal irrigation reveals a blocked nasolacrimal duct distal to the common canaliculus.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 55% , In the ASC 46%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 49% , Overnight stay-less than 24 hours 7% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 4%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 54%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 8%

Description of Pre-Service Work: The patient history, physical exam and appropriate preoperative tests are reviewed. The preoperative interval history and exam are documented in the patient record. The surgical plan is discussed with the patient, all questions are addressed and surgical consent is reviewed. The operative nostril is decongested with Afrin nasal spray twice separated by a ten minute interval. The surgical eye is confirmed with the patient, surgical and anesthesia team, and the forehead is marked to indicate the operative eye. After anesthesia is administered, the patient is positioned.

Description of Intra-Service Work: The operative eyelid is confirmed by the surgeon and surgical team. The patient is monitored with pulse oximetry and electrocardiography. The surgeon adds topical anesthesia to both eyes. A local anesthetic block is injected into the operative supratrochlear, infraorbital, anterior lacrimal crest regions and intra-nasally along the lacrimal crest and middle turbinate. The involved nostril is packed with a cotton pledget soaked in 2% lidocaine w/epinephrine. The eye, periocular area and nostril are prepped and draped. The nasal packing is removed. A fiber optic endoilluminator is inserted through the lacrimal canaliculi into the sac to transilluminate the lacrimal bone. A nasal endoscope is inserted for visualization. The nasal mucosa is incised vertically with a crescent blade and elevated with endoscopic forceps and periosteal elevators to fully expose the lacrimal bone. The lacrimal bone is removed with Kerrison or pituitary rongeurs. The final bony ostium should allow adequate clearance of the common canaliculus and the inferior sac. The exposed lacrimal sac mucosa is infiltrated with local anesthetic for vasoconstriction, incised, and the medial sac mucosa removed with forceps. Adequate lacrimal sac mucosal removal is confirmed by free flow of saline or fluorescein from the canaliculi through the nasal ostium, or direct visualization of the common internal punctum with the endoscope. Nasal dressing is applied. Antibiotic-steroid drops are placed in the operative eye.

Description of Post-Service Work: Pain management is discussed and the IV removed. The nostril is packed if excessive intranasal bleeding is noted. The patient and family are given detailed postoperative care instructions and appropriate prescriptions. An operative report is prepared, and required paperwork completed. Follow-up visits are scheduled.

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)		04/2013				
Presenter(s):	Wayne Koch, MD (AAO-HNS); Jane Dillon, MD (AAO-HNS); Stephen Kamenetzky, MD (AAO)					
Specialty(s):	AAO-HNS & AAO					
CPT Code:	31239					
Sample Size:	1355	Resp N:	105	Response: 7.7 %		
Description of Sample:	Random					
		<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
Service Performance Rate		0.00	2.00	5.00	15.00	1000.00
Survey RVW:		3.52	9.40	12.00	15.00	25.00
Pre-Service Evaluation Time:				40.00		
Pre-Service Positioning Time:				10.00		
Pre-Service Scrub, Dress, Wait Time:				10.00		
Intra-Service Time:		20.00	45.00	60.00	90.00	135.00
Immediate Post Service-Time:	<u>20.00</u>					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00			
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00		
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00	99239x 0.00	99217x 0.00		
Office time/visit(s):	<u>23.00</u>	99211x 0.00	12x 0.00	13x 1.00	14x 0.00	15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00	
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00		

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

3 -FAC Straightforward Patient/Difficult Procedure

<b>CPT Code:</b>	31239	<b>Recommended Physician Work RVU: 9.04</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		33.00	33.00	0.00
<b>Pre-Service Positioning Time:</b>		3.00	3.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		10.00	15.00	-5.00
<b>Intra-Service Time:</b>		60.00		
<b>Immediate Post Service-Time:</b>	20.00			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	0.00	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	0.00	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	19.00	99238x 0.5	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	23.00	99211x 0.00	12x 0.00	13x 1.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	0.00	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	0.00	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31292	010	15.90	RUC Time

CPT Descriptor Nasal/sinus endoscopy, surgical; with medial or inferior orbital wall decompression**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
22523	010	9.04	RUC Time	22,021

CPT Descriptor 1 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
38571	010	14.76	RUC Time	9,037

CPT Descriptor 2 Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
22523	010	9.04	RUC Time

CPT Descriptor Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 77      % of respondents: 73.3 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 31239</b>	<b>Key Reference CPT Code: 31292</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	46.00	90.00	
Median Intra-Service Time	60.00	140.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	138.00	
Median Discharge Day Management Time	19.0	0.00	
Median Office Visit Time	23.0	55.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>168.00</b>	<b>453.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.63	3.91
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.76	4.00
--	------	------

Urgency of medical decision making	3.10	3.69
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.46	4.35
--------------------------	------	------

Physical effort required	4.03	4.06
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.03	4.33
---	------	------

Outcome depends on the skill and judgment of physician	4.36	4.29
--	------	------

Estimated risk of malpractice suit with poor outcome	3.79	4.05
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.65	3.78
----------------------------------	------	------

Intra-Service intensity/complexity	3.99	4.19
------------------------------------	------	------

Post-Service intensity/complexity	3.40	3.50
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Why are these codes being reviewed?**

The nasal/sinus endoscopy code 31237 was identified in the CY 2012 Final Physician Fee Schedule by CMS as a potentially misvalued service. Following submission of an action plan to survey 31237 by the Academy, it was determined that 31237-31240 was a “family” of codes based on their location in the CPT book, and therefore, all four codes were required for survey by the RAW for April 2013. We note as a reminder for the RUC in reviewing this family of codes, that 31239 is the only 010 global in this “family”, and therefore, has an appropriately higher RVU and associated time required to perform this procedure.

### **Description of Random Survey**

All four codes in this family were surveyed by AAO-HNS. One of the codes, 31239, was surveyed jointly by Otolaryngology and Ophthalmology. The standard 010 global survey instrument was utilized with two revisions instructing respondents to include time for administering topical anesthetic, where appropriate, in the pre-service time and localized or injected anesthesia, where appropriate, in the intra service time. This change was approved by the Research Subcommittee. The Otolaryngology physician work recommendations were derived by conducting a random survey of our members. Surveys for 31239 were sent to nearly 1100 Otolaryngologists, including the subspecialty of rhinology, as well as to the Academy’s leadership and key committees such as the Rhinology Paranasal Sinus Committee which contains clinicians who were most likely to be familiar with the services under review. The American Academy of Ophthalmology’s survey for 31239 was distributed to 264 Ophthalmologists, who indicated an interest in ocular plastic procedures. Of the 1355 surveys distributed for 31239, 105 responses were received, a response rate of 7.7%.

### **Physician Time**

**Pre Time:** Following a review of the pre-time survey data, our expert panel determined that preservice package 3 (Straightforward Patient/Difficult Procedure) was most appropriate. Prepackage 3 assigns 33 minutes for evaluation, 3 minute for positioning, and 15 minutes for scrub, dress, and wait. Our expert panel felt this was the most appropriate package given that service is provided in the facility setting and both topical and general anesthetic are utilized for the endoscopy procedure. They believe this qualifies as a “difficult procedure” based on the fact that the surgical site is located in the corner of the eye and involved placing metal rods in the nose which can cause bleeding and has the risk of other complications. The expert panel reviewed the survey pre times and determined that 33 minutes for evaluation and 3 minutes for positioning were appropriate, however, they recommended reducing the scrub dress and wait package time of 15 minutes down to 10 to maintain consistency with the time allotted for scrub dress and wait by the survey respondents. This results in an overall preservice time recommendation of 33 minutes evaluation, 3 minutes for positioning, and 10 minutes for scrub, dress and wait, totaling 46 preservice minutes for 31239.

**Intra Time:** Our expert panel agreed with our surveyees regarding the time for intra service work and are recommending the survey median time of 60 minutes for intra service work.

**Post Time & Post Operative Visits:** Likewise, our experts felt that the survey’s post time was an accurate reflection of the post time required for this procedure and are recommending the median post time of 20 minutes. In addition, we are requesting the standard .5 discharge management visit (99238) which is typical for 010 global services performed in the facility where the patient is discharged on the same day as the procedure. Our expert panel also agreed with survey respondents that one visit, a 99213 office visit, is typical during the 5-10 days of the post operative period. This results in a request for a total of 168 minutes of physician work time for CPT 31239.

### **Physician Work Recommendation**

After concluding the survey, the results were analyzed by an expert panel and it was determined that the existing value for 31239 is appropriate and should be maintained. This is supported by our survey which had a higher median and 25<sup>th</sup> percentile, than the existing value of 9.33 RVUs. Our expert panel does not believe this service has changed, or that compelling evidence exists to increase the value of the code; **therefore, we recommend retention of the existing value of 9.33 RVUs for CPT 31239.**

This recommendation is supported by the key reference code 31292 which survey respondents said was greater in intensity and complexity, and as a result, has a higher work RVU of 15.90 and substantially more post operative work, resulting in a total time of 453 total minutes. We are also providing the following reference tables which include recently reviewed services which support our requested values for physician time and work for CPT 31239.

### **Comparison to key reference code**

<u>CPT Code</u>	<u>RVW</u>	<u>IWPUT</u>	<u>Total Time</u>	<u>Eval</u>	<u>Posit</u>	<u>SDW</u>	<u>INTRA</u>	<u>Post</u>	<u>Post Visits</u>
-----------------	------------	--------------	-------------------	-------------	--------------	------------	--------------	-------------	--------------------



<b>31292</b>	15.90	0.0449	453	90	0	0	140	30	193
<b>31239</b>	9.33	0.1064	168	33	3	10	60	20	42

**Comparison to MPC codes**

<b>CPT Code</b>	<b>Descriptor</b>	<b>RVW</b>	<b>IWPUT</b>	<b>Total Time</b>	<b>Eval</b>	<b>Posit</b>	<b>SDW</b>	<b>INTRA</b>	<b>Post</b>	<b>Post Visits</b>
<b>22523</b>	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic	9.04	0.1009	180	30	15	15	58	20	42
<b>31239</b>	Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy	9.33	0.1064	168	30	3	10	60	20	42
<b>38571</b>	Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy	14.76	0.0692	272	60	0	0	180	0	32

The table below compares the survey code to other RUC reviewed codes of similar time and work, providing further support that the recommended value for 31239 is appropriate.

<b>RUC Reviewed</b>	<b>CPT Code</b>	<b>Descriptor</b>	<b>RVW</b>	<b>IWPUT</b>	<b>Total Time</b>	<b>Eval</b>	<b>Posit</b>	<b>SDW</b>	<b>INTRA</b>	<b>Post</b>	<b>Post Visits</b>
2010	<b>22524</b>	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); lumbar	8.54	0.0973	177	30	15	15	55	20	42
2010	<b>22523</b>	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic	9.04	0.1009	180	30	15	15	58	20	42
2010	<b>22520</b>	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; thoracic	9.22	0.1291	177	30	15	15	45	30	42

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.  
☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.  
☒ Multiple codes allow flexibility to describe exactly what components the procedure included.  
☐ Multiple codes are used to maintain consistency with similar codes.  
☐ Historical precedents.

☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. This service is billed with CPT 68815, Probing of Nasolacrimal Duct, 51% of the time according to the five percent file 2011 data. Multiple procedure modifier -51 would be appended to CPT 68815 when billed in conjunction with 31239. SEE TABLE AT END OF SOR.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 31239

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology                      How often? Sometimes

Specialty Otolaryngology                      How often? Sometimes

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 3168

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This is three times the 2011 Medicare volume for this service which we believe accurately estimates the national frequency of this service.

Specialty Ophthalmology                      Frequency 1869                      Percentage 58.99 %

Specialty Otolaryngology                      Frequency 1267                      Percentage 39.99 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,056

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is based on the 2011 claims data from the 2013 RUC database.

Specialty Ophthalmology                      Frequency 623                      Percentage 58.99 %

Specialty Otolaryngology                      Frequency 422                      Percentage 39.96 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? No

## Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 31239

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**SERVICES REPORTED WITH MULTIPLE CPT CODES TABLE:**

	CPT	GLOBAL	CURRENT PRE TIME	CURRENT INTRA TIME	CURRENT POST TIME	CURRENT POST VISITS	CURRENT TOTAL TIME	CURRENT RVW
	31239	010	30	90	30	46	196	9.33
	68815-51	010	40	40	20	32	132	3.30
TOTAL After MPPR								10.98

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 31240	Tracking Number	Original Specialty Recommended RVU: <b>2.61</b>
		Presented Recommended RVU: <b>2.61</b>
Global Period: 000		RUC Recommended RVU: <b>2.61</b>

CPT Descriptor: Nasal/sinus endoscopy, surgical; with concha bullosa resection

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 30 year old presents with a history of nasal blockage, facial pressure, and recurrent maxillary sinusitis and an obstruction of the natural ostium of the left maxillary sinus from an abnormally large and pneumatized middle turbinate (a concha bullosa cell). The patient undergoes endoscopic resection of the obstructing concha bullosa.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 54%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 16%

**Description of Pre-Service Work:**

- After the decision is made to perform a nasal endoscopy with excision of a concha bullosa, the physician must perform the following steps to prepare the patient and the room for the procedure.
  - Assure appropriate selection, timing, and administration of DVT prophylaxis.
  - Assess need for beta-blockers, order as required.
  - Review medical history, pathology, and radiology report.
  - Review radiographic images.
  - Review results of preoperative testing (labs, EKG, CXR).
  - Review reports of consultants providing preoperative assessment and clearance as indicated.
  - Meet with patient and family to review planned procedure and postoperative management.
  - Reexamine patient to ensure that physical findings have not changed and dictate history and physical.
  - Obtain informed consent.
  - Review airway and medical management with anesthesiologist.
  - Review planned procedure with OR staff.
  - Verify that all required instruments and supplies are available, set up scopes, suction, light source, and photodocumentation equipment and ensure functionality.
  - Change into scrub clothes.
  - Observe/wait during induction of anesthesia and intubation.
  - Monitor/assist with positioning of the patient (supine, head slightly elevated)
  - Ensure that radiographic images are available in the OR.
- Cotton pledgts soaked with topical decongestant are placed in the nasal cavity under direct visualization.
- Monitor/assist with draping.

- Scrub and gown.
- Operating table is turned either 90 or 180 degrees.
- Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Previously placed pledgets are removed. An endoscope is utilized for visualization. Local anesthesia is injected into the anterior and posterior attachments of the concha bullosa. Cotton pledgets soaked with topical decongestant are placed adjacent to the concha bullosa, followed by a wait time to allow efficacy. A vertical incision is made through the anterior portion of the concha bullosa. Thru cutting instruments are utilized to extend the cut posteriorly, both at the anterior and inferior attachments. Care is taken not to excessively manipulate to concha bullosa. The anterior and posterior cuts are completed and the lateral aspect of the concha bullosa is removed. Bipolar electrocautery is applied to the area of the inferior attachment as this can be a source of major hemorrhage. The middle meatus is then packed with cotton pledgets soaked with topical decongestant, followed by a wait time to ensure adequate hemostasis. Once adequate hemostasis is confirmed, the patient is turned over to anesthesia and awoken from anesthesia.

#### Description of Post-Service Work:

- Monitor patient during reversal of anesthesia.
- Monitor transport of patient from OR to recovery room.
- Discuss postoperative recovery care with anesthesia and nursing staff.
- Write postoperative orders.
- Discuss procedure and operative findings with family and the patient.
- Write postoperative note. Dictate operative note and copy to referring physician.
- Monitor patient progress. Chart notes.
- Monitor overall medical condition of the patient including fluid balance, vital signs, and urinary function
- Assess pain scores and adequacy of analgesia.
- Discuss post-discharge management with nursing staff and answer questions
- Home restrictions (i.e., diet, activity) are discussed with the patient, family members and discharging nurse.
- Write prescriptions for medications and supplies needed post-discharge
- Perform medication reconciliation
- All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Wayne Koch, MD; Jane Dillon, MD				
<b>Specialty(s):</b>	AAO-HNS				
<b>CPT Code:</b>	31240				
<b>Sample Size:</b>	1090	<b>Resp N:</b>	125	<b>Response:</b> 11.4 %	
<b>Description of Sample:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	2.00	10.00	20.00	40.00	300.00
<b>Survey RVW:</b>	1.50	2.64	2.88	3.50	10.00
<b>Pre-Service Evaluation Time:</b>			25.00		
<b>Pre-Service Positioning Time:</b>			10.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10.00		
<b>Intra-Service Time:</b>	2.00	15.00	20.00	30.00	60.00
<b>Immediate Post Service-Time:</b>	<b>15.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

3 -FAC Straightforward Patient/Difficult Procedure

<b>CPT Code:</b>	31240	<b>Recommended Physician Work RVU: 2.61</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		25.00	33.00	-8.00
<b>Pre-Service Positioning Time:</b>		3.00	3.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		10.00	15.00	-5.00
<b>Intra-Service Time:</b>		20.00		
<b>Immediate Post Service-Time:</b>	<b>15.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31295	000	2.70	RUC Time

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

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
36556	000	2.50	RUC Time	513,832

CPT Descriptor 1 Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
51102	000	2.70	RUC Time	14,090

CPT Descriptor 2 Aspiration of bladder; with insertion of suprapubic catheter

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
36555	000	2.68	RUC Time

CPT Descriptor Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 36      % of respondents: 28.8 %**

**TIME ESTIMATES (Median)**

	<b>CPT Code: 31240</b>	<b>Key Reference CPT Code: <u>31295</u></b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	38.00	43.00	
Median Intra-Service Time	20.00	20.00	
Median Immediate Post-service Time	15.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
<b>Median Total Time</b>	<b>73.00</b>	<b>78.00</b>	
<b>Other time if appropriate</b>			

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered

3.00

3.19

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed

3.25

3.28

Urgency of medical decision making

2.36

2.42

**Technical Skill/Physical Effort (Mean)**

Technical skill required

3.39

3.42

Physical effort required

3.00

3.03

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality

3.22

3.25

Outcome depends on the skill and judgment of physician

3.47

3.44

Estimated risk of malpractice suit with poor outcome

3.08

3.06

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity

2.81

3.06

Intra-Service intensity/complexity

3.33

3.36

Post-Service intensity/complexity

2.94

2.94

---

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Why are these codes being reviewed?**

The nasal/sinus endoscopy code 31237 was identified in the CY 2012 Final Physician Fee Schedule by CMS as a potentially misvalued service. Following submission of an action plan to survey 31237 by the Academy, it was determined that 31237-31240 was a “family” of codes based on their location in the CPT book, and therefore, all four codes were required for survey by the RAW for April 2013.



**Description of Random Survey**

All four codes in this family were surveyed by AAO-HNS. The standard 000 global survey instrument was utilized with two revisions instructing respondents to include time for administering topical anesthetic, where appropriate, in the pre-service time and localized or injected anesthesia, where appropriate, in the intra service time. This change was approved by the Research Subcommittee. The Otolaryngology physician work recommendations were derived by conducting a random survey of our members. Surveys for 31240 were sent to nearly 1100 Otolaryngologists, including the subspecialty of rhinology, as well as to the Academy's leadership and key committees such as the Rhinology Paranasal Sinus Committee which contains clinicians who were most likely to be familiar with the services under review. Of the 1090 surveys distributed for 31240, 125 responses were received, a response rate of 11%.

**Physician Time**

**Pre Time:** Following a review of the pre-time survey data, our expert panel determined that preservice package 3 Facility - Straightforward patient/Difficult was most appropriate. Prepackage 3 assigns 33 minutes for evaluation, 3 minutes for positioning, and 15 minutes for scrub, dress, and wait. Our expert panel felt this was the most appropriate package given that service is predominantly provided in the facility setting and both topical and general anesthetic is utilized for the endoscopy procedure. The expert panel reviewed the survey pre times and recommended that the preservice time for evaluation be adjusted down to 25 minutes to maintain consistency with the survey responses. Similarly, they recommended that time for scrub, dress and wait be reduced from the package's 15 minutes down to 10 to match the time allotted for this work by survey respondents. This results in a total preservice time recommendation of 38 minutes.

**Intra Time:** Our expert panel agreed with our surveyees regarding the time for intra service work and are recommending the survey median time of 20 minutes for intra service work.

**Post Time:** Likewise, our experts felt that the survey's post time was an accurate reflection of the post time required for this procedure and are recommending the median post time of 15 minutes. This results in a request for a total of 73 minutes of physician work time for CPT 31240.

**Physician Work Recommendation**

After concluding the survey, the results were analyzed by an expert panel and it was determined that the existing RVU of 2.61 is appropriate for 31240. This is supported by our survey which had a higher median, and 25<sup>th</sup> percentile, than existing value of 2.61 RVUs. Our expert panel does not believe this service has changed, or that compelling evidence exists, to increase the value of the code; **therefore, we recommend retention of the existing value of 2.61 RVUs for CPT 31240.**

This recommendation is supported by the key reference code 31295 which survey respondents said was similar in intensity and complexity, but has a slightly higher work RVU of 2.70 and similar total physician time of 78 minutes. We are also providing the following reference tables which include recently reviewed services which support our requested values for physician time and work for CPT 31240.

**Comparison to key reference code**

<b>CPT Code</b>	<b>RVW</b>	<b>IWPUT</b>	<b>Total Time</b>	<b>Eval</b>	<b>Posit</b>	<b>SDW</b>	<b>INTRA</b>	<b>Post</b>
<b>31240</b>	2.61	0.0783	73	25	3	10	20	15
<b>31295</b>	2.70	0.0772	78	30	3	10	20	15

**Comparison to MPC codes**

<b>CPT Code</b>	<b>Descriptor</b>	<b>RVW</b>	<b>IWPUT</b>	<b>Total Time</b>	<b>Eval</b>	<b>Posit</b>	<b>SDW</b>	<b>INTRA</b>	<b>Post</b>
<b>36556</b>	Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older	2.50	0.1192	50	15	5	5	15	10
<b>31240</b>	Nasal/sinus endoscopy, surgical; with concha bullosa resection	2.61	0.0783	73	25	3	10	20	15
<b>51102</b>	Aspiration of bladder; with insertion of suprapubic catheter	2.70	0.0938	60	19	1	5	20	15

The table below compares the survey code to other RUC reviewed codes of similar time and work, providing further support that the recommended value for 31240 is appropriate.

<b>RUC Reviewed</b>	<b>CPT Code</b>	<b>Descriptor</b>	<b>RVW</b>	<b>IWPUT</b>	<b>Total Time</b>	<b>Eval</b>	<b>Posit</b>	<b>SDW</b>	<b>INTRA</b>	<b>Post</b>
---------------------	-----------------	-------------------	------------	--------------	-------------------	-------------	--------------	------------	--------------	-------------

2002	<b>56821</b>	Colposcopy of the vulva; with biopsy(s)	2.05	0.0745	45	15	0	0	20	10
2002	<b>57421</b>	Colposcopy of the entire vagina, with cervix if present; with biopsy(s) of vagina/cervix	2.20	0.0820	45	15	0	0	20	10
2002	<b>57454</b>	Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage	2.33	0.0885	45	15	0	0	20	10
2010	<b>90870</b>	Electroconvulsive therapy (includes necessary monitoring)	2.50	0.1071	36	10	1	0	20	5
2003	<b>36555</b>	Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age	2.68	0.0928	60	20	5	5	20	10
2010	<b>52281</b>	Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female	2.75	0.1120	46	10	1	5	20	10
2012	<b>32551</b>	Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open (separate procedure)	3.29	0.1011	83	30	3	10	20	20
2000	<b>16035</b>	Escharotomy; initial incision	3.74	0.1310	70	30	0	0	20	20

## SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.  
☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.  
☒ Multiple codes allow flexibility to describe exactly what components the procedure included.  
☐ Multiple codes are used to maintain consistency with similar codes.  
☐ Historical precedents.  
☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. This service is billed with CPT 30520, Repair of Nasal Septum, 58% of the time according to the five percent file 2011 data. Multiple procedure modifier -51 would be appended to CPT 31240 when billed in conjunction with 30520. SEE TABLE AT END OF SOR.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 31240

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otolaryngology

How often? Commonly



## SS Rec Summary

[illegible]

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor: Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)

Global Period: 000 Meeting Date: April 2013

**1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:** *We convened an expert panel to review the practice expense for 31237 which included our RUC Advisor and Alternate Advisor as well as two clinical experts who specialize in Rhinology. The practice expense inputs were revised using the 2003 PEAC approved inputs for 31237 as a reference.*

**2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale: *The practice expense inputs were derived using the 2003 PEAC approved inputs for 31237 as a reference.*

**3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:** *Our recommendations do not exceed PEAC approved standards for the facility setting.*

**4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:** *Our recommendations do not exceed the previous recommendations for 31237 in the facility setting.*

**5. Please describe in detail the clinical activities of your staff:**

**Pre-Service Clinical Labor Activities:**

For this procedure we believe the use of extensive clinical staff is required to complete pre-service diagnostic forms, coordinate pre-surgery services, schedule space and equipment, provide pre-service education and obtain consent, and conduct follow up phone calls and coordinate prescriptions.

**Intra-Service Clinical Labor Activities:**

There are no intra service clinical labor activities for this code.

**Post-Service Clinical Labor Activities:**

The only post service clinical activity is conducting a phone call and calling in any necessary prescriptions.

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor: Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)

Global Period: 000 Meeting Date: April 2013

1. **Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:** *We convened an expert panel to review the practice expense for 31237 which included our RUC Advisor and Alternate Advisor as well as two clinical experts who specialize in Rhinology. The practice expense inputs were revised using the 2003 PEAC approved inputs for 31237 as a reference.*
2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale: *The reference code utilized was the 2003 PEAC approved practice expense inputs for 31237.*
3. **If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:** *We are not making any recommendations which exceed PEAC standards.*
4. **If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:** *We are not recommending an increase over current staff times, but would note that we have reduced minutes on lines 22, 25, 27, and 30 which is offset by our requests for the addition of time, per PEAC standards, in lines 32, 34, and 35. These recommended changes in the assignment of minutes does not change the overall staff time recommended for this code in the non-facility setting.*

*We are recommending some revised supplies and equipment for 31237. Specifically, we recommend deletion of line 69 as lidocaine is included in the injection pack and we did not feel cocaine was needed in addition for this procedure. In addition, we recommend deletion of supplies in lines 78-81 and replacing with the PEAC approved standard endoscope cleaning pack SAO42. The compelling evidence for this change is a change from previous code-specific PE to adoption of an applicable standard or package. For equipment, we are adding two endoscopes, lines 87 and 88, as three scopes of varying degrees (which provide different angles of visualization) are used for this procedure and only one scope was previously listed for 31237.*

5. Please describe in detail the clinical activities of your staff:

**Pre-Service Clinical Labor Activities:** Clinical staff completes pre-service diagnostic and referral forms, coordinates pre-surgery services, provides pre-service education and obtains consent, conducts follow up phone calls and coordinates any necessary prescriptions.

**Intra-Service Clinical Labor Activities:** Staff greet the patient, gown them, and ensure appropriate medical records are available. They obtain vital signs, prepare the room with equipment and supplies, set up the scope, prepare and position the patient, and apply anesthesia. Clinical staff assists during the entire procedure and monitor the patient following the procedure. They clean the room and equipment, as well as the scope and surgical instrument package. They complete diagnostic forms, read any necessary x-ray, lab, pathology reports, and check dressing and provide home care instructions and coordinate prescriptions.

**Post-Service Clinical Labor Activities:** Clinical staff conducts a follow up phone call in the post-service period.

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor: Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage

Global Period: 000 Meeting Date: April 2013

**1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:** *We convened an expert panel to review the practice expense for 31238 which included our RUC Advisor and Alternate Advisor as well as two clinical experts who specialize in Rhinology. The practice expense inputs were revised using the 2003 PEAC approved inputs for 31238 as a reference.*

**2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale: *The practice expense inputs were derived using the 2003 PEAC approved inputs for 31238 as a reference.*

**3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:** *Our recommendations do not exceed PEAC approved standards for the facility setting.*

**4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:** *Our recommendations do not exceed the previous recommendations for 31238 in the facility setting.*

**5. Please describe in detail the clinical activities of your staff:**

**Pre-Service Clinical Labor Activities:**

For this procedure we believe the use of extensive clinical staff is required to complete pre-service diagnostic forms, coordinate pre-surgery services, schedule space and equipment, provide pre-service education and obtain consent, and conduct follow up phone calls and coordinate prescriptions.

**Intra-Service Clinical Labor Activities:**

There are no intra service clinical labor activities for this code.

**Post-Service Clinical Labor Activities:**

The only post service clinical activity is conducting a phone call and calling in any necessary prescriptions.

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor: Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage

Global Period: 000 Meeting Date: April 2013

1. **Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:** *We convened an expert panel to review the practice expense for 31238 which included our RUC Advisor and Alternate Advisor as well as two clinical experts who specialize in Rhinology. The practice expense inputs were revised using the 2003 PEAC approved inputs for 31238 as a reference.*
2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale: *The reference code utilized was the 2003 PEAC approved practice expense inputs for 31238.*
3. **If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:** *We are not making any recommendations which exceed PEAC standards.*
4. **If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:** *We are not recommending an increase over current staff times, but would note that we have reduced minutes on lines 25, 27, and 30 and deleted time for greeting the patient and obtaining vital signs, lines 21 and 22, since this code is typically billed with an E/M and we felt those minutes would be duplicative. These reductions in time are offset by our requests for the addition of time, per PEAC standards, in lines 32, 34, and 35. These recommended changes in the assignment of minutes do not exceed existing time for clinical staff work for 31238.*

*Regarding supplies and equipment for 31238, we are requesting the same changes made to CPT 31237 with a few additional changes. Specifically, we recommend deletion of line 69 as lidocaine is included in the injection pack and we did not feel cocaine was needed in addition for this procedure. In addition, we recommend deletion of supplies in lines 78-81 and replacing with the PEAC approved standard endoscope cleaning pack SAO42. The compelling evidence for this change is a change from previous code-specific PE to adoption of an applicable standard or package. We also request the addition of a new supply, line 84, to include a fibrillar (an invoice has been provided for this new supply). This is used to aid in the control of bleeding for this service. The compelling evidence for this change is that there has been a change in the technology and silver nitrate cautery is no longer sufficient, on its own, to control this type of hemorrhage. Therefore, we are adding supplies and equipment to reflect the necessary tools to control the nasal hemorrhage.*

*For equipment, we are adding two endoscopes, lines 87 and 88, as three scopes of varying degrees (which provide different angles of visualization) are used for this procedure and only one scope was previously listed for 31238. We also request the addition of new equipment, lines 96 and 97, to include bipolar cautery forceps and a biopolar cautery two-wire cable (an invoice has been provided for these pieces of equipment). These are also typically used to aid in the control of bleeding for this service. As noted above, the compelling evidence for this change is that there has been a change in the technology and silver nitrate cautery is no longer sufficient, on its own, to control this type of hemorrhage. Therefore, we are adding supplies and equipment to reflect the necessary tools to control the nasal hemorrhage.*

5. Please describe in detail the clinical activities of your staff:

**Pre-Service Clinical Labor Activities:** There is no pre-service clinical staff time for 31238 in the non-facility setting.



**Intra-Service Clinical Labor Activities:** Clinical staff prepares the room with equipment and supplies, set up the scope, prepare and position the patient, and apply anesthesia. Clinical staff assists during the entire procedure and monitor the patient following the procedure. They clean the room and equipment, as well as the scope and surgical instrument package. They complete diagnostic forms, read any necessary x-ray, lab, pathology reports, and check dressing and provide home care instructions and coordinate prescriptions.

**Post-Service Clinical Labor Activities:** Clinical staff conducts a follow up phone call in the post-service period and calls in any necessary prescriptions.

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor: Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy

Global Period: 010 Meeting Date: April 2013

**1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:** *Our societies convened an expert panel to review the practice expense for 31239 which included our RUC Advisors, Alternate Advisors and clinical experts who specialize in the procedure for both specialties. The practice expense inputs were revised using the 2003 PEAC approved inputs for 31239 as a reference.*

**2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale: *The practice expense inputs were derived using the 2003 PEAC approved inputs for 31239 as a reference.*

**3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:** *We are not recommending more minutes than the PE Subcommittee standards for CPT 31239.*

**4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:** *We are not requesting an increase over current inputs in clinical staff time. We do request some minor modifications from the prior practice expense, including removal of 7 minutes for providing pre-service education/obtaining consent, as well as the addition of 10 minutes during the post-service period, line 54, to clean the instrument pack during the post operative visit.*

*We are requesting modifications to the supplies and equipment for 31239 to reflect the necessary items for the office visit (99213) in the post operative period for 31239. The compelling evidence for this change is that previous PE supplies and equipment did not reflect the equipment/supplies required by the dominant specialty (Ophthalmology), therefore, previous inputs were based on Otolaryngology, but in actuality this service is currently provided primarily by Ophthalmologists according to utilization data. The new supplies we are requesting include the standard pack for an Ophthalmology visit (SA050), a 5-6 ml syringe, and the standard cleaning pack for cleaning/disinfecting the endoscope utilized during the post operative visit.*

*The new equipment includes a screening lane, listed on line 95, and a medium instrument pack. Both of these are standard pieces of equipment utilized during a routine ophthalmology post operative visit. The time assigned to the equipment is consistent with the time for the post operative office visit (36 minutes).*

**5. Please describe in detail the clinical activities of your staff:**

**Pre-Service Clinical Labor Activities:** For this procedure we believe the use of extensive clinical staff is required to complete pre-service diagnostic forms, coordinate pre-surgery services, schedule space and equipment, and conduct follow up phone calls and coordinate prescriptions.

**Intra-Service Clinical Labor Activities:**

The only intra service staff time for this service is 6 minutes for a half discharge management visit (99238).

**Post-Service Clinical Labor Activities:**

**CPT Code:** 31239  
**Specialty Society('s)** AAO-HNS

The clinical staff post time includes time for a post operative visit which is done in the physician office (99213) and time to clean the instrument pack utilized during the visit.

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor: Nasal/sinus endoscopy, surgical; with concha bullosa resection

Global Period: 000 Meeting Date: April 2013

**1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:** *We convened an expert panel to review the practice expense for 31240 which included our RUC Advisor and Alternate Advisor as well as two clinical experts who specialize in Rhinology. The practice expense inputs were revised using the 2003 PEAC approved inputs for 31240 as a reference.*

**2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale: *The practice expense inputs were derived using the 2003 PEAC approved inputs for 31240 as a reference.*

**3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:** *We are not recommending more minutes than the PE Subcommittee standards for CPT 31240.*

**4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:** *We are not requesting any changes to existing inputs for 31240.*

*There are no supplies or equipment requested for 31240 as this procedure is performed in the facility setting and is a 000 global.*

**5. Please describe in detail the clinical activities of your staff:**

**Pre-Service Clinical Labor Activities:** For this procedure we believe the use of extensive clinical staff is required to complete pre-service diagnostic forms, coordinate pre-surgery services, schedule space and equipment, provide pre-service education and obtain consent, and conduct follow up phone calls and coordinate prescriptions.

**Intra-Service Clinical Labor Activities:** There are no intra service clinical staff activities for 31240 as this procedure is facility based.

**Post-Service Clinical Labor Activities:** The clinical staff post time includes time for a follow up phone call and calling in any necessary prescriptions.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
1				REFERENCE CODE				REFERENCE CODE				REFERENCE CODE				REFERENCE CODE			
2	name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.			CPT 31237	CPT 31237	CPT 31238	CPT 31238	CPT 31239	CPT 31239	CPT 31240	CPT 31240								
3	Meeting Date: April 2013 Tab: 19 Specialty: REVISED AAO-HNS (& AAO for 31239)	CMS Code	Staff Type	Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)	Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)	Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage	Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage	Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy	Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy	Nasal/sinus endoscopy, surgical; with concha bullosa resection	Nasal/sinus endoscopy, surgical; with concha bullosa resection								
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	000	000	000	000	010	010	010	010	000	000	000	000
6	TOTAL CLINICAL LABOR TIME		L037D	109.0	36.0	99.0	36.0	94.0	36.0	80.0	36.0	0.0	108.0	0.0	82.0	0.0	33.0	0.0	33.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME		L037D	18.0	30.0	18.0	30.0	0.0	30.0	0.0	30.0	0.0	30.0	0.0	30.0	0.0	30.0	0.0	30.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		L037D	88.0	0.0	78.0	0.0	91.0	0.0	77.0	0.0	0.0	6.0	0.0	6.0	0.0	0.0	0.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME		L037D	3.0	6.0	3.0	6.0	3.0	6.0	3.0	6.0	0.0	72.0	0.0	46.0	0.0	3.0	0.0	3.0
10	PRE-SERVICE																		
11	Start: Following visit when decision for surgery or procedure made																		
12	Complete pre-service diagnostic & referral forms		L037D	5	5	5	5	0	5	0	5	0	5	0	5	0	5	0	5
13	Coordinate pre-surgery services		L037D	3	10	3	10	0	10	0	10	0	10	0	10	0	10	0	10
14	Schedule space and equipment in facility		L037D	0	5	0	5	0	5	0	5	0	5	0	5	0	5	0	5
15	Provide pre-service education/obtain consent		L037D	7	7	7	7	0	7	0	7	0	7	0	7	0	7	0	7
16	Follow-up phone calls & prescriptions		L037D	3	3	3	3	0	3	0	3	0	3	0	3	0	3	0	3
17	*Other Clinical Activity - specify:		L037D	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
18	End: When patient enters office/facility for surgery/procedure																		
19	SERVICE PERIOD																		
20	Start: When patient enters office/facility for surgery/procedure:																		
21	Greet patient, provide gowning, ensure appropriate medical records are available		L037D	3	0	3	0	3	0	0	0	0	0	0	0	0	0	0	0
22	Obtain vital signs		L037D	5	0	3	0	3	0	0	0	0	0	0	0	0	0	0	0
23	Provide pre-service education/obtain consent		L037D	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
24	Prepare room, equipment, supplies		L037D	2	0	2	0	2	0	2	0	0	0	0	0	0	0	0	0
25	Setup scope (non facility setting only)		L037D	6	0	5	0	6	0	5	0	0	0	0	0	0	0	0	0
26	Prepare and position patient/ monitor patient/ set up IV		L037D	2	0	2	0	2	0	2	0	0	0	0	0	0	0	0	0
27	Sedate/apply anesthesia		L037D	7	0	2	0	7	0	2	0	0	0	0	0	0	0	0	0
28	*Other Clinical Activity - specify:			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
29	Intra-service																		
30	Assist physician in performing procedure		L037D	40	0	20	0	45	0	25	0	0	0	0	0	0	0	0	0
31	Post-Service																		
32	Monitor pt. following service/check tubes, monitors, drains		L037D	5	0	5	0	5	0	5	0	0	0	0	0	0	0	0	0
33	Clean room/equipment by physician staff		L037D	3	0	3	0	3	0	3	0	0	0	0	0	0	0	0	0
34	Clean Scope		L037D	7	0	10	0	7	0	10	0	0	0	0	0	0	0	0	0
35	Clean Surgical Instrument Package		L037D	0	0	15	0	0	0	15	0	0	0	0	0	0	0	0	0
36	Complete diagnostic forms, lab & X-ray requisitions		L037D	3	0	3	0	3	0	3	0	0	0	0	0	0	0	0	0
37	Review/read X-ray, lab, and pathology reports		L037D	2	0	2	0	2	0	2	0	0	0	0	0	0	0	0	0
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions		L037D	3	0	3	0	3	0	3	0	0	0	0	0	0	0	0	0
39	*Other Clinical Activity - specify:																		
40	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			n/a		n/a	0	n/a		n/a	0	n/a	6	n/a	6	n/a		n/a	
41	Dischrg mgmt (1.0 x 99238) (enter 12 min)			n/a		n/a	0	n/a		n/a	0	n/a		n/a		n/a		n/a	
42	Dischrg mgmt (1.0 x 99239) (enter 15 min)			n/a		n/a	0	n/a		n/a	0	n/a		n/a		n/a		n/a	
43	End: Patient leaves office																		
44	POST-SERVICE Period																		
45	Start: Patient leaves office/facility																		
46	Conduct phone calls/call in prescriptions			3	6	3	6	3	6	3	6	0	0	0	0	0	3	0	3
47	Office visits: List Number and Level of Office Visits		L037D	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits
48	99211 16 minutes		16																
49	99212 27 minutes		27																
50	99213 36 minutes		36									2		1					
51	99214 53 minutes		53																
52	99215 63 minutes		63																
53	Total Office Visit Time			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	72.0	0.0	36.0	0.0	0.0	0.0	0.0
54	*Other Clinical Activity - specify: clean instrument pack													10					
55	End: with last office visit before end of global period																		

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
1				REFERENCE CODE				REFERENCE CODE				REFERENCE CODE				REFERENCE CODE			
2	name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.			CPT 31237		CPT 31237		CPT 31238		CPT 31238		CPT 31239		CPT 31239		CPT 31240		CPT 31240	
3	Meeting Date: April 2013 Tab: 19 Specialty: <b>REVISED</b> AAO-HNS (& AAO for 31239)	CMS Code	Staff Type	Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)	Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate			Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage	Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage			Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy	Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy	Nasal/sinus endoscopy, surgical; with concha bullosa resection	Nasal/sinus endoscopy, surgical; with concha bullosa resection				
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			000	000	000	000	000	000	000	000	010	010	010	010	000	000	000	000
56	MEDICAL SUPPLIES**																		
		CODE	UNIT																
57	pack, minimum multi-specialty visit	SA048	pack	1	0	1	0	1	0	1	0	-	0	0	0	-	-	0	0
58	pack, ophthalmology visit	SA050	pack	-	-	-	-	-	-	-	-	-	0	0	1	-	-	-	-
59	syringe 5-6ml	SC057	item	-	-	-	-	-	-	-	-	-	0	0	1	-	-	-	-
60	pack, basic injection	SA041	pack	1	0	1	0	1	0	1	0	-	0	0	0	-	-	0	0
61	applicator, sponge-tipped	SG009	item	0	-	3	-	0	-	3	-	-	-	-	-	-	-	-	-
62	drape, sterile, for Mayo stand	SB012	item	0	-	1	-	0	-	1	-	-	-	-	-	-	-	-	-
63	gauze, non-sterile	SG051	item	0	-	4	-	0	-	4	-	-	-	-	-	-	-	-	-
64	lidocaine 1%-2% inj (Xylocaine)	SH047	ml	0	-	5	-	0	-	5	-	-	-	-	-	-	-	-	-
65	needle, 18-27g	SC029	item	0	-	2	-	0	-	2	-	-	-	-	-	-	-	-	-
66	syringe 10 cc	SC051	item	0	-	1	-	0	-	1	-	-	-	-	-	-	-	-	-
67	underpad 2ftx3ft (Chux)	SB044	item	0	-	1	-	0	-	1	-	-	-	-	-	-	-	-	-
68	gloves, sterile	SB024	pair	0	-	1	0	0	-	1	0	-	1	-	0	-	-	-	-
69	gown, patient	SB026	item	-	-	-	-	-	-	-	-	-	1	-	0	-	-	-	-
70	gown, staff, impervious	SB027	item	-	-	-	-	-	-	-	-	-	1	-	0	-	-	-	-
71	mask, surgical	SB033	item	-	-	-	-	-	-	-	-	-	1	-	0	-	-	-	-
72	canister, suction	SD009	item	1	0	1	0	1	0	1	0	-	1	0	1	-	-	0	0
73	tubing, suction, non-latex (6ft uou)	SD132	item	2	0	2	0	2	0	2	0	-	2	0	2	-	-	0	0
74	cottonoid	SG031	item	2	0	2	0	2	0	2	0	-	4	0	0	-	-	0	0
75	packing, gauze w-petrolatum, 0.5in (6yd uou)	SG066	item	1	0	1	0	1	0	1	0	-	0	0	0	-	-	0	0
76	cocaine 4% solution, topical	SH025	ml	4	0	0	0	4	0	0	0	-	4	0	0	-	-	-	-
77	basin, emesis	SJ010	item	1	0	1	0	1	0	1	0	-	0	0	0	-	-	0	0
78	oxymetazoline nasal spray (Afrin) (15ml uou)	SJ037	item	2	1	2	0	2	1	2	0	-	2	0	1	-	-	0	0
79	silver nitrate applicator	SJ046	item	1	0	1	0	1	0	1	0	-	0	0	0	-	-	0	0
80	swab-pad, alcohol	SJ053	item	2	0	2	0	2	0	2	0	-	0	0	0	-	-	0	0
81	paper, photo printing (8.5 x 11)	SK058	item	2	0	2	0	2	0	2	0	-	2	0	0	-	-	0	0
82	atomizer tip shield (RhinoGuard)	SM001	item	2	0	2	0	2	0	2	0	-	1	0	0	-	-	0	0
83	Atomizer tips (disposable)	SL464	item	2	1	2	0	2	1	2	0	-	1	0	0	-	-	0	0
84	pack, cleaning and disinfecting, endoscope	SA042	pack	0	0	1	0	0	0	1	0	-	0	0	1	-	-	0	0
85	cleaning brush, endoscope	SM010	item	2	0	0	0	2	0	0	0	-	2	-	0	-	-	-	-
86	gloves, non-sterile	SB022	pair	1	0	0	0	1	0	0	0	-	2	-	0	-	-	-	-
87	glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)	SM018	oz	4	0	0	0	4	0	0	0	-	4	-	0	-	-	-	-
88	glutaraldehyde test strips (Cidex, Metrex)	SM019	item	1	0	0	0	1	0	0	0	-	2	-	0	-	-	-	-
89	endoscope anti-fog solution	SM014	ml	2	0	2	0	2	0	2	0	-	2	0	0	-	-	0	0
90	enzymatic detergent	SM015	oz	4	0	4	0	4	0	4	0	-	4	0	0	-	-	0	0
91	Fibrillar, surgical	NEW		-	-	-	-	NEW	-	1	0	-	-	-	-	-	-	-	-
92	EQUIPMENT																		
		CODE																	
93	endoscope, rigid, sinoscopy, 30 degree	ES013		91	0	41.0	0	94	0	46.0	0	-	72	0	36.0	-	-	0	0
94	endoscope, rigid, sinoscopy, 0 degree	ES013		0	0	41.0	0	0	0	46.0	0	-	-	-	-	-	-	-	-
95	endoscope, rigid, sinoscopy, 70 degree	ES013		0	0	41.0	0	0	0	46.0	0	-	-	-	-	-	-	-	-
96	video system, endoscopy (processor, digital capture, monitor, printer, cart)	ES031		91	0	29.0	0	94	0	34.0	0	-	72	0	36.0	-	-	0	0
97	instrument pack, medium (\$1500 and up)	EQ138		91	0	41.0	0	94	0	46.0	0	-	0	0	36.0	-	-	0	0
98	light, fiberoptic headlight w-source	EQ170		91	0	29.0	0	94	0	34.0	0	-	72	0	36.0	-	-	0	0
99	suction and pressure cabinet, ENT (SMR)	EQ234		91	0	29.0	0	94	0	34.0	0	-	72	0	0	-	-	0	0
100	mayo stand	EF015		91	0	29.0	0	94	0	34.0	0	-	72	0	0	-	-	0	0
101	chair with headrest, exam, reclining	EF008		91	0	29.0	0	94	0	34.0	0	-	72	0	0	-	-	0	0
102	lane, screening (oph)	EL006		-	-	-	-	-	-	-	-	-	0	0	36.0	-	-	-	-
103	LANDOLT BIPOLAR COAGULATION FORCEPS	NEW		-	-	-	-	NEW	-	34.0	0	-	-	-	-	-	-	-	-

AMA/Specialty Society RVS Update Committee Summary of Recommendations  
*CMS Requests Final Rule for 2013 Screen*

April 2013

**Implantation and Removal of Patient Activated Cardiac Event Recorder**

In the Final Rule for the 2013 Medicare Fee Schedule, a request was made to review CPT codes 33282 *Implantation of patient-activated cardiac event recorder* and 33284 *Removal of an implantable, patient-activated cardiac event recorder* in the non-facility setting. CMS was asked to establish appropriate non-facility PE RVUs for these services. CMS acknowledged that the Agency received very few Medicare claims for these services in the non-facility setting; nonetheless, the Agency believed it was appropriate to consider the relative resources involved in furnishing these services in the non-facility setting. CMS reiterated that the valuation of a service under the PFS in a particular setting does not address whether those services and the setting in which they are furnished are medically reasonable and necessary for a patient's medical needs and condition. CMS proposed to review CPT codes 33282 and 33284 and requested recommendations from the RUC and other public commenters on the appropriate physician work RVUs (as measured by time and intensity), and facility and non-facility direct PE inputs for these services. The RUC reviewed the survey data and confirmed that these procedures are typically performed in a hospital under moderate sedation.

**33282 *Implantation of patient-activated cardiac event recorder***

The RUC reviewed the survey results from 36 electrophysiologists and agreed that a work RVU of 3.50, the survey 25<sup>th</sup> percentile is appropriate for this procedure. The RUC noted that this value is a reduction from the current work RVU of 4.80. The RUC reviewed key reference code 33212 *Insertion of pacemaker pulse generator only; with existing single lead* (work RVU=5.26) and determined that 33212 requires 20 minutes more intra-service time and is a more complex procedure requiring more physician work, therefore it should be valued higher. The RUC also compared 33282 to CPT codes 20102 *Exploration of penetrating wound (separate procedure); abdomen/flank/back* (work RVU=3.98) and 64633 *Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint* (work RVU=3.84) and agreed that both reference codes require more physician time and work to perform compared to the surveyed code.

**The RUC recommends a work RVU of 3.50 for CPT code 33282.**

**33284 Removal of an implantable, patient-activated cardiac event recorder**

The RUC reviewed the survey results from 36 electrophysiologists and agreed that a work RVU of 3.00, the survey 25<sup>th</sup> percentile is appropriate for this procedure. The RUC noted that this value is lower than the current work RVU of 3.14. To support this value, the RUC reviewed key reference code 33233 *Removal of permanent pacemaker pulse generator only* (work RVU=3.39) and determined that since this is a more complex procedure requiring more physician work, it should be valued higher. The RUC also compared 33284 to CPT code 46945 *Hemorrhoidectomy, internal, by ligation other than rubber band; single hemorrhoid column/group* (work RVU=2.21) and agreed that 33284 required more physician work and complexity. **The RUC recommends a work RVU of 3.00 for CPT code 33284.**

**Practice Expense**

The RUC accepted the direct PE inputs with minor modifications as recommended by the PE Subcommittee.

**Work Neutrality**

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

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
33282	Implantation of patient-activated cardiac event recorder  (Initial implantation includes programming. For subsequent electronic analysis and/or reprogramming, use 93285, 93291, 93298, 93299)	090	3.50
33284	Removal of an implantable, patient-activated cardiac event recorder	090	3.00



**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 33282	Tracking Number	Original Specialty Recommended RVU: <b>3.98</b>
		Presented Recommended RVU: <b>3.50</b>
Global Period: 090		RUC Recommended RVU: <b>3.50</b>

CPT Descriptor: Implantation of patient-activated cardiac event recorder

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 42-year-old white female, with a history of syncopal spells with inconclusive results using various investigations. The patient continues to have distressing symptoms somewhat infrequently. A history and physical were performed. The procedure, indications, potential complications and alternatives were explained to the patient who appeared to understand and indicated the same. Opportunity for questions was provided and informed consent obtained.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 94%

Is moderate sedation inherent to this procedure in the office setting?

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: A pertinent history is obtained, and physical examination is performed. All laboratory tests, including blood tests, chest x-ray, and ECG, are reviewed. The risks and benefits of and alternatives to the procedure are discussed with the patient and family, and informed consent is obtained. The history, physical examination, and subsequent discussion are documented in the patient's records. The patient is prepared for the procedure using standard, sterile technique, and the surgical site and surrounding area are cleaned with an antimicrobial agent. Drapes are then placed to create a sterile field. The patient may require administration of conscious sedation. Local anesthetic is injected into the skin and subcutaneous tissue, and a 2 cm length incision is made down to the subcutaneous fat. Additional local anesthetic is placed in the subcutaneous plane as needed for patient comfort during the procedure.

Description of Intra-Service Work: Using blunt dissection, a subcutaneous pocket the size and shape of the recording device is created deeply enough to improve patient comfort and reduce the risk for skin erosion of the device. Hemostasis is maintained using standard techniques. The device is then inserted into the pocket. The ECG signal quality and amplitude are verified by placing the programmer head in a sterile sleeve over the recorder, establishing telemetry. The waveform is evaluated on the programmer screen, and the gain is adjusted to optimize waveform amplitude. The device may require repositioning or orientation within the pocket until adequate signal amplitude is achieved. Once the signal amplitude is satisfactory, the device is sutured to the adjacent underlying tissue using nonabsorbable sutures through the anchoring suture holes in the device to prevent rotation or migration following implantation. The incision is then closed with subcuticular absorbable sutures and a cutaneous nonabsorbable suture.

Description of Post-Service Work: The wound is dressed, the device is programmed using a pacemaker programmer, and record is initiated. The results of the procedure are reviewed with the patient, and the patient is educated on the operation of

the implantable event recorder. Standard postoperative care and follow-up procedures are reviewed with the patient and all questions answered.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Richard Wright, MD; Amit Shanker, MD; Mark Schoenfeld, MD; David Slotwiner, MD				
<b>Specialty(s):</b>	ACC, HRS				
<b>CPT Code:</b>	33282				
<b>Sample Size:</b>	466	<b>Resp N:</b>	36	<b>Response:</b>	7.7 %
<b>Description of Sample:</b>	random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	5.00	<b>9.00</b>	15.00	50.00
<b>Survey RVW:</b>	0.70	3.50	<b>5.00</b>	5.39	12.00
<b>Pre-Service Evaluation Time:</b>			<b>40.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>10.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>15.00</b>		
<b>Intra-Service Time:</b>	10.00	20.00	<b>25.00</b>	36.25	60.00
<b>Immediate Post Service-Time:</b>	<b>15.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>23.00</b>	99211x 0.00	12x 0.00	13x 1.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1b-FAC Straightforw Pat Procedure(w sedate/anes)

<b>CPT Code:</b>	33282	<b>Recommended Physician Work RVU: 3.50</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>19.00</b>	<b>19.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>1.00</b>	<b>1.00</b>	<b>0.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>5.00</b>	<b>5.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>25.00</b>		
<b>Immediate Post Service-Time:</b>	<b>15.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>19.00</b>	99238x 0.5	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>23.00</b>	99211x 0.00	12x 0.00	13x 1.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
33212	090	5.26	RUC Time

CPT Descriptor Insertion of pacemaker pulse generator only; with existing single lead**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
33213	090	5.53	RUC Time	0

CPT Descriptor 2 Insertion of pacemaker pulse generator only; with existing dual leads

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
64633	010	3.84	RUC Time

CPT Descriptor Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.****Number of respondents who choose Key Reference Code:** 24      **% of respondents:** 66.6 %**TIME ESTIMATES (Median)**

	<b>CPT Code:</b> <b>33282</b>	<b>Key Reference CPT Code:</b> <b>33212</b>	<b>Source of Time</b> <b>RUC Time</b>
Median Pre-Service Time	25.00	22.00	
Median Intra-Service Time	25.00	45.00	
Median Immediate Post-service Time	15.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	23.0	23.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

<b>Median Total Time</b>	<b>107.00</b>	<b>129.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.42	2.92
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.58	3.25
--	------	------

Urgency of medical decision making	2.75	2.88
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.79	3.21
--------------------------	------	------

Physical effort required	2.54	2.83
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.33	2.88
---	------	------

Outcome depends on the skill and judgment of physician	2.83	3.17
--	------	------

Estimated risk of malpractice suit with poor outcome	2.58	3.21
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.71	2.75
----------------------------------	------	------

Intra-Service intensity/complexity	2.67	3.17
------------------------------------	------	------

Post-Service intensity/complexity	2.54	2.71
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The codes that describe implantation and removal of patient-activated implantable loop recorders were reviewed in response to CMS' request that nonfacility inputs be created and that both codes undergo review of work and PE. Despite

ACC and HRS concerns that such a review was unwarranted, the societies complied with the wishes of the RAW and the RUC to review the codes for work and facility PE.

Code 33282 describes the work to implant the device. A joint RVS panel of ACC and HRS physicians familiar with the services reviewed the survey data. Given the relatively small utilization, the survey was robust and completed by physicians who have experience with the services.

The survey showed that the service is performed in a hospital under moderate sedation and the patient is sent home the same day. Based on established RUC standards, the panel included a half-day hospital discharge as part of the recommendation as well.

Survey respondents identified a median of one follow-up visit for this service. This is a reduction from the current level of two 99213 visits. The panel recommends the survey result of one 99213 visit.

The key reference service is 33213, insertion only of a pacemaker pulse generator; with existing dual leads. Respondents who selected the key reference service felt 33282 was generally less intense/complex than the reference code. This aligns with the time and RVW results.

The panel did not believe a compelling evidence argument could be made to support the median survey RVW of 5.00. However, the panel also felt the 25<sup>th</sup> percentile work RVW of 3.50 would undervalue the insertion code and create a rank order anomaly with 25<sup>th</sup> percentile recommendation for the related removal code. The panel reviewed a number of 90- and 10-day services with similar times and RVWs in search of a crosswalk and supporting comparator codes. The panel recommends a work value of 3.98. This value is a direct crosswalk to CPT code 20102 that describes the work of exploring a penetrating wound in the abdomen or back. This value is supported by additional, similar comparators codes included in the attached summary spreadsheet.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 33282

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty cardiology/electrophysiology                      How often? Sometimes

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 30900

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Most of these services are provided to non-Medicare aptients. We estimate that ratio at 3 to 1, multiplying the below estimation by 3.

Specialty cardiology/electrophysiology	Frequency 30900	Percentage 100.00 %
--	-----------------	---------------------

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 10,300 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Utilization has increased an average of 17% the past 4 years. Applying that rate of increased utilization to 2011 data, and considering the increasing utility of these devices in the population, we predict the service may be provided around 10,300 times in 2013.

Specialty cardiology/electrophysiology	Frequency 17,000	Percentage 100.00 %
--	------------------	---------------------

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 33282

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 33284	Tracking Number	Original Specialty Recommended RVU: <b>3.00</b>
		Presented Recommended RVU: <b>3.00</b>
Global Period: 090		RUC Recommended RVU: <b>3.00</b>

CPT Descriptor: Removal of an implantable, patient-activated cardiac event recorder

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 42-year-old white female with a history of syncopal spells, the cause of which was recently diagnosed using an insertable loop recorder. A history and physical were performed. The procedure, indications, potential complications and alternatives were explained to the patient who appeared to understand and indicated the same. Opportunity for questions was provided and informed consent obtained.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 97%

Is moderate sedation inherent to this procedure in the office setting?

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: The nature of the procedure, along with its risks and benefits, are reviewed with the patient, and a pertinent history and physical examination are performed. Pertinent laboratory tests are reviewed, and informed consent is obtained. The history, physical examination, and discussion are documented in the patient's record. The patient is prepared for the procedure using standard, sterile technique. The surgical site and surrounding area are cleaned and prepared with an antimicrobial solution, and drapes are placed to create a sterile field. The patient may require conscious sedation. Local anesthetic is injected into the skin and subcutaneous fat, and the previously created pocket that contains the device is opened.

Description of Intra-Service Work: The sutures anchoring the recorder to the subcutaneous tissue are cut, and the device is removed from the pocket. The pocket is the flushed with an antimicrobial solution and closed with subcuticular absorbable sutures and a subcutaneous nonabsorbable suture.

Description of Post-Service Work: The wound is dressed. The results of the procedure are reviewed with the patient along with standard postoperative care and follow-up procedures.



**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Richard Wright, MD; Amit Shanker, MD; Mark Schoenfeld, MD; David Slotwiner, MD				
<b>Specialty(s):</b>	ACC, HRS				
<b>CPT Code:</b>	33284				
<b>Sample Size:</b>	466	<b>Resp N:</b>	34	<b>Response:</b>	7.2 %
<b>Description of Sample:</b>	random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	2.00	5.00	10.00	50.00
<b>Survey RVW:</b>	2.00	3.00	3.35	3.48	9.00
<b>Pre-Service Evaluation Time:</b>			30.00		
<b>Pre-Service Positioning Time:</b>			10.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			15.00		
<b>Intra-Service Time:</b>	10.00	15.00	20.00	30.00	45.00
<b>Immediate Post Service-Time:</b>	<u>10.00</u>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<u>23.00</u>	99211x 0.00	12x 0.00	13x 1.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1b-FAC Straightforw Pat Procedure(w sedate/anes)

<b>CPT Code:</b>	33284	<b>Recommended Physician Work RVU: 3.00</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		19.00	19.00	0.00
<b>Pre-Service Positioning Time:</b>		1.00	1.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00
<b>Intra-Service Time:</b>		20.00		
<b>Immediate Post Service-Time:</b>	<u>10.00</u>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<u>19.00</u>	99238x 0.5	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<u>23.00</u>	99211x 0.00	12x 0.00	13x 1.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
33233	090	3.39	RUC Time

CPT Descriptor Removal of permanent pacemaker pulse generator only**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
33213	090	5.53	RUC Time	0

CPT Descriptor 2 Insertion of pacemaker pulse generator only; with existing dual leads

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 30      % of respondents: 88.2 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 33284</b>	<b>Key Reference CPT Code: 33233</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	25.00	45.00	
Median Intra-Service Time	20.00	53.00	
Median Immediate Post-service Time	10.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	0.00	
Median Office Visit Time	23.0	32.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
<b>Median Total Time</b>	<b>97.00</b>	<b>160.00</b>	

Other time if appropriate		
---------------------------	--	--

**INTENSITY/COMPLEXITY MEASURES (Mean)**(of those that selected Key  
Reference code)**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.30	2.43
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.33	2.47
--	------	------

Urgency of medical decision making	2.03	2.23
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.33	2.70
--------------------------	------	------

Physical effort required	2.27	2.50
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.10	2.63
---	------	------

Outcome depends on the skill and judgment of physician	2.20	2.57
--	------	------

Estimated risk of malpractice suit with poor outcome	2.10	2.47
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.17	2.37
----------------------------------	------	------

Intra-Service intensity/complexity	2.30	2.70
------------------------------------	------	------

Post-Service intensity/complexity	2.17	2.40
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Code 33284 describes the work to remove a patient-activated implantable loop recorder. Given the relatively small utilization, the survey was robust and completed by physicians who have experience with the services.

The survey showed that the service is performed in a hospital but the patient is sent home the same day. Based on established RUC standards, the panel included a half-day hospital discharge as part of the recommendation as well.

Survey respondents identified a median of one follow-up visit for this service. This is a reduction from the current level of two 99213 visits. The panel recommends the survey result of one 99213 visit.

The key reference service is 33233, removal of permanent pacemaker pulse generator only. Respondents who selected the key reference service felt 33284 was less intense/complex than the reference code. This aligns with the time and RVU results. The panel did not believe the changes in intraservice and postservice times could support a work recommendation at the median. As such, the panel recommends a work value of 3.00, the survey 25<sup>th</sup>-percentile value.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 33282

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty cardiology/electrophysiology

How often? Sometimes

Specialty

How often?

Specialty

How often?

Estimate the number of times this service might be provided nationally in a one-year period? 10800

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Most of these services are provided to non-Medicare aptients. We estimate that ratio at 3 to 1, multiplying the below estimation by 3.

Specialty cardiology/electrophysiology

Frequency 10800

Percentage 100.00 %

Specialty

Frequency

Percentage

%

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3,600

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Utilization has increased an average of 6% the past 4 years. Applying that rate of increased utilization to 2011 data, and considering the increasing utility of these devices in the population, we predict the service may be provided around 3,600 times in 2013.

Specialty cardiology/electrophysiology	Frequency 3600	Percentage 34.95 %
--	----------------	--------------------

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 33284

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

## SS Rec Summary

[illegible]

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor:

33282 Implantation of patient-activated cardiac event recorder

33284 Removal of an implantable, patient-activated cardiac event recorder

Global Period: .090 Meeting Date: April 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

A specialty panel representing cardiology and electrophysiology discussed the practice expense requirements for the various codes and determined that the standard 90-day global inputs for a straightforward patient and procedure under anesthesia would apply.

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale: The existing codes were used for comparison codes.

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time: n/a

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence: n/a

5. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The standard times have been applied for pre-service clinical labor time to complete preservice diagnostic & referral forms, coordinate presurgery services, schedule space and equipment in facility, provide preservice education/obtain consent, and make follow-up phone calls and prescriptions.

Intra-Service Clinical Labor Activities:

The standard 6 minutes has been applied for these inpatient procedures for one half discharge day management related services.

Post-Service Clinical Labor Activities:

Standard times to ready patient/records and assist the physician at each post-op office visit have been applied.

	A	B	C	D	E	F	G	H	I	J	K
1				REFERENCE CODE				REFERENCE CODE			
2	<p><b>*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.</b></p> <p><b>**Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.</b></p>			33282		33282		33284		33284	
3	<b>Meeting Date: April 2013</b> <b>Tab: 20</b> <b>Specialty: cardiology/electrophysiology</b>	CMS Code	Staff Type	Implantation of patient-activated cardiac event recorder				Removal of an implantable, patient-activated cardiac event recorder			
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD				090		090		090		090
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	138.0	0.0	102.0	0.0	138.0	0.0	102.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	60.0	0.0	60.0	0.0	60.0	0.0	60.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	6.0	0.0	6.0	0.0	6.0	0.0	6.0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	72.0	0.0	36.0	0.0	72.0	0.0	36.0
10	PRE-SERVICE										
11	Start: Following visit when decision for surgery or procedure made										
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5		5		5		5
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20		20		20		20
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8		8		8		8
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		20		20		20		20
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		7		7		7		7
17	*Other Clinical Activity - specify:										
18	End: When patient enters office/facility for surgery/procedure										
19	SERVICE PERIOD										
20	Start: When patient enters office/facility for surgery/procedure:										
21	Greet patient, provide gowning, ensure appropriate medical records are available										
22	Obtain vital signs										
23	Provide pre-service education/obtain consent										
24	Prepare room, equipment, supplies										
25	Setup scope (non facility setting only)										
26	Prepare and position patient/ monitor patient/ set up IV										
27	Sedate/apply anesthesia										
28	*Other Clinical Activity - specify:										
29	Intra-service										
30	Assist physician in performing procedure										
31	Post-Service										
32	Monitor pt. following service/check tubes, monitors, drains										
33	Clean room/equipment by physician staff										
34	Clean Scope										
35	Clean Surgical Instrument Package										
36	Complete diagnostic forms, lab & X-ray requisitions										
37	Review/read X-ray, lab, and pathology reports										
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions										
39	*Other Clinical Activity - specify:										
40	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)	L037D	RN/LPN/MTA	n/a	6	n/a	6	n/a	6	n/a	6
41	Dischrg mgmt (1.0 x 99238) (enter 12 min)			n/a		n/a		n/a		n/a	
42	Dischrg mgmt (1.0 x 99239) (enter 15 min)			n/a		n/a		n/a		n/a	
43	End: Patient leaves office										
44	POST-SERVICE Period										
45	Start: Patient leaves office/facility										
46	Conduct phone calls/call in prescriptions										
47	Office visits: List Number and Level of Office Visits										
48	99211 16 minutes		16								
49	99212 27 minutes		27								
50	99213 36 minutes	L037D	36	2		1		2		1	
51	99214 53 minutes		53								



	A	B	C	D	E	F	G	H	I	J	K
1				REFERENCE CODE				REFERENCE CODE			
2	<p><b>*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.</b></p> <p><b>**Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.</b></p>			33282		33282		33284		33284	
3	<p><b>Meeting Date: April 2013</b></p> <p><b>Tab: 20</b></p> <p><b>Specialty: cardiology/electrophysiology</b></p>	CMS Code	Staff Type	Implantation of patient-activated cardiac event recorder				Removal of an implantable, patient-activated cardiac event recorder			
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD				090		090		090		090
52	99215 63 minutes		63								
53	Total Office Visit Time			0.0	72.0	0.0	36.0	0.0	72.0	0.0	36.0
54	*Other Clinical Activity - specify:										
55	End: with last office visit before end of global period										

	A	B	C	D	E	F	G	H	I	J	K
1				REFERENCE CODE				REFERENCE CODE			
2	<p><b>*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.</b></p> <p><b>**Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.</b></p>			33282		33282		33284		33284	
3	<p><b>Meeting Date: April 2013</b></p> <p><b>Tab: 20</b></p> <p><b>Specialty: cardiology/electrophysiology</b></p>	CMS Code	Staff Type	Implantation of patient-activated cardiac event recorder				Removal of an implantable, patient-activated cardiac event recorder			
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD				090		090		090		090
56	MEDICAL SUPPLIES**										
		CODE	UNIT								
57	pack, minimum multi-specialty visit	SA048	pack		2		1		2		1
58	pack, post-op incision care (suture)	SA054	kit		1		1		1		1
59											
60											
61											
62											
63	EQUIPMENT										
		CODE									
64	table, exam	EF023			72		36		72		36
65											
66											
67											
68											

AMA/Specialty Society RVS Update Committee Summary of Recommendations  
*Harvard-Valued Annual Allowed Charges Greater than \$10 million Screen*

April 2013

**Renal Allotransplantation**

CPT code 50360 *Renal allotransplantation, implantation of graft; without recipient nephrectomy* was identified through the Harvard-Valued Annual Allowed Charges  $\geq$  \$10 million screen. The RUC recommended survey of physician work and review of practice expense for this service.

The specialty societies presented compelling evidence to justify a change in the physician work value. The physician work and time components of CPT code 50360 were valued in the Harvard studies. Since that time, there has been a change in patient population and donor grafts. The number of transplants performed annually in patients aged 50 years or older has steadily increased, and the number performed annually in patients aged 65 years or older tripled between 1998 and 2011. In addition, diabetes and hypertension as the primary cause of renal failure has increased in kidney transplant recipients. The effects of these diseases, along with increased time on dialysis at the time of transplant, have resulted in higher prevalence of peripheral vascular disease, coronary artery disease and cerebrovascular disease at the time of transplant, often requiring vascular procedures prior to transplantation. These co-morbidities and prior interventions translate into more complex and intense work in the pre, intra and post-operative transplant period.

Increases in the number of candidates on the waiting list and relatively flat organ donation rates have resulted in steady decreases in transplant rates for adult wait-listed candidates. In 1998, the deceased donor transplant rate was 20.6 transplants per 100 wait-list years, compared with 11.4 transplants per 100 wait-list years in 2011. As a result of the flat organ donation rates and increasing number of candidates on the waiting list, the percentage of deceased donors who had co-morbidities that would affect the graft has increased; the major components of the kidney donor risk index (KDRI) has increased over time. In combination with an older, sicker, and more complex typical recipient, a more marginal graft results in higher complexity and intensity of work both intra-operatively and post-operatively, including but not limited to delayed graft function, requiring post-transplant dialysis, higher risk of infection, higher need for post-transplant assessment of the graft, including biopsy, and generally increased post-transplant morbidity.

As mentioned above, CPT code 50360 was reviewed as part of the Harvard study. The Harvard reports indicate that the pre-, intra-, and post-operative time estimates were collected from five general surgeons. However, transplant surgeons were not part of the Harvard study. In 1992, CPT code 50360 underwent CMS Refinement Panel review and the work RVU was increased from 26.43 to 27.71. However, there is no discussion of this change in the Federal Register.

In 1997, a CMS contractor was tasked with transforming the post-operative time from the Harvard study into hospital and office visits. This was undertaken so that changes in the work RVUs for Evaluation and Management (E/M) codes after the first Five-Year-Review could be incorporated into codes with a global period of 10 or 90 days. The Harvard post-op time data was transformed into hospital and office visits. This transformation increased the total Harvard time from 839 to 1,526 minutes and resulted in a negative IWPOT. Most noticeable is the change in hospital visit time from 308 minutes in the Harvard study to 978 minutes using E/M visits. The RUC agreed with the specialty society that the methodology to impute frequency and level of post-op E/M visits was flawed. Therefore, the RUC agreed with the specialty society that there is compelling evidence that the current value for this procedure is potentially misvalued. This marks the first time this procedure has been surveyed for both time and physician work by surgeons familiar with the procedure.

The RUC reviewed survey data from 109 transplant specialists and agreed that the survey 25<sup>th</sup> percentile slightly overestimated the physician work and complexity. The RUC noted that the number of post-operative visits has decreased, but as mentioned, these were imputed rather than based on survey data. The RUC reviewed key reference code 47780 *Anastomosis, Roux-en-Y, of extrahepatic biliary ducts and gastrointestinal tract* (work RVU=42.32, intra-service time=240 minutes) and noted that 50360 required 30 minutes less intra service time, less hospital visits, but more office visits. The RUC agreed that CPT code 50360 should be valued lower. In addition, the RUC reviewed MPC codes 33512 *Coronary artery bypass, vein only; 3 coronary venous grafts* (work RVU=43.98, intra service time=213 minutes) and 33426 *Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring* (work RVU=43.28, intra-service time= 205 minutes) and noted that although 50360 requires similar intra-service work, 33512 and 33426 require more total physician work and time, and therefore, should be valued slightly higher.

In addition, the RUC determined that an additional 50 minutes of pre service evaluation time is appropriate due to the extensive time required to evaluate the patient and coordinate with other health care providers after the patient's admission to the hospital and prior to surgery. Specifically, after the patient is admitted to the hospital, the surgeon performs a history and physical examination, reviews the patient's medical record and current laboratory data to ensure suitability for transplant. This work exceeds the standard pre-service work associated with most major surgical operations for the typical recipient, as the surgeon will not have had the opportunity to assess the patient for months, possibly years, prior to the transplant. Therefore, for recipients with complicated past medical histories and the typical co-morbidities, consultation with the referring and transplant center nephrologist and anesthesiologist is completed to rule out any prohibitive medical conditions and to determine if urgent dialysis is required prior to surgery. If the latter is required, coordination with the dialysis service is initiated to schedule the operating room making sure that the graft is not exposed to unacceptable cold ischemic times. Similarly, if any further evaluation is required, this will also need to be completed in the context of optimal cold ischemic times. The additional pre-service evaluation time is consistent with other RUC reviewed transplant procedures, but less than 32851 *Lung transplant, single; without cardiopulmonary bypass* and 33945 *Heart transplant, with or without recipient cardiectomy*. **The RUC recommends a work RVU of 40.90 for CPT code 50360.**

### **Practice Expense:**

The RUC accepted the direct PE inputs as submitted by the specialty society.

<b>CPT Code (•New)</b>	<b>CPT Descriptor</b>	<b>Global Period</b>	<b>Work RVU Recommendation</b>
50360	Renal allotransplantation, implantation of graft; without recipient nephrectomy	090	40.90

## AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 50360      Tracking Number

Original Specialty Recommended RVU: **43.00**Presented Recommended RVU: **43.00**

Global Period: 090

RUC Recommended RVU: **40.90**

CPT Descriptor: Renal allotransplantation, implantation of graft; without recipient nephrectomy

### CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 61-year-old male with end stage renal disease secondary to Type II diabetes and hypertension has been on dialysis and the transplant waiting list for 4 years. He has peripheral vascular disease and a BMI of 33. He is cardiac high risk and is ASA Grade 4. A matched cadaver graft from a 58-year-old donor who died of stroke becomes available. After backbench biopsy site repair and anatomical reconstruction of the graft (reported separately), a kidney transplant without native nephrectomy is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

### Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 100%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 39%

### Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: After being notified of a potential organ offer for an identified recipient the surgeon logs onto the UNOS web portal (UNET) to review the electronic medical record of the donor. The suitability of the donor is determined based on past medical and surgical history, age, ABO blood-type compatibility and organ quality. If suitable, a provisional yes is entered into the UNET donor system. For certain donors, such as those with advanced age or underlying medical or surgical comorbidities, the OPO may be contacted to arrange for renal biopsy and placement of the kidneys on perfusion pump at the time of organ retrieval. Organs procured in remote locations require more complicated travel arrangements such as commercial air-flight and additional ground transportation. These arrangements need to be coordinated with the OPO to ensure that the organ will arrive in a suitable time for safe use. For recipients with complicated past medical histories, consultation with the referring nephrologists and anesthesia personnel is performed to determine if urgent dialysis is required before surgery and to rule out any prohibitive medical conditions. After the patient is admitted to the hospital, the surgeon performs a history and physical examination, reviews the patients' medical record and current laboratory data to ensure suitability for transplant. This examination will particularly focus on any recent infections, hospitalizations, or recent sensitization events such as transfusions. The patient and family are counseled and operative consent is obtained. The operative site is marked prior to proceeding to the operating room and preoperative orders are written, including beta blockers, antibiotics, DVT prophylaxis and induction immunosuppression. Once there is confirmation of a crossmatch and the organ has been visualized as part of a back table preparation (separately reported), the recipient is brought to the operating room. The surgeon assists in placing intravenous access (typically difficult in ESRD patients who have PVD) and placing a Foley catheter (typically difficult as these patients often do not produce urine). The surgical area is prepped and draped. A comprehensive "time out" is undertaken by the entire operating room team, including reviewing the UNOS ID and the blood type of donor and recipient, that antibiotics have been given within 1 hour

of incision, VTE prophylaxis with either Venodyne boots or heparin is in place as well as reviewing the timing of anti-rejection and any other medications such as volume expanders or diuretics with anesthesia personnel.

**Description of Intra-Service Work:** A standard iliac fossa incision is performed. The retroperitoneal space is entered with division of the inferior epigastric vessels and a retractors are placed for appropriate exposure. In a female recipient, the round ligament may be divided and in a male recipient the cord structures must be identified and retracted. The iliac vessels in the pelvis are exposed, ligating any branches and overlying lymphatic vessels. The vessels are examined for their suitability and if appropriate, they are test clamped. If the vessels are diseased, which is not uncommon, further cephalad dissection or even contralateral side dissection may be needed to find a suitable place to implant the organ. The prepared donor organ (backbench work, when performed, is separately reported) is then brought into the operative field. Heparin may be given prior to vessel clamping. The iliac vein is clamped and an incision made on its anterior surface. The renal vein is then anastomosed to this opening using 5-0 Prolene sutures in a running fashion. Next, vascular clamps are placed on the iliac artery and an incision is made on its anterior surface. This opening is widened with an aortic punch. The inside of the artery is examined to look for plaque or an intimal flap which may complicate the anastomosis and cause embolization into the kidney or leg. If found, tacking sutures using 6-0 Prolene are used to suture down these plaques or flaps to the side wall. The renal artery is then anastomosed to the iliac artery using 6-0 Prolene sutures in a running fashion. The vessels are then unclamped slowly, leaving the arterial inflow last to minimize embolization to the kidney. Mannitol and furosemide may be given prior to reperfusion to minimize ischemia reperfusion injury and promote diuresis. The anastomoses and kidney surfaces are examined for hemostasis. If there is evidence of vasospasm or suboptimal arterial flow, papaverine and/or verapamil may be injected into the artery. Once satisfied with the vascular anastomoses, the retractors are repositioned to help identify the bladder. This may be difficult as often many ESRD patients do not make urine. The surgeon may insufflate the bladder with solution to help find it. The lateral aspect of the bladder is dissected, going through the detrusor muscle to identify the bladder mucosa. The donor ureter is then trimmed and spatulated to widen its mouth. The bladder mucosa is then opened and the ureter is sown to it using 5-0 PDS sutures. Hemostasis is once again confirmed. A drain is placed. After confirming correct instrument and lap pad counts, the wound is closed in layers.

**Description of Post-Service Work: Post-operative Work - Hospital:** Apply dressings. Monitor patient during reversal of anesthesia. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff. Monitor hourly urine output. Perform an ultrasound of the kidney to confirm patent vasculature. Serial blood tests are ordered and reviewed to confirm no evidence of bleeding and improvement of kidney function. Abnormal chemistry results may necessitate urgent dialysis for the patient with consultation with nephrology personnel. Discuss procedure and outcome with family. Write postoperative note. Dictate operative report. Write orders for transferring to surgical floor and discuss ongoing care with floor nurses. Daily rounds are made with a multidisciplinary team, including a transplant pharmacist and transplant dietician. Ultrasounds to evaluate for vascular or ureteral problems are performed as necessary. Monitor fluid and electrolyte status and renal function. Immunosuppression and prophylactic antibiotic medications are evaluated on a daily basis. Many of these patients have co-morbidities which need to be addressed in the postoperative period. These include hypertension and diabetes, which may be worsened in the post transplant period and need monitoring, treatment and consultation with endocrinology and cardiology personnel. Manage dressings to wound daily, monitoring status of incision, looking for signs of infection as well as drain output. Continue prophylaxis for DVT. Monitor daily for adequacy. Assess need for beta-blockers, order as required. Assess pain scores and adequacy of analgesia. Review nursing/other staff patient chart notes. Write orders for labs, films (if indicated), medications, diet, and patient activity. Chart patient progress notes daily. Answer patient and family questions. Answer nursing/other staff questions. Prior to discharge, the patient and family will be given detailed instructions on their medications and potential side effects to look for, as well as protocol post-operative expectations for the patients. Discharge includes appropriate paperwork, patient and family counseling, dietary instruction, provision of prescriptions and arranging for follow-up. If there is persistent delayed graft function, with the patient needing to be discharged while still on dialysis, arrangements need to be made with the dialysis center to perform dialysis in close conjunction with the transplant center, frequently in a tapering schedule. All appropriate medical records are completed, including day of discharge progress notes, discharge summary, discharge instructions, and insurance forms.

#### **Post-operative Work - Office:**

Office visits for post-transplant patients require complex chronic care, where the primary goal of short-term and long-term medical follow-up is to enable surveillance for signs and symptoms of renal allograft dysfunction. At the first post-discharge visit, a comprehensive review of systems and physical exam is performed concentrating on potential complications from the surgery. Management of the operative wound, assessment for surgical site infection, and drain management are all performed. All discharge medications, including those for pain, hypertension, diabetes, and anti-microbial therapy are reviewed and adjusted as appropriate.

Post-op office visits (after the initial visit) include a complete review of the patient's medical record and review of interval chart notes. This is important since the patient will likely have been seen and/or monitored by other transplant team providers (eg, pharmacists, home health care, therapy, dietician) who have entered notes in the medical record. The transplant surgeon will continue assessment of the patient for medical or surgical complications, including but not limited to bleeding, infection, wound complications, venous thrombosis, and pulmonary complications. Removal of skin staples is delayed to at least 3 weeks because the surgeon has to be certain that the wound is well healed; which is complicated by immunosuppressive drugs.

Post-op office visits also include assessment of graft function to determine when the patient can cease hemodialysis; including review of volume status, evidence of uremia/azotemia, and serum BUN and creatinine determinations. Careful monitoring is necessary because, although a graft may have great initial function, there are a number of reasons why renal function may decline, including drug nephrotoxicity, acute tubular necrosis, recurrent disease, and obviously acute rejection. Review of drugs and lab studies is an important component of each visit requiring complex medical decision making and considerable time. In combination with medication adherence history and physical examination, lab results and imaging assist the transplant surgeon in assessment of graft function. Postoperatively, comorbid diseases are typical and need to be aggressively managed. Both traditional and nontraditional cardiovascular risk factors, including the concurrent presence of PVD, contribute to CVD morbidity and mortality in kidney transplant recipients. Therefore, aggressive treatment of hypertension and hyperlipidemia is necessary since these diseases are established risk factors for CVD mortality in kidney transplant recipients. Similarly, new-onset diabetes after transplantation has been identified as one of the most important factors associated with reduced graft function and patient and graft survival. The transplant surgeon will write orders for a multifaceted approach of weight control, diet and exercise, oral medication and insulin as necessary for tight glycemic control. In addition to CVD related evaluation and management, the transplant surgeon will monitor for infections which remain the second most common cause of death in kidney transplant recipients.

At the end of each encounter, the surgeon will write orders for further evaluation, dictate progress notes for the medical chart, and communicate with referring physicians and consultants as appropriate.



**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Michael Abecassis, MD; Thomas Cooper, MD				
<b>Specialty(s):</b>	transplant surgery; urological surgery				
<b>CPT Code:</b>	50360				
<b>Sample Size:</b>	927	<b>Resp N:</b>	109	<b>Response:</b> 11.7 %	
<b>Description of Sample:</b>	random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	1.00	25.00	35.00	50.00	108.00
<b>Survey RVW:</b>	35.00	43.00	46.50	50.00	60.00
<b>Pre-Service Evaluation Time:</b>			90.00		
<b>Pre-Service Positioning Time:</b>			15.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			20.00		
<b>Intra-Service Time:</b>	150.00	180.00	210.00	240.00	360.00
<b>Immediate Post Service-Time:</b>	<u>45.00</u>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<u>210.00</u>	99231x 1.00	99232x 2.00	99233x 2.00	
<b>Discharge Day Mgmt:</b>	<u>38.00</u>	99238x 1.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<u>158.00</u>	99211x 0.00	12x 0.00	13x 1.00	14x 2.00 15x 1.00
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

4 - FAC Difficult Patient/Difficult Procedure

<b>CPT Code:</b>	50360	<b>Recommended Physician Work RVU: 40.90</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		90.00	40.00	50.00
<b>Pre-Service Positioning Time:</b>		3.00	3.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		20.00	20.00	0.00
<b>Intra-Service Time:</b>		210.00		
<b>Immediate Post Service-Time:</b>	<u>45.00</u>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<u>210.00</u>	99231x 1.00	99232x 2.00	99233x 2.00
<b>Discharge Day Mgmt:</b>	<u>38.00</u>	99238x 1.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<u>158.00</u>	99211x 0.00	12x 0.00	13x 1.00 14x 2.00 15x 1.00
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
47780	090	42.32	RUC Time

CPT Descriptor Anastomosis, Roux-en-Y, of extrahepatic biliary ducts and gastrointestinal tract**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
33512	090	43.98	RUC Time	2,492

CPT Descriptor 1 Coronary artery bypass, vein only; 3 coronary venous grafts

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
33426	090	43.28	RUC Time	6203

CPT Descriptor 2 Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
35103	090	43.62	RUC Time

CPT Descriptor Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta involving iliac vessels (common, hypogastric, external)**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 33      % of respondents: 30.2 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 50360</b>	<b>Key Reference CPT Code: 47780</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	113.00	75.00	
Median Intra-Service Time	210.00	240.00	
Median Immediate Post-service Time	45.00	40.00	
Median Critical Care Time	0.0	70.00	
Median Other Hospital Visit Time	210.0	250.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	158.0	86.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

<b>Median Total Time</b>	<b>774.00</b>	<b>799.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.42	3.69
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.45	3.44
Urgency of medical decision making	4.12	3.34

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.24	3.97
--------------------------	------	------

Physical effort required	4.03	3.91
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.52	3.84
Outcome depends on the skill and judgment of physician	4.52	4.19
Estimated risk of malpractice suit with poor outcome	3.33	3.53

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.97	3.50
Intra-Service intensity/complexity	4.27	3.88
Post-Service intensity/complexity	3.79	3.13

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**WHY IS THIS CODE BEING REVIEWED**

Code 50360 was identified by CMS through a Harvard-valued annual allowed charges greater than \$10 million screen.

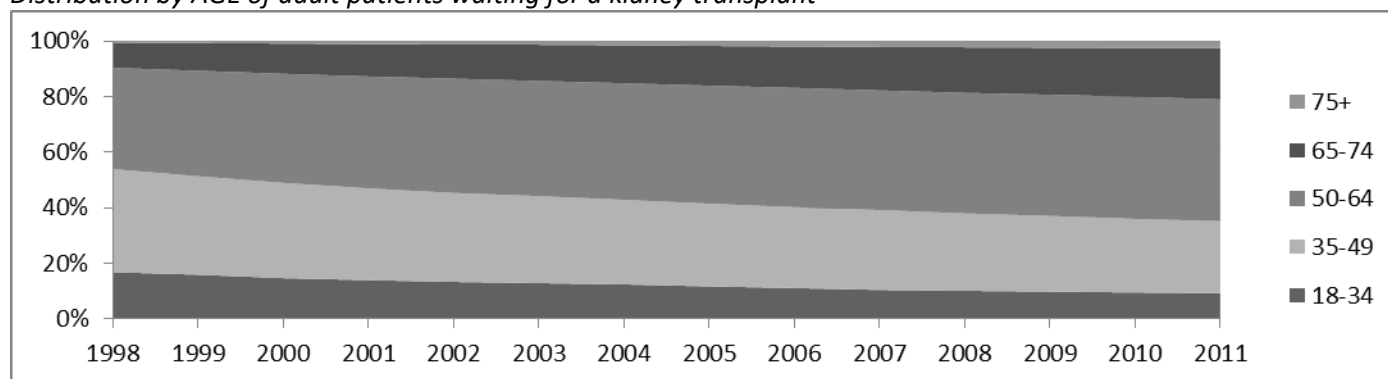
## COMPELLING EVIDENCE

Kidney transplantation (50360) was last reviewed during the Harvard study prior to publication of the first Physician Fee schedule in 1992. Since that review in the late 1980's, the patient receiving a kidney transplant and the characteristics of the donor graft have changed. The data presented below are taken from the UNOS 2011 Annual Data Report, which is a comprehensive report of the Organ Procurement and Transplantation Network (OPTN) and U.S. Scientific Registry of Transplant Recipients (SRTR).

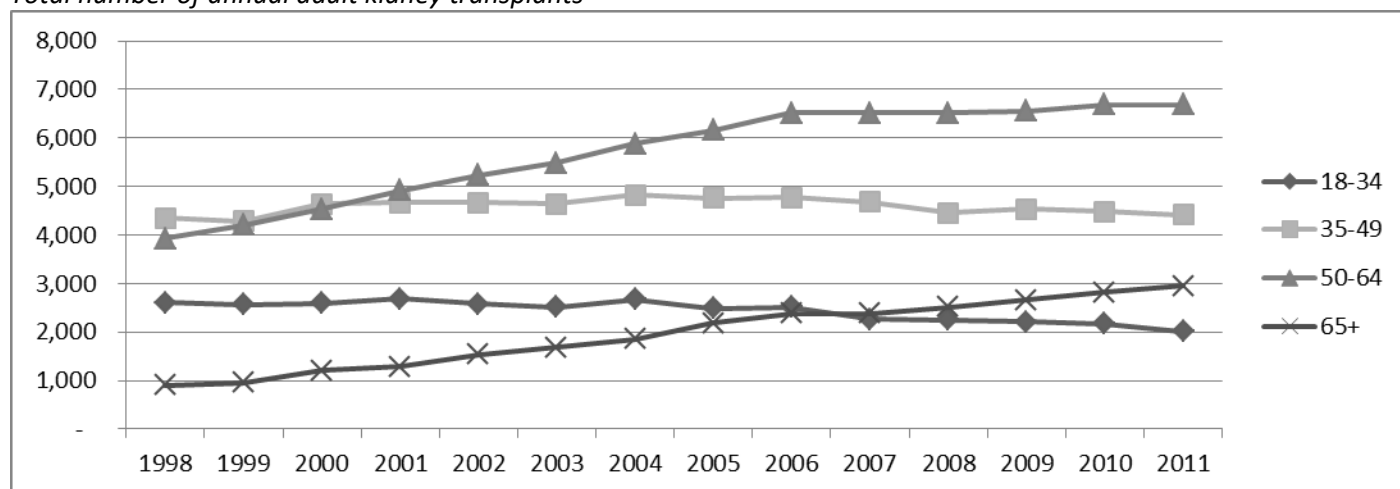
### 1. Change in Patient - AGE

The number of kidney transplant candidates on the waiting list continues to increase each year. Commensurate with the increasing age of candidates on the waiting list, the number of transplants performed annually in patients aged 50 years or older has steadily increased, and the number performed annually in patients aged 65 years or older tripled between 1998 and 2011.

*Distribution by AGE of adult patients waiting for a kidney transplant*



*Total number of annual adult kidney transplants*



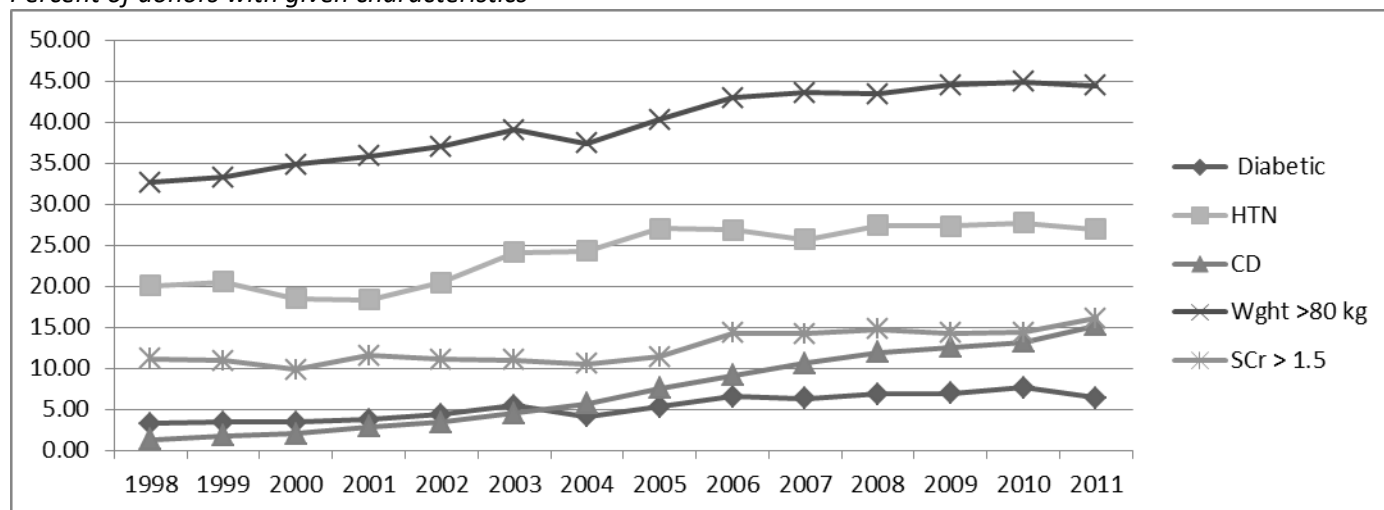
### 2. Change in Patient - Comorbidities

Diabetes and hypertension as the primary cause of renal failure has increased in kidney transplant recipients. The effects of these diseases, along with increased time on dialysis at the time of transplant, have resulted in a higher prevalence of peripheral vascular disease, coronary artery disease, and cerebrovascular disease at the time of transplant, often requiring vascular procedures prior to transplantation. These comorbidities and prior interventions translate into more complex and intense work in the pre-, intra-, and post-operative transplant period.

### 3. Change in Donor Grafts

Increases in the number of candidates on the waiting list and relatively flat organ donation rates have resulted in steady decreases in transplant rates for adult wait-listed candidates. In 1998, the deceased donor transplant rate was 20.6 transplants per 100 wait-list years, compared with 11.4 transplants per 100 wait-list years in 2011. As a result of the flat organ donation rates and increasing number of candidates on the waiting list, the percentage of deceased donors with co-morbidities that would affect the graft has increased; the major components of the kidney donor risk index (KDRI) has increased over time. In combination with an older, sicker, and more complex typical recipient, a more marginal graft results in higher complexity and intensity of work both intra-operatively and post-operatively, including but not limited to delayed graft function, requiring post-transplant dialysis, higher risk of infection, higher need for post-transplant assessment of the graft, including biopsy, and generally increased post-transplant morbidity.

*Percent of donors with given characteristics*



### 4. Flawed Methodology Related to Post-operative Visits

Kidney transplantation (50360) was reviewed as part of the Harvard study. The Harvard reports indicate that the pre-, intra-, and post-operative time estimates shown below were collected from five general surgeons (transplant surgeons were not part of the Harvard study).

source	CPT	Total time	eval	posit	sdw	intra	Immed-post	hosp	off
Hvd	50360	839	71	0	25	183	62	308	190

Code 50360 underwent CMS Refinement Panel review in 1992 and the wRVU was increased from 26.43 to 27.71. There is no discussion of this change in the Federal Register.

In 1997, a CMS contractor (Dan Dunn) was tasked with transforming the post-operative time from the Harvard study into hospital and office visits. This was undertaken so that changes in the wRVUs for E/M codes after the first five-year-review could be incorporated into codes with a global period of 10 or 90 days. The Harvard post-op time data was transformed into hospital and office visits, as shown below. This transformation increased the total Harvard time from 839 to 1,526 minutes and resulted in a negative IWPUP of -0.220. Most noticeable is the change in hospital visit time from 308 minutes in the Harvard study to 978 minutes using E/M visits.

Source	CPT	IWPUP	RVW	Tot	HV	OV	eval	posit	sdw	intra	Im-post	99291	99231	99238	99213
Dunn 1997	50360	-0.220	27.05	1526	978	207	71	0	25	183	62	10	12	1	9

Even after two increases in wRVU to account for increases in wRVUs for E/M services, the current wRVU for 50360 continues to have a negative IWPUT (-0.144).

Source	CPT	IWPUT	RVW	Tot	HV	OV	eval	posit	sdw	intra	Im-post	99291	99231	99238	99213
2013 PFS	50360	-0.144	40.90	1526	978	207	71	0	25	183	62	10	12	1	9

We believe it is clear from this discussion that the methodology to impute frequency and level of post-op E/M visits was flawed.

## RECOMMENDATION DISCUSSION

### Survey Process

The American Society of Transplant Surgeons and American Urological Association conducted a standard RUC survey. Surveys were sent to the entire ASTS membership. A crosscheck with AUA indicated overlap in membership between ASTS and AUA transplant specialists. Of the 927 survey requests sent, 109 responses were received. All respondents indicated experience in performing the procedure in the past 12 months.

### Pre-time Recommendation: 90/3/20

Package 4 (difficult patient/difficult procedure) is appropriate with the addition of 50 minutes to the evaluation component. Kidney transplantation requires significant pre-operative work prior to surgery. As described in the pre-service work description on the first page of this SoR, the surgeon is required to thoroughly evaluate both the patient and the graft prior to surgery, and more importantly, to “match” the graft with the donor not only from an immunological perspective, but also from a risk/benefit perspective. For each graft, a surgeon must first decide on a number of patients to be “crossed-matched” against a specific donor. Even when the cross-match is favorable for a specific donor, a surgeon may turn down a graft offer for that particular recipient, while potentially accepting the same graft for another recipient.

With respect to the deceased donor graft, this involves evaluation of the donor's medical history electronically to confirm suitability for the intended transplant recipient. For donors with advanced age or underlying medical or surgical comorbidities (typical), evaluation is necessary to determine if renal biopsy or placement of the kidney on perfusion pump at the time of organ retrieval is required, and when appropriate, interpretation of the biopsy and pump parameters enter into the decision to accept or not accept the graft. A final decision is often made upon inspection of the graft.

With respect to the patient, the transplant surgeon contacts the patient to explain the nature of the donor graft and any inherent risks associated with the particular donor graft. Once the patient agrees to the transplant, he/she will come to the hospital for admission. After the patient is admitted to the hospital, the surgeon performs a history and physical examination, reviews the patients’ medical record and current laboratory data to ensure suitability for transplant. This work exceeds the standard pre-service work associated with most major operations for the typical recipient, as the surgeon will not have had the opportunity to assess the patient for months or even years prior to the transplant. Therefore, for recipients who have complicated past medical histories and the typical co-morbidities, consultation with the referring nephrologist, and with the transplant nephrologist at the transplant center, and with anesthesia personnel is performed to determine whether i) any further evaluation is needed to rule out potential medical contraindications, or ii) urgent dialysis is required before surgery. If the latter is the case, coordination with the dialysis service is needed to schedule the operating room making sure that the graft is not exposed to unacceptable cold ischemic times (CIT). Similarly, if any further evaluation is required, this needs to be done in the context of optimal CIT. Note that code 50360 is not billed with an E/M service.

### Post-operative Work

The survey indicated that a hospital visit was not typical on the day of surgery after discharge from recovery to the surgical ward. The survey median length of stay was 6 days and median number and level of hospital visits were 2x99233, 2x99232, 1x99231, and 1x99238. For the first few days after surgery, the patient is monitored closely for signs of graft rejection and vascular or ureteral problems. Labs and imaging is ordered and reviewed daily as needed.

Comorbid diseases (ie, HTN, diabetes) are also closely monitored, as these typically worsen and are brittle in the postoperative period. After discharge from the hospital, the patient is typically seen four times prior to the transplant surgeon transferring care to a nephrologist. The initial visits require high to moderate complexity of decision making regarding the graft function and patient comorbid disease management. A comprehensive or detailed exam is required, along with coordination with other health professionals caring for the patient. These include but are not limited to communicating with pharmacy, nephrology, and infectious diseases providers, and coordinating home care and patient evaluation with visiting nurse services, home care services for catheter care, home infusion services for antibiotic coverage and home rehabilitation services.

### **wRVU Recommendation**

Based on a comparison to the key reference code, MPC codes, and other RUC reviewed services, we recommend the survey 25<sup>th</sup> percentile wRVU of 43.00.

### **Comparison to Key Reference Code**

The 33 respondents that chose 47780 as their reference code rated the intensity and complexity of 50360 higher for 9 of the 11 measures. With respect to fitness to rate, 29 of the 33 respondents had experience performing 47780 in the past 12 months. The pre-operative work for 50360 is significantly greater and of higher complexity. Although 50360 requires less intra-time, the work is more intense (ie, higher IWPUT) because renal transplantation requires two vascular and one ureteral anastomosis, often performed in diseased vessels and atrophied bladder. Anything short of a technically perfect vascular anastomosis can jeopardize the viability of the graft and the success of the transplant. In the 477980 procedure, a single biliary anastomosis is performed that is technically less challenging and maybe salvaged even with complication with conservative management such as percutaneous drainage or operative revision. Intraoperative time during renal transplantation is shorter compared to 47780 since exposure of the iliac vessels can be achieved relatively quickly whereas exposure of the hepatic ducts may take longer but less intense. However, after exposure is obtained, renal transplantation requires a high level of focused work to not only identify an appropriate site for anastomosis but also factoring the need for urinary reconstruction. With diseased iliac vessels, obtaining an appropriate site for anastomosis within these constraints can be difficult and may require vascular reconstruction.

CPT	DECS	IWPUT	RVW	TOT TIME	EVAL	POSIT	SDW	INTRA	IM-POST	99291	99233	99232	99231	99238	99215	99214	99213
<b>47780</b>	Anastomosis, Roux-en-Y, of extrahepatic biliary ducts and gastrointestinal tract	<b>0.090</b>	<b>42.32</b>	<b>799</b>	45	15	15	<b>240</b>	40	1	2	2	3	1.0		1	2
<b>50360</b>	Renal allotransplantation, implantation of graft; without recipient nephrectomy	<b>0.118</b>	<b>43.00</b>	<b>744</b>	90	3	20	<b>210</b>	45		2	2	1	1.0	1	2	1

### **Comparison to Other Frequently Chosen Reference Codes**

Two other frequently chosen reference codes familiar to transplant surgeons demonstrate similar intra-operative intensities.

CPT	DECS	IWPUT	RVW	TOT TIME	EVAL	POSIT	SDW	INTRA	IM-POST	99291	99233	99232	99231	99238	99215	99214	99213	99212
<b>50360</b>	Renal allotransplantation	<b>0.118</b>	<b>43.00</b>	<b>744</b>	90	3	20	<b>210</b>	45		2	2	1	1.0	1	2	1	
<b>47125</b>	Hepatectomy, resection of liver; total left lobectomy	<b>0.124</b>	53.04	<b>855</b>	75			<b>225</b>	45	2	2	3	2	1.0			2	1
<b>47130</b>	Hepatectomy, resection of liver; total right lobectomy	<b>0.134</b>	57.19	<b>870</b>	75			<b>240</b>	45	2	2	3	2	1.0			2	1

**PRE-TIME AND POSTOP OFFICE VISIT Comparison to Other Transplant Codes**

The survey median additional pre-time and level of office visits compare well with other transplant codes reviewed by the RUC.

CPT	DECS	IWPUT	RVW	TOT TIME	PRE	INTRA	IM-POST	99291	99233	99232	99231	99238	99215	99214	99213
50360	Renal allotransplantation	0.118	43.00	744	113	210	45		2	2	1	1.0	1	2	1
32851	Lung transplant, single	0.095	59.64	1165	140	240	90	3.5	3	3	1	1.0	1	1	
33945	Heart transplant	0.117	89.50	1716	272	325	85	3.5	5	6	1	1.0	1	2	3

**Comparison to MPC Codes**

The recommended wRVU of 43.00 (IWPUT=0.118) compares well with MPC codes 33512 and 33426.

CPT	DECS	IWPUT	RVW	TOT TIME	EVAL	POSIT	SDW	INTRA	IM-POST	99291	99233	99232	99231	99238	99215	99214	99213	99212
50360	Renal allotransplantation	0.118	43.00	744	90	3	20	210	45		2	2	1	1.0	1	2	1	
33426	Repair of mitral valve	0.111	43.28	776	60	15	20	205	40	1	3	2	1	1.0		1	1	
33512	Cabg vein three	0.103	43.98	832	60	15	20	213	40	1	4	2	1	1.0		1		1

**Comparison to Other RUC Reviewed Codes**

The recommended wRVU of 43.00 (IWPUT=0.118) compares well with other RUC reviewed codes that have a wRVU near 43.00.

CPT	DECS	IWPUT	RVW	TOT TIME	EVAL	POSIT	SDW	INTRA	IM-POST	99291	99233	99232	99231	99238	99215	99214	99213	99212
50360	Renal allotransplantation	0.118	43.00	744	90	3	20	210	45		2	2	1	1.0	1	2	1	
33781	Repair great vessels defect	0.095	43.21	738	60	12	15	280	40	1		2	6	1.0			1	
33779	Repair great vessels defect	0.096	43.23	733	60	15	15	280	40	1	1	1	4	1.0		1		
35103	Repair artery rupture groin	0.117	43.62	740	60			180	60	2		3	4	1.0			2	1
33780	Repair great vessels defect	0.103	43.90	731	60	15	15	260	50	1		2	6	1.0			1	

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.  
☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.  
☒ Multiple codes allow flexibility to describe exactly what components the procedure included.  
☐ Multiple codes are used to maintain consistency with similar codes.  
☐ Historical precedents.  
☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your



scenario. 50323 (Backbench standard preparation of cadaver donor renal allograft prior to transplantation, including dissection and removal of perinephric fat, diaphragmatic and retroperitoneal attachments, excision of adrenal gland, and preparation of ureter(s), renal vein(s), and renal artery(s), ligating branches, as necessary). The 2010 Medicare 5% beneficiary file indicates that code 50323 was reported ~60% of the time by the same physician on the same day. This work will always be necessary to prepare the donor graft, and may be performed by the surgeon who retrieves the organ, an independent surgeon working at the back bench, or the transplant surgeon. Code 50323 is carrier priced and paid only by report.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 50360

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty general surgery-transplant surgeon                      How often? Commonly

Specialty urological surgeon                      How often? Sometimes

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 15321

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. UNOS 2011 data - surgical specialty distribution not available

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 9,916  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2011 Medicare database

Specialty general surgery-transplant surgeon	Frequency 9000	Percentage 90.76 %
Specialty urological surgeon	Frequency 700	Percentage 7.05 %
Specialty	Frequency	Percentage %

Do many physicians perform this service across the United States? Yes

## Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 50360

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AF	AG	AH	AI	AJ
3	ISSUE: Renal Allotransplantation																															
4	TAB: 21																															
5						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							Office				
6	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX		Time	EVAL	POSIT	SDW	MIN	25th	MED	75th		MAX	POST	91	92	33	32	31	38	39	15	14	13
7	REF	47780	Anastomosis,	33	0.090			42.32			799	45	15	15			240			40	1		2	2	3	1.0		1	2			
8	HVD	50360	Harvard Time									71		25			183			62			308					190				
9	Dunn	50360	Renal allotransp		-0.144			40.90			1526	71		25			183			62	10				12	1.0		9				
10	SVY	50360	Renal allotran	109	0.134	35.00	43.00	46.50	50.00	60.00	786	90	15	20	150	180	210	240	360	45			2	2	1	1.0		1	2	1		
11	REC		Current		0.108	40.90					774	90	3	20			210			45			2	2	1	1.0		1	2	1		

**AMA/Specialty Society Update Process**  
**Practice Expense Summary of Recommendation**  
**Facility Direct Inputs**

CPT Long Descriptor:

50360 Renal allotransplantation, implantation of graft; without recipient nephrectomy

Global Period: 090

Meeting Date: April 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: Representatives of the American Society of Transplant Surgeons and the American Urological Surgeons utilized the practice expense details accepted by the RUC and CMS in 2004.
2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale: N/A
3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time: An additional 30 minutes has been added to the typical 60 minutes assigned to 90-day global procedures. All work performed once the patient is admitted to the hospital relevant to the recipient procedure falls under Medicare Part B. this is in sharp contrast to all work performed prior to admission, including evaluation, listing, maintenance on waiting list, up to and including organ offer, which fall under Medicare Part A. While the latter non-physician work is typically performed by hospital staff, the former is typically performed by nurse coordinators involved in the post transplant care and commonly the responsibility of the surgical team. This transition of care is highly regulated and has been and continues to be the topic of OIG investigations and therefore most programs are acutely aware of the need to abide by these regulatory directives.
4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence: N/A
5. Please describe in detail the clinical activities of your staff:

**CLINICAL STAFF TYPE:** It has previously been accepted that transplant surgeons will have an RN as their typical staff type, therefore, "RN" is indicated for all clinical staff activities.

Pre-Service Clinical Labor Activities:

Standard time of 60 minutes for major surgical procedures (90-day global) is indicated . An additional 30 minutes has been added to the typical 60 minutes assigned to 90-day global procedures. All work performed once the patient is admitted to the hospital relevant to the recipient procedure falls under Medicare Part B. this is in sharp contrast to all work performed prior to admission, including evaluation, listing, maintenance on waiting list, up to and including organ offer, which fall under Medicare Part A. While the latter non-physician work is typically performed by hospital staff, the former is typically performed by nurse coordinators involved in the post transplant care and commonly the responsibility of the surgical team. This transition of care is highly regulated and has been and continues to be the topic of OIG investigations and therefore most programs are acutely aware of the need to abide by these regulatory directives.

Intra-Service Clinical Labor Activities:

The RUC database indicates discharge day management at 99238 level for the living donor procedure codes. The PEAC standard 12 minutes of clinical staff activity for 99238 is shown on the spreadsheet.

Post-Service Clinical Labor Activities:

Standard times for each office visit.

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor:

50360 Renal allotransplantation, implantation of graft; without recipient nephrectomy

Global Period: 090

Meeting Date: April 2013

**THIS IS A FACILITY-ONLY PROCEDURE. THERE ARE NO NONFACILITY INPUTS RECOMMENDED.**

- 
1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:
  2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:
  3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:
  4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:
  5. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:

	A	B	C	D	E	F	G
1				REFERENCE CODE			
2	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.			50360		50360	
3	Meeting Date: April 2013 Tab: 21 Specialty: ASTS, AUA	CMS Code	Staff Type	Renal allotransplantation, implantation of graft; without recipient nephrectomy		Renal allotransplantation, implantation of graft; without recipient nephrectomy	
4	LOCATION			Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			90	90	90	90
6	TOTAL CLINICAL LABOR TIME	L051A	RN	N/A	426	N/A	307
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L051A	RN	0	90	0	90
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	0	12	0	12
9	TOTAL POST-SERV CLINICAL LABOR TIME	L051A	RN	0	324	0	205
10	PRE-SERVICE						
11	Start: Following visit when decision for surgery or procedure made						
12	Complete pre-service diagnostic & referral forms				5		5
13	Coordinate pre-surgery services	L051A	RN		20		20
14	Schedule space and equipment in facility	L051A	RN		8		8
15	Provide pre-service education/obtain consent	L051A	RN		20		20
16	Follow-up phone calls & prescriptions	L051A	RN		7		7
17	*Other Clinical Activity - specify: Complex multidisciplinary coordination of care	L051A	RN		30		30
18	End: When patient enters office/facility for surgery/procedure						
19	SERVICE PERIOD						
20	Start: When patient enters office/facility for surgery/procedure:						
39	*Other Clinical Activity - specify:						
41	Dischrg mgmt (1.0 x 99238) (enter 12 min)	L051A	RN	n/a	12	n/a	12
43	End: Patient leaves office						
44	POST-SERVICE Period						
45	Start: Patient leaves office/facility						
47	Office visits: List Number and Level of Office Visits			# visits	# visits	# visits	# visits
48	99211 16 minutes		16				
49	99212 27 minutes		27				
50	99213 36 minutes		36		9		1
51	99214 53 minutes		53				2
52	99215 63 minutes		63				1
53	Total Office Visit Time	L051A	RN	0	324	0	205
54	*Other Clinical Activity - specify:						
55	End: with last office visit before end of global period						
56	MEDICAL SUPPLIES**						
57	pack, minimum multi-specialty visit	SA048	pack		9		4
58	pack, post-op incision care (suture & staple)	SA053	pack		1		
59	pack, post-op incision care (staple)	SA052	pack				1
60							
61	EQUIPMENT						
62	exam table	E11001			324		205
63	exam lamp	E30006			324		205

AMA/Specialty Society RVS Update Committee Summary of Recommendations  
*Site of Service Anomaly / CMS Fastest Growing / CMS Requests: Final Rule for 2013*

April 2013

**Percutaneous Implantation of Neurostimulator –PE Only**

In the Final Rule for 2013, CPT code 63650 *Percutaneous implantation of neurostimulator electrode array, epidural* was identified by stakeholders as a procedure performed in the non-facility setting. CMS requested non-facility practice expense (PE) inputs. The RUC determined that review of physician work is not necessary at this time, as this service was last surveyed in February 2008 and re-reviewed in October 2010. The RUC recommended that the service be referred to the PE Subcommittee for review at the April 2013 RUC meeting. The specialty clarified that 63650 is frequently furnished in the physician office and that 2 arrays are required. The PE Subcommittee noted that this code was previously a 090-day global and still retains its pre-service time for a standard 090-day global. The current standard is 0 minutes for a 010-day global in the facility setting. However, if the specialty can justify time, 15 minutes of pre-service time for minimal use of clinical staff or 30 minutes for extensive use of clinical staff may be appropriate. The specialty society confirmed that there is extensive use of clinical staff and the pre-service time was modified from 090-day global standard of 60 minutes to 30 minutes in the facility. The PE Subcommittee reviewed the non-facility clinical staff time input *Obtain vital signs* and reduced it to 3 minutes for 1-3 vital signs and reduced *Setup scope (non facility setting only)* to 0 minutes because there is no scope utilized for this service. The PE Subcommittee also adjusted equipment minutes. **The RUC reviewed and approved the direct practice expense inputs with modifications as recommended by the Practice Expense Subcommittee.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
63650		Percutaneous implantation of neurostimulator electrode array, epidural	010	7.15 (No Change) (PE Input Recommendations Only)

based on the proportion of indirect expense to direct expense that is typical of other psychiatric services, and is not on par with other services that require similar investments in capital equipment and high-cost, disposable supplies.

Historically, we have contractor-priced (meaning our claims processing contractors develop payment rates) for services with resource costs that cannot be appropriately valued within the generally applicable PE methodology used to price services across the PFS. Because there is no mechanism to develop appropriate payment rates for these services within our current methodology, we proposed to contractor price these codes for CY 2013.

*Comment:* One commenter objected to the proposal to contractor price these codes for CY 2013 and suggested that CMS should establish PE RVUs using the generally applicable PE methodology and must endeavor in ensuing rulemaking to revise the methodology to refine any values the agency views as “anomalous.” The commenter also questioned CMS’s assumption that the direct costs for psychiatrists who furnish these services “far exceed” the direct costs for psychiatrists who do not furnish these services. The commenter stated that CMS made this assessment without any empirical support and that CMS needs to conduct a survey or obtain other data from psychiatrists before drawing any conclusions regarding the appropriateness of Medicare payment rates on this basis.

*Response:* We understand the commenter’s objections, but as we explained in the proposal, we do not believe that there is a mechanism within the current methodology that allows us to develop appropriate payment rates for these services. We agree with the commenter that it may be appropriate to consider potential changes to the practice expense methodology to accommodate changing circumstances of medical practice. We do not agree with the commenter, however, that we have no means to pay appropriately for services when we recognize areas where the practice expense methodology is inadequate and that we must establish national RVUs based on that methodology, even when it does not accommodate the unique circumstances of particular services. Instead, we believe that in outlier cases, contractor pricing allows Medicare to pay more appropriately for particular services furnished to beneficiaries.

In our proposal, we pointed out that the direct costs incurred by psychiatrists reporting the codes far exceed the direct

costs typical to any other service predominantly furnished by psychiatrists. The commenter objected to this assertion and claimed it was made without any empirical support. We made that assertion based on comparing the direct practice expense input costs for transcranial magnetic stimulation services and the current direct practice expense input costs in the direct PE database for services predominantly furnished by the specialty based on Medicare claims data. In our examination of 20 frequently billed psychiatry services (where greater than half of the Medicare allowed services were reported by psychiatrists), the total direct costs (clinical labor, disposable medical supplies, or medical equipment) in the direct PE input database summed to under \$10 for all but 3 of these 20 services. Examples of these services include CPT codes 90807 (Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services), 90862 (Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy), and 90845 (Psychoanalysis). For the three where the direct PE input costs summed to greater than \$10, HCPCS code M0064 (Brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental psychoneurotic and personality disorders), and CPT codes 90865 (Narcosynthesis for psychiatric diagnostic and therapeutic purposes (eg, sodium amobarbital (Amytal) interview)), and 90870 (Electroconvulsive therapy (includes necessary monitoring)), the service with the highest direct cost sum was \$32.24. In contrast, the transcranial magnetic stimulation services treatment delivery (CPT code 90867) included direct PE inputs that summed to direct costs of \$145.19. The disparity between the TMS direct costs and the direct costs in other frequent psychiatry codes was the basis for our assertion that the direct costs for this service far exceeded the direct costs typical to any other service predominantly furnished by psychiatrists. Thus, we continue to believe our decision to contractor price these codes is the proper one.

*Comment:* Another commenter requested that CMS use the existing methodology to price the codes or contractor price the codes. This commenter also urged CMS to consider

alternate sources of data for resource costs as they become available, or to make appropriate future refinements to the practice expense methodology.

*Response:* We appreciate the commenter’s support for our proposal as a suitable means of pricing the services. We will consider appropriate means to develop national prices for these services in the context of potential changes to the practice expense methodology and the availability of new data sources.

After consideration of these public comments, we are finalizing our proposal to contractor price CPT codes 90867, 90868, and 90869 for CY 2013.

#### d. Spinal Cord Stimulation Trial Procedures in the Nonfacility Setting

Stakeholders have recently brought to our attention that CPT code 63650 (Percutaneous implantation of neurostimulator electrode array, epidural) is frequently furnished in the physician office setting but is not priced in that setting. We note that the valuation of a service under the PFS in particular settings does not address whether those services are medically reasonable and necessary in the case of individual patients, including being furnished in a setting appropriate to the patient’s medical needs and condition. However, because these services are being furnished in the nonfacility setting, we believed that CPT code 63650 should be reviewed to establish appropriate nonfacility inputs. We proposed to review CPT code 63650 and requested recommendations from the AMA RUC and other public commenters on the appropriate physician work RVUs (as measured by time and intensity), and facility and nonfacility direct PE inputs for this service. We understand that disposable leads comprise a significant resource cost for this service and are currently separately reportable to Medicare for payment purposes when the service is furnished in the physician office setting. Disposable medical supplies are not considered prosthetic devices paid under the Durable Medical Equipment, Prosthetic/Orthotic, and Supplies (DMEPOS) fee schedule and generally are incorporated as nonfacility direct PE inputs to PE RVUs. We sought comment on establishing nonfacility PE RVUs for CPT code 63650.

*Comment:* Several commenters expressed concerns regarding the possibility of establishing nonfacility PE RVUs for this service based on the assumption that the nonfacility PFS payment rate would be lower than the rate paid by the Medicare hospital outpatient prospective payment system

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor:

Global Period: 10 Meeting Date: April 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Clinical labor standards were followed and reviewed by the various societies RUC representatives.

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

Reference code 63663: Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed. This was used as comparator code as it represents a similar procedure and equipment, labor intensity, practice expense and intensity. This procedure has been valued in the non-facility setting. The comparator code is used to revise or replace a lead previously implanted whereas the code under review is for a new trial placement.

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time: N/A

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence: N/A

5. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Completion of diagnostic and referral forms for required preauthorization and scheduling.

Intra-Service Clinical Labor Activities:

Education and consent for this procedure is involved. The procedure requires active patient involvement intra-operatively in order for the surgery to be a success. The patient's pain pattern must be reviewed and confirmed, what is to be expected in the OR including from a pt participation stand-point. The key to a good trial is a prepared pt who understands that they must work with the doctor to be sure they are getting optimal coverage of their area of pain with the stimulator trial lead placement. Small lead movements (cephalad/caudad/lateral) can result in changes in the area of stimulation coverage and /or uncomfortable stimulation and therefore the pts needs to be able to report what they are feeling accurately. Pts are awake and must be properly mentally prepared for a trial. The clinical staff will also perform the usual requirements of preparing the room, assembling films, setting up the fluoroscopy C-arm, starting an IV



and monitoring for sedation.

An assistant, usually an RN, is required to be in the room attending to the patient at all times during the procedure. In addition to directly assisting the physician the patient is monitored and lightly sedated. At the conclusion of successful placement the RN must apply sterile dressings, assist in anchoring the lead, affix the screening cable.

A radiologic technician assists throughout the procedure. The c-arm is prepared and set to the preferred setting for patient body habitus and location of intended lead. A pre-operative image is obtained after to ensure correct position on table. Images are obtained throughout the procedure until the leads have been successfully positioned and programmed to adequate effect. After suturing the trial lead to the skin a final film is required for documentation of lead position.

Post-Service Clinical Labor Activities:

Please see also the pre-service rationale regarding complexity of instructions to patients for effective trial that must also be reviewed post-operatively. In addition, the post op instructions for care of the wound and equipment and how to manage medications are very complex. The patient operates the equipment completely on their own after the surgery & it takes time to educate the patient. This is entirely different from all other procedures done in the pain treatment world. For other procedures the patient is essentially a passive conduit, following an injection or even a pump trial the pt is not required to know how to operate a complex piece of medical equipment. Post-op the patient must be taught on their unique set of programs and how to operate their hand held device. Think of teaching someone to use a new cell phone with some new apps.

	A	B	C	D	E	F	G	H	I
1				REFERENCE CODE		CURRENT INPUTS		RECOMMENDATION	
2	more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.			Reference CPT Code <b>63663</b>		CPT Code <b>63650</b>		CPT Code <b>63650</b>	
3	Meeting Date: April 25-28, 2013 Tab: 22 Specialty: ASIPP,AAPM, AANS, CNS, ASA, ISIS	CMS Code	Staff Type	CPT CODE DESCRIPTOR: Revision including replacement, when performed, of spinal neurostimulator electrode		CPT CODE DESCRIPTOR: Percutaneous implantation of neurostimulator electrode array, epidural		CPT CODE DESCRIPTOR: Percutaneous implantation of neurostimulator electrode array, epidural	
4	LOCATION			Non Fac	Fac	Non Fac	Fac	Non Fac	Fac
5	GLOBAL PERIOD			10	10	10	10	10	10
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	164.0	72.0	0.0	102.0	132.0	72.0
7	TOTAL CLINICAL LABOR TIME	L041B	Rad Tech	56.0	0.0	0.0	0.0	60.0	0.0
8	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	3.0	30.0	0.0	60.0	3.0	30.0
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	125.0	6.0	0.0	6.0	93.0	6.0
10	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L041B	Rad Tech	56.0	0.0	0.0	0.0	60.0	0.0
11	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	36.0	36.0	0.0	36.0	36.0	36.0
12	PRE-SERVICE								
13	Start: Following visit when decision for surgery or procedure made								
14	Complete pre-service diagnostic & referral forms			0	5	0	5	0	5
15	Coordinate pre-surgery services			0	10	0	20	0	10
16	Schedule space and equipment in facility			0	5	0	8	0	5
17	Provide pre-service education/obtain consent			0	7	0	20	0	7
18	Follow-up phone calls & prescriptions			0	3	0	7	0	3
19	*Other Clinical Activity - specify: set up fluoro room	L041B		3	0	0	0	3	0
20	End: When patient enters office/facility for surgery/procedure								
21	SERVICE PERIOD								
22	Start: When patient enters office/facility for surgery/procedure:								
23	Greet patient, provide gowning, ensure appropriate medical records are available	L037D		3		0		3	
24	Obtain vital signs	L037D		5		0		3	
25	Provide pre-service education/obtain consent	L037D		3		0		3	
26	Prepare room, equipment, supplies	L037D		2		0		2	
27	Setup scope (non facility setting only)	L037D		5		0		0	
28	Prepare and position patient/ monitor patient/ set up IV	L037D		2		0		2	
29	Sedate/apply anesthesia	L037D		2		0		2	
30	*Other Clinical Activity - specify:								
31	Intra-service								
32	Assist physician in performing procedure	L037D	RN/LPN/MTA	70		0		60	
33	Assist physician in performing procedure	L041B	Rad Tech	51		0		55	
34	Post-Service								
35	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MTA	15		0		15	
36	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	3		0		3	
37	Clean Scope	L037D	RN/LPN/MTA	0		0		0	
38	Clean Surgical Instrument Package	L037D	RN/LPN/MTA	15		0		0	
39	Complete diagnostic forms, lab & X-ray requisitions								
40	Review/read X-ray, lab, and pathology reports								
41	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions								
42	*Other Clinical Activity - specify: Clean fluoro equipment	L041B	Rad Tech	5		0		5	
43	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			n/a	6	n/a	6	n/a	6
44	Dischrg mgmt (1.0 x 99238) (enter 12 min)			n/a		n/a		n/a	
45	Dischrg mgmt (1.0 x 99239) (enter 15 min)			n/a		n/a		n/a	
46	End: Patient leaves office								
47	POST-SERVICE Period								
48	Start: Patient leaves office/facility								
49	Conduct phone calls/call in prescriptions								
50	Office visits: List Number and Level of Office Visits			# visits		# visits		# visits	
51	99211 16 minutes								
52	99212 27 minutes								
53	99213 36 minutes	L037D	RN/LPN/MTA	1	1		1	1	1
54	99214 53 minutes								
55	99215 63 minutes								
56	Total Office Visit Time			36.0	36.0	0.0	36.0	36.0	36.0
57	*Other Clinical Activity - specify:								
58	End: with last office visit before end of global period								

	A	B	C	D	E	F	G	H	I
1				REFERENCE CODE		CURRENT INPUTS		RECOMMENDATION	
2	more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.			Reference CPT Code 63663		CPT Code 63650		CPT Code 63650	
3	Meeting Date: April 25-28, 2013 Tab: 22 Specialty: ASIPP,AAPM, AANS, CNS, ASA, ISIS	CMS Code	Staff Type	CPT CODE DESCRIPTOR Revision including replacement, when performed, of spinal neurostimulator electrode		CPT CODE DESCRIPTOR: Percutaneous implantation of neurostimulator electrode array, epidural		CPT CODE DESCRIPTOR: Percutaneous implantation of neurostimulator electrode array, epidural	
4	LOCATION			Non Fac	Fac	Non Fac	Fac	Non Fac	Fac
5	GLOBAL PERIOD			10	10	10	10	10	10
59	MEDICAL SUPPLIES**	CODE							
60	pack, minimum multi-specialty visit (includes the following) <i>Patient gown, disposable 1 item 11107</i> <i>Exam table paper 7 feet 11111</i> <i>Pillow case 1 item 11112</i> <i>Gloves, non-sterile 2 pair 11302</i> <i>Thermometer probe cover, disposable 1 item 11509</i>	SA048		2	1	0	1	2	1
61	pack, post-op incision care (suture) (includes the following) <i>Kit, suture removal (1 item)</i> <i>povidone soln (Betadine) (10 ml)</i> <i>gauze, sterile 4inx4in (2 items)</i> <i>gloves, sterile (1 pair)</i> <i>steri-strip (6 strip uou) (2 items)</i> <i>swab-pad, alcohol (2 items)</i> <i>tape, surgical paper 1 in (Micropore) (12 inches)</i> <i>tincture of benzoin, swab (1 item)</i>	SA054		1	1	0	1	1	1
62	pack, basic injection (includes the following) <i>applicator, sponge-tipped (3 items)</i> <i>bandage, strip 0.75in x 3in (1 item)</i> <i>cap, surgical (1 item)</i> <i>drape, sterile barrier 16in x 29in (1 item)</i> <i>drape, sterile, for Mayo stand (1 item)</i> <i>gauze, sterile 4in x 4in (2 items)</i> <i>gloves, sterile (2 pair)</i> <i>gown, staff, impervious (1 item)</i> <i>gown, surgical, sterile (1 item)</i> <i>lidocaine 1%-2% inj (Xylocaine) (5 ml)</i> <i>mask, surgical (1 item)</i> <i>needle, 18-27g (2 items)</i> <i>povidone soln (Betadine) (10 ml)</i> <i>syringe 3ml (1 item)</i> <i>underpad 2ftx3ft (Chux) (1 item)</i>	SA041		1		0		1	
63	pack, cleaning, surgical instruments (includes the following) <i>gloves, non-sterile</i> <i>gown staff, impervious</i> <i>face shield, splash protection</i> <i>autoclave bag</i> <i>autoclave tape</i> <i>enzymatic detergent</i> <i>cleaning brush, instruments</i>	SA043		1		0		0	
64	tray, epidural	SA064				0		0	
65	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item	1		0		1	
66	canister, suction	SD009	item	1		0		1	
67	electrode, ECG (single)	SD053				0		3	
68	suture, vicryl, 3-0 to 6-0, p, ps	SF040		1					
69	suture, silk, 2-0 to 5-0, x, fs, c	SF039				0		1	
70	cautery, monopolar, pencil-handpiece	SF020		1					
71	cautery, patient ground pad w-cord	SF021		1					
72	scalpel with blade, surgical (#10-20)	SF033		1					
73	chlorhexidine 4.0% (Hibiclens)	SH098				0		1	
74	kit, scissors and clamp	SA027				0		1	
75	drape, sterile, c-arm, fluoro	SB008				0		1	
76	drape, sterile, fenestrated 16in x 29in	SB011				0		1	
77	drape, sterile, three-quarter sheet	SB014		1					
78	drape-cover, sterile, OR light handle	SB016		1					
79	shoe covers, surgical	SB039		1					
80	scrub brush (impregnated)	SM023		1					
81	bandage, Kling, non-sterile 2in	SG017	item			0	2	2	2
82	Trial lead array	New				0		1	
83	Trial screening kit	New						1	

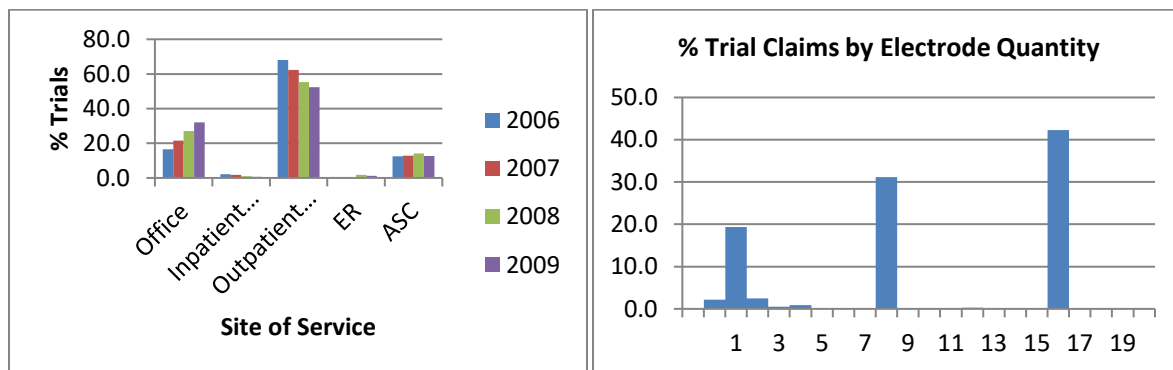
	A	B	C	D	E	F	G	H	I
1				REFERENCE CODE		CURRENT INPUTS		RECOMMENDATION	
2	more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.			Reference CPT Code <b>63663</b>		CPT Code <b>63650</b>		CPT Code <b>63650</b>	
3	Meeting Date: April 25-28, 2013 Tab: 22 Specialty: ASIPP,AAPM, AANS, CNS, ASA, ISIS	CMS Code	Staff Type	CPT CODE DESCRIPTOR Revision including replacement, when performed, of spinal neurostimulator electrode		CPT CODE DESCRIPTOR: Percutaneous implantation of neurostimulator electrode array, epidural		CPT CODE DESCRIPTOR: Percutaneous implantation of neurostimulator electrode array, epidural	
4	LOCATION			Non Fac	Fac	Non Fac	Fac	Non Fac	Fac
5	GLOBAL PERIOD			10	10	10	10	10	10
84	EQUIPMENT	CODE							
85	Fluoroscopic System, Mobile. C-Arm	ER031				0		69	
86	table, exam	EF023		36 minutes	36 minutes		36	36	36
87	table, fluoroscopy	EF024				0		84	
88	room, radiographic-fluoroscopic	EL014		99 minutes					
89	light, surgical	EF014		99 minutes					
90	x-ray view box, 4 panel	ER067		2 minutes					
91	stretcher	EF018		10 minutes		0		15	
92	electrocautery-hyfreacator, up to 45 watts	EQ110		99 minutes					
93	Instrument pack, basic (\$500-\$1499)	EQ137		99 minutes					
94	Vital Signs Monitor ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011				0		84	

### Background on CMS Request for 63650

With office based trials for spinal cord stimulation (SCS) the expense of the lead array is reimbursed using the Level II HCPCS code L8680 billed as one unit per each "electrode" or "contact". A typical lead array is an assembly of contacts consisting of 4, 8 and recently 16 contacts per lead array. In usual clinical parlance the array is referred to as the "lead" and each "electrode" as a "contact". More than one lead is often implanted.

CMS revised the long code descriptor for code L8680 effective January 2010 from *"implantable neurostimulator electrode, each"* to *"implantable neurostimulator electrode (with any number of contact points), each"*. The January 2010 DMEPOS payment for this code remained unchanged from 2009 to 2010. CMS previously clarified that use of the term "electrode" in the definition of L8680 referred, correctly, to each contact point and that the DMEPOS payment rate for L8680 was established on that basis. There are no PE RVUs established for the procedure in this setting. The average Medicare reimbursement is about \$430 per contact.

Whereas permanent SCS implant procedures are facility-based, over the past 10 years trials have increasingly migrated to the office setting. Current RUC database list utilization of 63650 in Physician office as 35.86%. From MarketScan® Commercial Claims and Encounters Database (MSCCAE) from Thomson Reuters (Healthcare) Inc. 2006 -2009:



The report of quantities 1 or 2 likely reflect incorrect documentation and represents 1 or 2 leads. The most common reported electrode quantity is 16 in this data base from 2009.

CMS issued the following statement in the 2012 MPFS on page 49-50:

*"Stakeholders have recently brought to our attention that CPT code 63650 (Percutaneous implantation of neurostimulator electrode array, epidural) is frequently furnished in the physician office setting but is not priced in that setting... We understand that disposable leads comprise a significant resource cost for this service and are currently separately reportable to Medicare for payment purposes when the service is furnished in the physician office setting. Disposable medical supplies are not considered prosthetic devices paid under the Durable Medical Equipment, Prosthetic/Orthotic, and Supplies (DMEPOS) fee schedule and generally are incorporated as nonfacility direct PE inputs to PE RVUs. We seek comment on establishing nonfacility PE RVUs for CPT code 63650"*

In 2012 this service was identified as potentially misvalued in the NPRM for 2013. The work was recently reviewed for CY 2012. The RUC recommended that the **PE only** be reviewed by the April 2013 meeting.

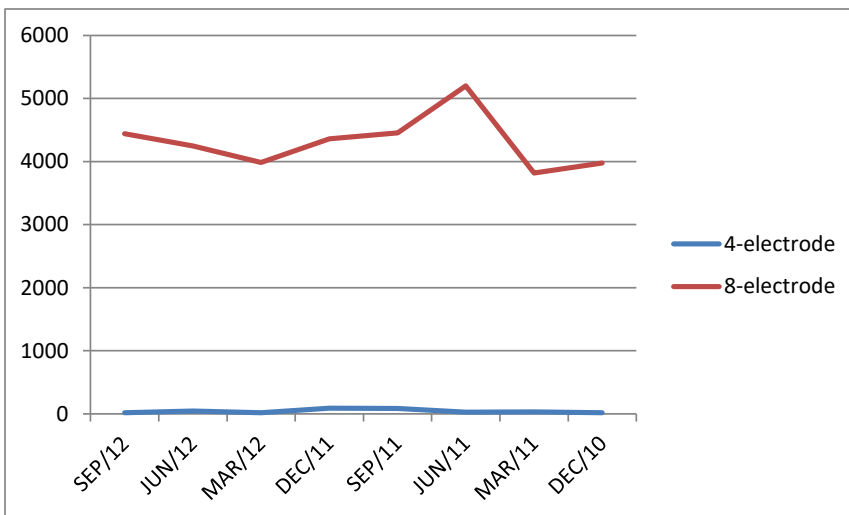
## Lead Pricing

Trial lead pricing from the major manufacturers is variable. It appears to be related to market forces including competitive concerns, volume of business by the implanter, geographic area and payor mix. While Industry does publish list pricing for the leads they are almost always highly discounted. In addition to the lead pricing *per se* s screening kit, usually one per patient (which includes a number of cables and programming devices) is required. Finally there are various regional dependent amounts of tax that is applied.

The lead array that is by far the most commonly used is an 8 electrode (contact) array. Although one manufacturer does supply 4 contract arrays the list pricing is within \$100. Additionally, one manufacturer (Boston Scientific Inc) has recently introduced a 16 contact array. Overall usage in the non-facility setting is unknown but given the new entry into the market is likely to low. List pricing on this lead is \$3900 as compared to \$1815 for the 8 contact array. Medtronic list price for all leads and models is the same at \$1390. Market prices are unclear, variable and viewed as confidential by the manufacturers.

## IMS Health Hospital Supply Index volume – 8-e vs 4-e lead sales

Trial lead models only, not permanent used for temporary trials.



We have provided de-identified representative invoices for 8 electrode trial leads from all three of the major manufacturers and from various practice settings and regions. The range is \$500 to \$1150 each in this sampling. Screening kits range from \$50 to \$200 depending on manufacturer, region and discount. In some cases this appears to be bundled into the invoice price for two leads.



	A	B	C	D	E	F	G	H	I
1				REFERENCE CODE		CURRENT INPUTS		RECOMMENDATION	
2	more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.			Reference CPT Code <b>63663</b>		CPT Code <b>63650</b>		CPT Code <b>63650</b>	
3	Meeting Date: April 25-28, 2013 Tab: 22 Specialty: ASIPP,AAPM, AANS, CNS, ASA, ISIS	CMS Code	Staff Type	CPT CODE DESCRIPTOR: Revision including replacement, when performed, of spinal neurostimulator electrode		CPT CODE DESCRIPTOR: Percutaneous implantation of neurostimulator electrode array, epidural		CPT CODE DESCRIPTOR: Percutaneous implantation of neurostimulator electrode array, epidural	
4	LOCATION			Non Fac	Fac	Non Fac	Fac	Non Fac	Fac
5	GLOBAL PERIOD			10	10	10	10	10	10
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	164.0	72.0	0.0	102.0	147.0	72.0
7	TOTAL CLINICAL LABOR TIME	L041B	Rad Tech	56.0	0.0	0.0	0.0	60.0	0.0
8	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	3.0	30.0	0.0	60.0	3.0	30.0
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	125.0	6.0	0.0	6.0	108.0	6.0
10	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L041B	Rad Tech	56.0	0.0	0.0	0.0	60.0	0.0
11	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	36.0	36.0	0.0	36.0	36.0	36.0
12	PRE-SERVICE								
13	Start: Following visit when decision for surgery or procedure made								
14	Complete pre-service diagnostic & referral forms			0	5	0	5	0	5
15	Coordinate pre-surgery services			0	10	0	20	0	10
16	Schedule space and equipment in facility			0	5	0	8	0	5
17	Provide pre-service education/obtain consent			0	7	0	20	0	7
18	Follow-up phone calls & prescriptions			0	3	0	7	0	3
19	*Other Clinical Activity - specify: set up fluoro room	L041B		3	0	0	0	3	0
20	End: When patient enters office/facility for surgery/procedure								
21	SERVICE PERIOD								
22	Start: When patient enters office/facility for surgery/procedure:								
23	Greet patient, provide gowning, ensure appropriate medical records are available	L037D		3		0		3	
24	Obtain vital signs	L037D		5		0		3	
25	Provide pre-service education/obtain consent	L037D		3		0		3	
26	Prepare room, equipment, supplies	L037D		2		0		2	
27	Setup scope (non facility setting only)	L037D		5		0		0	
28	Prepare and position patient/ monitor patient/ set up IV	L037D		2		0		2	
29	Sedate/apply anesthesia	L037D		2		0		2	
30	*Other Clinical Activity - specify:								
31	Intra-service								
32	Assist physician in performing procedure	L037D	RN/LPN/MTA	70		0		60	
33	Assist physician in performing procedure	L041B	Rad Tech	51		0		55	
34	Post-Service								
35	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MTA	15		0		15	
36	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	3		0		3	
37	Clean Scope	L037D	RN/LPN/MTA	0		0		0	
38	Clean Surgical Instrument Package	L037D	RN/LPN/MTA	15		0		15	
39	Complete diagnostic forms, lab & X-ray requisitions								
40	Review/read X-ray, lab, and pathology reports								
41	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions								
42	*Other Clinical Activity - specify: Clean fluoro equipment	L041B	Rad Tech	5		0		5	
43	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			n/a	6	n/a	6	n/a	6
44	Dischrg mgmt (1.0 x 99238) (enter 12 min)			n/a		n/a		n/a	
45	Dischrg mgmt (1.0 x 99239) (enter 15 min)			n/a		n/a		n/a	
46	End: Patient leaves office								
47	POST-SERVICE Period								
48	Start: Patient leaves office/facility								
49	Conduct phone calls/call in prescriptions								
50	Office visits: List Number and Level of Office Visits			# visits		# visits		# visits	
51	99211 16 minutes								
52	99212 27 minutes								
53	99213 36 minutes	L037D	RN/LPN/MTA	1	1		1	1	1
54	99214 53 minutes								
55	99215 63 minutes								
56	Total Office Visit Time			36.0	36.0	0.0	36.0	36.0	36.0
57	*Other Clinical Activity - specify:								
58	End: with last office visit before end of global period								

	A	B	C	D	E	F	G	H	I
1				REFERENCE CODE		CURRENT INPUTS		RECOMMENDATION	
2	more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.			Reference CPT Code 63663		CPT Code 63650		CPT Code 63650	
3	Meeting Date: April 25-28, 2013 Tab: 22 Specialty: ASIPP,AAPM, AANS, CNS, ASA, ISIS	CMS Code	Staff Type	CPT CODE DESCRIPTOR Revision including replacement, when performed, of spinal neurostimulator electrode		CPT CODE DESCRIPTOR: Percutaneous implantation of neurostimulator electrode array, epidural		CPT CODE DESCRIPTOR: Percutaneous implantation of neurostimulator electrode array, epidural	
4	LOCATION			Non Fac	Fac	Non Fac	Fac	Non Fac	Fac
5	GLOBAL PERIOD			10	10	10	10	10	10
59	MEDICAL SUPPLIES**	CODE							
60	pack, minimum multi-specialty visit (includes the following) <i>Patient gown, disposable 1 item 11107</i> <i>Exam table paper 7 feet 11111</i> <i>Pillow case 1 item 11112</i> <i>Gloves, non-sterile 2 pair 11302</i> <i>Thermometer probe cover, disposable 1 item 11509</i>	SA048		2	1	0	1	2	1
61	pack, post-op incision care (suture) (includes the following) <i>Kit, suture removal (1 item)</i> <i>povidone soln (Betadine) (10 ml)</i> <i>gauze, sterile 4inx4in (2 items)</i> <i>gloves, sterile (1 pair)</i> <i>steri-strip (6 strip uou) (2 items)</i> <i>swab-pad, alcohol (2 items)</i> <i>tape, surgical paper 1 in (Micropore) (12 inches)</i> <i>tincture of benzoin, swab (1 item)</i>	SA054		1	1	0	1	1	1
62	pack, basic injection (includes the following) <i>applicator, sponge-tipped (3 items)</i> <i>bandage, strip 0.75in x 3in (1 item)</i> <i>cap, surgical (1 item)</i> <i>drape, sterile barrier 16in x 29in (1 item)</i> <i>drape, sterile, for Mayo stand (1 item)</i> <i>gauze, sterile 4in x 4in (2 items)</i> <i>gloves, sterile (2 pair)</i> <i>gown, staff, impervious (1 item)</i> <i>gown, surgical, sterile (1 item)</i> <i>lidocaine 1%-2% inj (Xylocaine) (5 ml)</i> <i>mask, surgical (1 item)</i> <i>needle, 18-27g (2 items)</i> <i>povidone soln (Betadine) (10 ml)</i> <i>syringe 3ml (1 item)</i> <i>underpad 2ftx3ft (Chux) (1 item)</i>	SA041		1		0		1	
63	pack, cleaning, surgical instruments (includes the following) <i>gloves, non-sterile</i> <i>gown staff, impervious</i> <i>face shield, splash protection</i> <i>autoclave bag</i> <i>autoclave tape</i> <i>enzymatic detergent</i> <i>cleaning brush, instruments</i>	SA043		1		0		1	
64	tray, epidural	SA064				0		0	
65	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item	1		0		1	
66	canister, suction	SD009	item	1		0		1	
67	electrode, ECG (single)	SD053				0		3	
68	suture, vicryl, 3-0 to 6-0, p, ps	SF040		1					
69	suture, silk, 2-0 to 5-0, x, fs, c	SF039				0		1	
70	cautery, monopolar, pencil-handpiece	SF020		1					
71	cautery, patient ground pad w-cord	SF021		1					
72	scalpel with blade, surgical (#10-20)	SF033		1					
73	chlorhexidine 4.0% (Hibiclens)	SH098				0		1	
74	kit, scissors and clamp	SA027				0		1	
75	drape, sterile, c-arm, fluoro	SB008				0		1	
76	drape, sterile, fenestrated 16in x 29in	SB011				0		1	
77	drape, sterile, three-quarter sheet	SB014		1					
78	drape-cover, sterile, OR light handle	SB016		1					
79	shoe covers, surgical	SB039		1					
80	scrub brush (impregnated)	SM023		1					
81	bandage, Kling, non-sterile 2in	SG017	item			0	2	2	2
82	Array	New				0		2	



	A	B	C	D	E	F	G	H	I
1				REFERENCE CODE		CURRENT INPUTS		RECOMMENDATION	
2	more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.			Reference CPT Code 63663		CPT Code 63650		CPT Code 63650	
3	Meeting Date: April 25-28, 2013 Tab: 22 Specialty: ASIPP,AAPM, AANS, CNS, ASA, ISIS	CMS Code	Staff Type	CPT CODE DESCRIPTOR Revision including replacement, when performed, of spinal neurostimulator electrode		CPT CODE DESCRIPTOR: Percutaneous implantation of neurostimulator electrode array, epidural		CPT CODE DESCRIPTOR: Percutaneous implantation of neurostimulator electrode array, epidural	
4	LOCATION			Non Fac	Fac	Non Fac	Fac	Non Fac	Fac
5	GLOBAL PERIOD			10	10	10	10	10	10
83	EQUIPMENT	CODE							
84	Fluoroscopic System, Mobile. C-Arm	ER031				0		60	
85	table, exam	EF023		36 minutes	36 minutes		36	36	36
86	table, fluoroscopy	EF024				0		60	
87	room, radiographic-fluoroscopic	EL014		99 minutes					
88	light, surgical	EF014		99 minutes					
89	x-ray view box, 4 panel	ER067		2 minutes					
90	stretcher	EF018		10 minutes		0		10	
91	electrocautery-hyfreacator, up to 45 watts	EQ110		99 minutes					
92	Instrument pack, basic (\$500-\$1499)	EQ137		99 minutes					
93	Vital Signs Monitor ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011				0		60	

AMA/Specialty Society RVS Update Committee Summary of Recommendations  
*Harvard-Valued Annual Allowed Charges Greater than \$10 million Screen*

April 2013

**Aqueous Shunt**

CPT code 66180 was identified through the Harvard-Valued Annual Allowed Charges  $\geq$  \$10 million screen. In January 2013, the RUC recommended survey of physician work and review of practice expense for this family of services. The direct practice expense inputs were reviewed at the January 2013 meeting. However, the review of physician work was postponed for review at the April 2013 RUC meeting in order to assure the surveyed post-operative visits were calculated correctly.

In April 2013, the American Academy of Ophthalmology noted that based on data from the last meeting the specialty society was informed that 66180 is typically reported (73%) with 67255 *Scleral reinforcement (separate procedure); with graft* and it appears that these services should be surveyed as a bundled code. The specialty society requested that 66180 and 66185 be referred to CPT to create codes to describe with and without patch. The specialty society also noted that they will survey 67255 with this family of services. **The RUC agreed and recommends that these services be referred to the CPT Editorial Panel for revision.**

**Practice Expense**

The Practice Expense Subcommittee reviewed the direct practice expense inputs for 66180 and 66185 in January 2013. The RUC recommends reaffirming the practice expense inputs as reviewed and approved by the RUC at the January 2013 RUC meeting.

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
66180	Aqueous shunt to extraocular reservoir (eg, Molteno, Schocket, Denver-Krupin)	090	Refer to CPT (Practice Expense Recommendations attached)

66185	Revision of aqueous shunt to extraocular reservoir  (For removal of implanted shunt, use 67120)	090	Refer to CPT  (Practice Expense Recommendations attached)
67255	Scleral reinforcement (separate procedure); with graft	090	Refer to CPT

**AMA/Specialty Society Update Process**  
**Practice Expense Summary of Recommendation**  
**Facility Direct Inputs**

CPT Long Descriptor: 66180 Aqueous shunt to extraocular reservoir (eg, Molteno, Schocket, Denver-Krupin)

Global Period: 090

Meeting Date: 4/2013

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Academy convenes a Consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. Additionally we use other physicians who have the appropriate expertise. The consensus committee reviewed the current PE details and made the appropriate changes to clinical time in order to match the survey results and any standard packages that are now applicable as compared to the current facility input. The existing supplies and equipment were also reviewed and any needed adjustments were also applied.

If you have provided any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:

This code is an existing code being evaluated per CMS request in the 2013 NPRM Table 7.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Standard 90-day global times to: Complete pre-service diagnostic & referral forms; Coordinate pre-surgery services; Schedule space and equipment in facility; Provide pre-service education/obtain consent, and follow-up phone calls & prescriptions.

Intra-Service Clinical Labor Activities:

Standard 6 minutes for discharge day management coordination.

Post-Service Clinical Labor Activities:

Standard times for 8 post-operative office visits at the appropriate levels.

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor: 66185 Revision of aqueous shunt to extraocular reservoir

Global Period: 090

Meeting Date: 4/2013

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Academy convenes a Consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. Additionally we use other physicians who have the appropriate expertise. The consensus committee reviewed the current PE details and made the appropriate changes to clinical time in order to match the survey results and any standard packages that are now applicable as compared to the current facility input. The existing supplies and equipment were also reviewed and any needed adjustments were also applied

If you have provided any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:

This code is an existing code being evaluated per CMS request in the 2013 NPRM Table 7.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Standard 90-day global times to: Complete pre-service diagnostic & referral forms; Coordinate pre-surgery services; Schedule space and equipment in facility; Provide pre-service education/obtain consent, and follow-up phone calls & prescriptions.

Intra-Service Clinical Labor Activities:

Standard 6 minutes for discharge day management coordination.

Post-Service Clinical Labor Activities:

Standard times for 7 post-operative office visits at the appropriate levels.

	A	B	C	D	E	F	G	H	I	J	K	L	M
1				<b>REFERENCE CODE</b>		Tab 23		<b>REFERENCE CODE</b>		Tab 23		Tab 14 (In the family as 66180/66185)	
2	<b>Note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.</b>			<b>66180</b>		<b>66180</b>		<b>66185</b>		<b>66185</b>		<b>6618x1</b>	
3	<b>Meeting Date: 4/2013 Tab: 14/23 Specialty: Ophthalmology</b>	<b>CMS Code</b>	<b>Staff Type</b>	Aqueous shunt to extraocular reservoir		Aqueous shunt to extraocular reservoir		Revision of Aqueous shunt to extraocular reservoir		Revision of Aqueous shunt to extraocular reservoir		Insertion of anterior segment drainage device, without extraocular reservoir	
4	<b>LOCATION</b>			<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>
5	<b>GLOBAL PERIOD</b>			<b>N/A</b>	<b>90</b>	<b>N/A</b>	<b>90</b>	<b>N/A</b>	<b>90</b>	<b>N/A</b>	<b>90</b>	<b>N/A</b>	<b>90</b>
6	<b>TOTAL CLINICAL LABOR TIME</b>				<b>264</b>	<b>0.0</b>	<b>327.0</b>		<b>228.0</b>	<b>0.0</b>	<b>291.0</b>	<b>0.0</b>	<b>363.0</b>
7	<b>TOTAL PRE-SERV CLINICAL LABOR TIME</b>				<b>60</b>	<b>0.0</b>	<b>60.0</b>		<b>60.0</b>	<b>0.0</b>	<b>60.0</b>	<b>0.0</b>	<b>60.0</b>
8	<b>TOTAL SERVICE PERIOD CLINICAL LABOR TIME</b>				<b>6</b>	<b>0.0</b>	<b>6.0</b>		<b>6.0</b>	<b>0.0</b>	<b>6.0</b>	<b>0.0</b>	<b>6.0</b>
9	<b>TOTAL POST-SERV CLINICAL LABOR TIME</b>				<b>198</b>	<b>0.0</b>	<b>261.0</b>		<b>162.0</b>	<b>0.0</b>	<b>225.0</b>	<b>0.0</b>	<b>297.0</b>
10	<b>PRE-SERVICE</b>												
11	<b>Start: Following visit when decision for surgery or procedure made</b>												
12	Complete pre-service diagnostic & referral forms	L038A	COMT/COT/RN/CST		<b>5</b>		<b>5</b>		<b>5</b>		<b>5</b>		<b>5</b>
13	Coordinate pre-surgery services	L038A	COMT/COT/RN/CST		<b>20</b>		<b>20</b>		<b>20</b>		<b>20</b>		<b>20</b>
14	Schedule space and equipment in facility	L038A	COMT/COT/RN/CST		<b>8</b>		<b>8</b>		<b>8</b>		<b>8</b>		<b>8</b>
15	Provide pre-service education/obtain consent	L038A	COMT/COT/RN/CST		<b>20</b>		<b>20</b>		<b>20</b>		<b>20</b>		<b>20</b>
16	Follow-up phone calls & prescriptions	L038A	COMT/COT/RN/CST		<b>7</b>		<b>7</b>		<b>7</b>		<b>7</b>		<b>7</b>
17	Other Clinical Activity - <i>specify</i> :												
18	<b>End: When patient enters office/facility for surgery/procedure</b>												
19	<b>SERVICE PERIOD</b>												
20	<b>Start: When patient enters office/facility for surgery/procedure:</b>												
30	<b>Post-Service</b>												
38	Other Clinical Activity - <i>specify</i> :												
39	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)				<b>6</b>	<b>n/a</b>	<b>6</b>		<b>6</b>	<b>n/a</b>	<b>6</b>	<b>n/a</b>	<b>6</b>
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)					<b>n/a</b>				<b>n/a</b>		<b>n/a</b>	
41	Dischrg mgmt (1.0 x 99239) (enter 15 min)					<b>n/a</b>				<b>n/a</b>		<b>n/a</b>	
42	<b>End: Patient leaves office</b>												
43	<b>POST-SERVICE Period</b>												
44	<b>Start: Patient leaves office/facility</b>												
45	Conduct phone calls/call in prescriptions												
46	<b>Office visits: List Number and Level of Office Visits</b>			<b># visits</b>	<b># visits</b>	<b># visits</b>	<b># visits</b>	<b># visits</b>	<b># visits</b>	<b># visits</b>	<b># visits</b>	<b># visits</b>	<b># visits</b>
47	99211 16 minutes		16										
48	99212 27 minutes		27				<b>3</b>				<b>3</b>		<b>3</b>
49	99213 36 minutes		36		<b>5.5</b>		<b>5</b>		<b>4.5</b>		<b>4</b>		<b>6</b>
50	99214 53 minutes		53										
51	99215 63 minutes		63										
52	<b>Total Office Visit Time</b>	L038A	COMT/COT/RN/CST		<b>198</b>	<b>0.0</b>	<b>261.0</b>		<b>162.0</b>	<b>0.0</b>	<b>225.0</b>	<b>0.0</b>	<b>297.0</b>
53	Other Clinical Activity - <i>specify</i> :												
54	<b>End: with last office visit before end of global period</b>												

AMA Specialty Society Recommendation

	A	B	C	D	E	F	G	H	I	J	K	L	M
1				<b>REFERENCE CODE</b>		Tab 23		<b>REFERENCE CODE</b>		Tab 23		Tab 14 (In the family as 66180/66185)	
2	<b>Note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.</b>			<b>66180</b>		<b>66180</b>		<b>66185</b>		<b>66185</b>		<b>6618x1</b>	
3	<b>Meeting Date: 4/2013 Tab: 14/23 Specialty: Ophthalmology</b>	<b>CMS Code</b>	<b>Staff Type</b>	Aqueous shunt to extraocular reservoir		Aqueous shunt to extraocular reservoir		Revision of Aqueous shunt to extraocular reservoir		Revision of Aqueous shunt to extraocular reservoir		Insertion of anterior segment drainage device, without extraocular reservoir	
4	<b>LOCATION</b>			<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>
5	<b>GLOBAL PERIOD</b>			<b>N/A</b>	<b>90</b>	<b>N/A</b>	<b>90</b>	<b>N/A</b>	<b>90</b>	<b>N/A</b>	<b>90</b>	<b>N/A</b>	<b>90</b>
55	<b>MEDICAL SUPPLIES</b>	<b>CODE</b>	<b>UNIT</b>										
56	pack, ophthalmology visit (w dilation)	SA082	pack		<b>5.5</b>		<b>8</b>		<b>4.5</b>		<b>7</b>		<b>9</b>
57	Povidone soln (Betadine)	SJ041	ml		<b>24</b>				<b>24</b>				
58	Blade, surgical, super	SF006	each		<b>1</b>				<b>1</b>				
59	lidocaine 2% w-epi inj	SH049	ml		<b>20</b>				<b>20</b>				
60	prednisolone acet 1% oph soln (5ml)	SJ041	5ml		<b>1</b>				<b>1</b>				
61	<b>EQUIPMENT</b>	<b>CODE</b>											
62	Lane, exam (oph)	EL005	minutes		<b>198</b>		<b>261</b>		<b>162</b>		<b>225</b>		<b>297</b>
63													
64													
65													
66													

AMA/Specialty Society RVS Update Committee Summary of Recommendations  
*Harvard-Valued Annual Allowed Charges Greater than \$10 million Screen*

April 2013

**Repair of Eyelid**

CPT code 67917 *Repair of ectropion; extensive (eg, tarsal strip operations)* was identified through the Harvard-Valued Annual Allowed Charges  $\geq$  \$10 million screen. In October 2012, the RUC recommended survey of physician work and review of practice expense for this family of services at the April 2013 RUC meeting.

The RUC noted that for all the codes the current values were below the 25<sup>th</sup> percentile of the survey. The RUC evaluated potential cross-walk codes for each code and considered whether they supported the current value, a lower value or a higher value. For many of the codes, the RUC determined that the current value undervalued the service, but there was not compelling evidence to justify an increase above current values. After a robust discussion of the codes, the RUC determined that the current values or lower values were appropriate and identified cross-walk codes to justify current values. Deliberations of the RUC were made more difficult by a scarcity of RUC-surveyed cross-walk codes with the same global period and similar intra times and total times.

**67914 Repair of ectropion; suture**

The RUC reviewed the survey results from 33 ophthalmologists for CPT code 67914 and determined that the current work RVU of 3.75 appropriately accounts for the physician work required to perform this service. The survey 25<sup>th</sup> percentile work RVU was above the current work RVU, but the specialty societies indicated and the RUC agreed that there was not compelling evidence to increase the value. This 090-day global service includes 25 minutes pre-service, 20 minutes intra-service, 10 minutes immediate post-service, a half day discharge day management and 3 office visits. The RUC compared 67914 to 26160 *Excision of lesion of tendon sheath or joint capsule (eg, cyst, mucous cyst, or ganglion), hand or finger* (090-day global, work RVU = 3.57, 20 minutes intra-service time, a half day discharge day management and 3 office visits) and 21073 *Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an anesthesia service (ie, general or monitored anesthesia care)* (090-day global, work RVU = 3.35, 20 minutes intra-service time, and 4 office visits) and determined that a work RVU of 3.75 for 67914 is appropriate relative to these similar services. **The RUC recommends a work RVU of 3.75 for CPT code 67914.**



### **67915 Repair of ectropion; thermocauterization**

The RUC reviewed CPT code 67915 and determined that the survey respondents overestimated the work required to perform these services. Therefore, the RUC recommends a crosswalk to CPT code 28470 *Closed treatment of metatarsal fracture; without manipulation, each* (090-global, work RVU = 2.03, 15 minutes of intra-service time and 3 office visits). CPT code 67915 is a 090-day global service that includes 23 minutes pre-service, 10 minutes intra-service, 5 minutes immediate post-service and 2 office visits. CPT code 67915 requires 5 minutes less intra-service time than 28470, but is more intense involving a procedure on the eye compared to the foot. For additional support, the RUC referenced similar service 46945 *Hemorrhoidectomy, internal, by ligation other than rubber band; single hemorrhoid column/group* (090-global, work RVU = 2.21, 15 minutes intra-service time and 2 office visits). **The RUC recommends a work RVU of 2.03 for CPT codes 67915.**

### **67916 Repair of ectropion; excision tarsal wedge**

The RUC reviewed CPT code 67916 and determined that the current work RVU of 5.48 appropriately accounts for the physician work required to perform this service. The survey 25<sup>th</sup> percentile work RVU was above the current work RVU, but the specialty societies indicated and the RUC agreed that there was not compelling evidence to increase the work value at this time. CPT code 67916 is a 090-day global service that includes 25 minutes pre-service, 25 minutes intra-service, 10 minutes immediate post-service, a half day discharge day management and 3 office visits. The RUC compared 67916 to 28525 *Open treatment of fracture, phalanx or phalanges, other than great toe, includes internal fixation, when performed, each* (090-day global, work RVU = 5.62, 30 minutes intra-service time, a half day discharge day management and 4 office visits) and determined that 28525 requires 5 more minutes of intra-service time and slightly more physician work than the surveyed service. Thus, using magnitude estimation the RUC recommends maintaining the current work RVU. **The RUC recommends a work RVU of 5.48 for CPT code 67916.**

### **67917 Repair of ectropion; extensive (eg, tarsal strip operations)**

The RUC reviewed the survey results from 34 ophthalmologists for CPT code 67917 and compared it to 67924 *Repair of entropion; extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)* (recommended work RVU = 5.93). CPT code 67917 is a 090-day global service that includes 25 minutes pre-service, 33 minutes intra-service, 10 minutes immediate post-service, a half day discharge day management and 3 office visits. The RUC noted that 67917 requires 33 minutes intra-service time compared to 40 minutes intra-service time for 67924, however it is more intense to perform extensive repair to the ectropion. The specialty societies indicated and the RUC agreed that the current work RVU of 6.19 for 67917 represents too much of a difference between the repair of the entropion service and should be the same as 67924. The RUC also compared 67917 to similar services 58600 *Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral* (090-day global, work RVU 5.91, 35 minutes intra-service time, 1 discharge day management and 1 office visit) and 23071 *Excision, tumor, soft tissue of*

*shoulder area, subcutaneous; 3 cm or greater* (090-day global, work RVU=5.91, 45 minutes intra-service time, a half day discharge day management and 2 office visits) and determined a work RVU of 5.93 is appropriate compared to these similar services. **The RUC recommends a work RVU of 5.93 for CPT code 67917.**

#### **67921 Repair of entropion; suture**

The RUC reviewed the survey results from 34 ophthalmologists for CPT code 67921 and determined that the current work RVU of 3.47 appropriately accounts for the work required to perform this service. CPT code 67921 is a 090-day global service that includes 25 minutes pre-service, 15 minutes intra-service, 5 minutes immediate post-service, a half day discharge day management and 3 office visits. For additional support to maintain the current value, the RUC referenced similar services 21073 *Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an anesthesia service (ie, general or monitored anesthesia care)* (090-day global, work RVU=3.45, 20 minutes intra-service time and 4 office visits) and 26160 *Excision of lesion of tendon sheath or joint capsule (eg, cyst, mucous cyst, or ganglion), hand or finger* (090-day global, work RVU = 3.57, 20 minutes intra-service time, a half day discharge day management and 3 office visits). **The RUC recommends a work RVU of 3.47 for CPT code 67921.**

#### **67922 Repair of entropion; thermocauterization**

The RUC reviewed CPT code 67922 and determined that the survey respondents overestimated the work required to perform these services. Therefore, the RUC recommends a crosswalk to CPT code 28470 *Closed treatment of metatarsal fracture; without manipulation, each* (090-global, work RVU = 2.03, 15 minutes of intra-service time and 3 office visits). CPT code 67922 is a 090-day global service that includes 23 minutes pre-service, 10 minutes intra-service, 10 minutes immediate post-service and 2 office visits. CPT code 67922 requires 5 minutes less intra-service time than 28470, but is more intense involving a procedure on the eye compared to the foot. For additional support, the RUC referenced similar service 46945 *Hemorrhoidectomy, internal, by ligation other than rubber band; single hemorrhoid column/group* (090-global, work RVU = 2.21, 15 minutes intra-service time and 2 office visits). **The RUC recommends a work RVU of 2.03 for CPT codes 67922.**

#### **67923 Repair of entropion; excision tarsal wedge**

The RUC reviewed CPT code 67923 and determined it requires the same physician work as 67916 *Repair of ectropion; excision tarsal wedge* (recommending a work RVU of 5.48). CPT code 67923 is a 090-day global service that includes 25 minutes pre-service, 25 minutes intra-service, 10 minutes immediate post-service, a half day discharge day management and 3 office visits. The RUC compared 67923 to 28525 *Open treatment of fracture, phalanx or phalanges, other than great toe, includes internal fixation, when performed, each* (090-day global, work RVU = 5.62, 30 minutes intra-service time, a half day discharge day management and 4 office visits) and determined that 28525 requires 5 more minutes of intra-

service time and slightly more physician work than the surveyed service, therefore using magnitude estimation a work RVU of 5.48 appropriately places CPT code 67923 relative to other similar services. The RUC recommends reducing the work RVU to 5.48 for CPT code 67923, the same as 67916. **The RUC recommends a work RVU of 5.48 for CPT code 67923.**

**67924 Repair of entropion; extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)**

The RUC reviewed 67924 and determined that the current work RVU of 5.93 appropriately accounts for the physician work required to perform this service. CPT code 67924 is a 090-day global service that includes 25 minutes pre-service, 40 minutes intra-service, 10 minutes immediate post-service, a half day discharge day management and 3 office visits. The RUC supported maintaining the current work RVU comparing 67924 to similar services 58600 *Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral* (090-day global, work RVU 5.91, 35 minutes intra-service time, 1 discharge day management and 1 office visit) and 23071 *Excision, tumor, soft tissue of shoulder area, subcutaneous; 3 cm or greater* (090-day global, work RVU=5.91, 45 minutes intra-service time, a half day discharge day management and 2 office visits). **The RUC recommends a work RVU of 5.93 for CPT code 67924.**

**Work Neutrality**

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

**Practice Expense**

The RUC accepted the direct PE inputs with modifications as recommended by the PE Subcommittee.

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
67914	Repair of ectropion; suture	090	3.75 (No Change)
67915	thermocauterization	090	2.03

67916	excision tarsal wedge	090	5.48 (No Change)
67917	extensive (eg, tarsal strip operations) (For correction of everted punctum, use 68705)	090	5.93
67921	Repair of entropion; suture	090	3.47 (No Change)
67922	thermocauterization	090	2.03
67923	excision tarsal wedge	090	5.48
67924	extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation) (For repair of cicatricial ectropion or entropion requiring scar excision or skin graft, see also 67961 et seq)	090	5.93 (No Change)

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 67914	Tracking Number	Original Specialty Recommended RVU: <b>3.75</b>
		Presented Recommended RVU: <b>3.75</b>
Global Period: 090		RUC Recommended RVU: <b>3.75</b>

CPT Descriptor: Repair of ectropion; suture

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 70 year old female has progressive ocular irritation, redness, and daily eyelash matting associated with the lower eyelid margin lifted off the eye. Her symptoms do not respond to eyelid hygiene, topical lubricants, antibiotics and steroids. The examination confirms eversion of the lower eyelid margin and breakdown of the ocular surface.

Percentage of Survey Respondents who found Vignette to be Typical: 73%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 6% , In the ASC 39%, In the office 55%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 68%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 19%

Description of Pre-Service Work: The patient history, physical exam and appropriate preoperative tests are reviewed. The preoperative interval history and exam are documented. Photographs are reviewed. The surgical plan is discussed with the patient, all questions are addressed and surgical consent is reviewed. The forehead is marked to indicate the operative eye. The patient is positioned and the surgical eye is confirmed with the patient, surgical and anesthesia team. The eye and periocular area are prepped and draped. After conscious sedation is initiated, the surgeon adds topical anesthesia to both eyes and injects a local anesthetic block to the operative eyelid while the patient is monitored. The eye and periocular area are prepped and draped.

Description of Intra-Service Work: The lower eyelid conjunctiva is grasped with forceps just below the tarsus and pushed inferiorly to estimate the amount of rotation needed to replace the eyelid margin against the globe. An appropriate lower eyelid crease is marked with methylene blue. A series of double armed 4-0 absorbable horizontal mattress sutures are placed full thickness through the eyelid from the conjunctival side just inferior to the tarsus, grasping the lower eyelid retractors and emerging from the marked lower eyelid skin crease. This requires four sutures to provide a stable eyelid margin. Hemostasis is obtained with direct pressure. The sutures are tied to create a deep cutaneous crease and rotate the eyelid margin an appropriate amount. The sutures may require removal and/or adjustment to ensure the eyelid margin, crease and lash positions are adequate.

Description of Post-Service Work: The eye, incision and eyelids are cleaned and the wounds dressed with antibiotic drops and ointment. Pain management is discussed and the IV removed. The patient and family are given detailed postoperative care instructions and appropriate prescriptions. An operative report is prepared, and required paperwork completed. Follow-up visits are scheduled.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Stephen A. Kamenetzky, M.D./Tamara Fountain, M.D.				
<b>Specialty(s):</b>	AAO and American Society of Ophthalmic Plastic and Reconstructive Surgeons				
<b>CPT Code:</b>	67914				
<b>Sample Size:</b>	368	<b>Resp N:</b>	33	<b>Response:</b> 8.9 %	
<b>Description of Sample:</b>	Random sample of members were pulled from the AAO and American Society of Ophthalmic Plastic and Reconstructive Surgeons membership databases.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	0.00	10.00	30.00	100.00
<b>Survey RVW:</b>	0.90	4.22	5.25	6.80	12.00
<b>Pre-Service Evaluation Time:</b>			30.00		
<b>Pre-Service Positioning Time:</b>			5.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10.00		
<b>Intra-Service Time:</b>	3.00	15.00	20.00	25.00	45.00
<b>Immediate Post Service-Time:</b>	<b>10.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>114.00</b>	99238x 1.00 99239x 0.00 99217x 2.00			
<b>Office time/visit(s):</b>	<b>69.00</b>	99211x 0.00 12x 0.00 13x 3.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1b-FAC Straightforw Pat Procedure(w sedate/anes)

<b>CPT Code:</b>	67914	<b>Recommended Physician Work RVU: 3.75</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		19.00	19.00	0.00
<b>Pre-Service Positioning Time:</b>		1.00	1.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00
<b>Intra-Service Time:</b>		20.00		
<b>Immediate Post Service-Time:</b>	<b>10.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>19.00</b>	99238x 0.5 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>55.00</b>	99211x 0.00 12x 2.00 13x 1.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00		

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
67911	090	7.50	RUC Time

CPT Descriptor Correction of lid retraction**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
21031	090	3.30	RUC Time	818

CPT Descriptor 1 Excision of torus mandibularis

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
64721	090	4.97	RUC Time	110,695

CPT Descriptor 2 Neuroplasty and/or transposition; median nerve at carpal tunnel

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
26160	090	3.57	RUC Time

CPT Descriptor Excision of lesion of tendon sheath or joint capsule (eg, cyst, mucous cyst, or ganglion), hand or finger**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11      % of respondents: 33.3 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 67914</b>	<b>Key Reference CPT Code: 67911</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	25.00	35.00	
Median Intra-Service Time	20.00	50.00	
Median Immediate Post-service Time	10.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	55.0	64.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
<b>Median Total Time</b>	<b>129.00</b>	<b>183.00</b>	
<b>Other time if appropriate</b>			

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.18	3.27
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.91	3.18
--	------	------

Urgency of medical decision making	2.45	2.64
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.27	3.73
--------------------------	------	------

Physical effort required	2.82	3.36
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.82	3.27
---	------	------

Outcome depends on the skill and judgment of physician	3.73	3.82
--	------	------

Estimated risk of malpractice suit with poor outcome	2.64	3.18
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.00	3.27
----------------------------------	------	------

Intra-Service intensity/complexity	3.00	3.55
------------------------------------	------	------

Post-Service intensity/complexity	2.64	2.91
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Another eyelid repair procedure, CPT 67917 Repair of ectropion; extensive (e.g., tarsal strip operations), was identified in the CY 2013 Final Physician Fee Schedule by CMS as a potentially misvalued service. The Academy submitted an action plan to the RAW in October 2012 identifying the entire family as including the ectropion procedures of CPT Codes 67914, 67915, 67916 and 67917 as well the entropion procedures of CPT 67921, 67922 67923 and 67924 to survey for consideration at the April 2013 AMA RUC meeting.



**CPT 67914 Survey Analysis**

The Academy survey for CPT 67914 had 33 respondents. The median WRVU was 5.25 and the 25<sup>th</sup> percentile was 4.22. The median IST was 20 minutes. There were three postoperative visits in the 90-day global period. The current value of the code is 3.75. Preservice package 1B was chosen. The primary reference code CPT 67911 *Correction of lid retraction* was RUC reviewed in August 2005. It has an RVU of 7.50. For all categories, respondents indicated that the reference code was more intense and complex than the surveyed code.

**Recommendation for CPT 67914**

The typical patient has symptomatic eversion of the lower eyelid margin with symptoms of redness, tearing and matting of the lashes. The surgical techniques to correct this problem have changed little over the years. The volume for this code is low at 2300/yr. This surgery is performed primarily in patients who are too frail to undergo a more extensive lid procedure. The code has a 90-day global period and is performed primarily in the facility setting.

The AAO expert panel which was familiar with the surgery and the RUC process reviewed the results. The panel felt that it was a good survey. The panel agreed that the surveyed code was less work than the reference code. The panel felt that there is no compelling evidence that the current code is misvalued. Therefore, the panel recommended that the current value of 3.75 WRVU be maintained. This value is less than the survey 25<sup>th</sup> percentile.

There are many codes in the database that have similar values to the recommended value for this code. CPT 26160 *Excision of lesion of tendon sheath or joint capsule (e.g., cyst, mucous cyst, or ganglion), hand or finger* (RUC reviewed Aug 2005) has a WRVU of 3.57 and the same IST and number of postoperative visits. CPT 25259, *Manipulation, wrist, under anesthesia* (RUC 2001) has an RVU of 4.04, and the same 20 minute IST. Similarly CPT 24300(RUC 2001), *Manipulation, elbow, under anesthesia* has an identical work and IST. Both of these codes have more postoperative visits than the surveyed code. CPT 28890, *Extracorporeal shock wave, high energy, performed by a physician or other qualified health care professional, requiring anesthesia other than local, including ultrasound guidance, involving the plantar fascia* (RUC Feb 2005) has an IST of 25 minutes but lower postoperative work and a WRVU of 3.45. CPT 24357, *Tenotomy, elbow, lateral or medial (e.g., epicondylitis, tennis elbow, golfer's elbow); percutaneous* (RUC 2007) has the same IST and a WRVU of 5.44. It has one additional postoperative visit. These comparison codes indicate that 67914 is fairly valued at the recommended WRVU of 3.75.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology

How often? Sometimes

Specialty Plastic & Reconstructive

How often? Rarely

Specialty

How often?

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,303

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC Database

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States? No

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 67914

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 67915	Tracking Number	Original Specialty Recommended RVU: <b>2.25</b>
		Presented Recommended RVU: <b>2.25</b>
Global Period: 090		RUC Recommended RVU: <b>2.03</b>

CPT Descriptor: Repair of ectropion; thermocauterization

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: An 80 year old male nursing facility patient with multiple health co-morbidities develops progressive ocular irritation, redness, and daily eyelash matting associated with the eversion of the lower eyelid margin. His symptoms fail to respond to eyelid hygiene, topical lubricants, antibiotics and steroids. The examination confirms eversion of the lower eyelid margin with erythema and eyelash matting.

Percentage of Survey Respondents who found Vignette to be Typical: 87%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 9% , In the ASC 26%, In the office 65%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 63%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 25%

Description of Pre-Service Work: The patient history, physical exam and appropriate preoperative tests are reviewed. The preoperative interval history and exam are documented. Photographs are reviewed. The surgical plan is discussed with the patient, all questions are addressed and surgical consent is reviewed. The forehead is marked to indicate the operative eye. The patient is positioned and the surgical eye is confirmed with the patient, surgical and anesthesia team. The eye and periocular area are prepped and draped. The surgeon adds topical anesthesia to both eyes and injects a local anesthetic block to the operative eyelid while the patient is monitored.

Description of Intra-Service Work: A hot temperature cautery unit is inspected and determined to be in working order. A vertical traction suture may be placed with a 4-0 silk suture in the central lower eyelid margin. The lower eyelid is everted over a Desmarre retractor. The conjunctiva is marked with methylene blue along a line just inferior to the tarsal plate. Cauterized spots are created along the marked line. The depth, number and placement of the cautery are adjusted to allow an appropriate cicatricial inward rotation of the eyelid margin.

Description of Post-Service Work: The eye, incision and eyelids are cleaned and the wounds dressed with antibiotic drops. Pain management is discussed with patient. The patient and family are given detailed postoperative care instructions and appropriate prescriptions. An operative report is prepared, and required paperwork completed. Follow-up visits are scheduled.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Stephen A. Kamenetzky, M.D./Tamara Fountain, M.D.				
<b>Specialty(s):</b>	AAO and American Society of Ophthalmic Plastic and Reconstructive Surgeons				
<b>CPT Code:</b>	67915				
<b>Sample Size:</b>	368	<b>Resp N:</b>	23	<b>Response:</b> 6.2 %	
<b>Description of Sample:</b>	Random sample of members were pulled from the AAO and American Society of Ophthalmic Plastic and Reconstructive Surgeons membership databases.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	0.00	0.00	4.00	30.00
<b>Survey RVW:</b>	3.30	4.00	4.25	4.90	9.00
<b>Pre-Service Evaluation Time:</b>			20.00		
<b>Pre-Service Positioning Time:</b>			5.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			7.00		
<b>Intra-Service Time:</b>	0.00	7.50	10.00	15.00	45.00
<b>Immediate Post Service-Time:</b>	<b>5.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>46.00</b>	99211x 0.00 12x 0.00 13x 2.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

6 - NF Procedure with sedation/anesthesia care

<b>CPT Code:</b>	67915	<b>Recommended Physician Work RVU: 2.03</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		17.00	17.00	0.00
<b>Pre-Service Positioning Time:</b>		1.00	1.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00
<b>Intra-Service Time:</b>		10.00		
<b>Immediate Post Service-Time:</b>	<b>5.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>32.00</b>	99211x 0.00 12x 2.00 13x 0.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00		

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
23075	090	4.21	RUC Time

CPT Descriptor Excision soft tissue tumor, shoulder area; subcutaneous**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
46930	090	1.61	RUC Time	17,848

CPT Descriptor 1 Destruction of internal hemorrhoid(s) by thermal energy (eg, infrared coagulation, cautery, radiofrequency)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
12052	010	2.87	RUC Time	77,119

CPT Descriptor 2 Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
26600	090	2.60	RUC Time

CPT Descriptor Closed treatment of metacarpal fracture, single; without manipulation, each bone**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 7      % of respondents: 30.4 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 67915</b>	<b>Key Reference CPT Code: <u>23075</u></b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	23.00	34.00	
Median Intra-Service Time	10.00	10.00	
Median Immediate Post-service Time	5.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	19.00	
Median Office Visit Time	32.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
<b>Median Total Time</b>	<b>70.00</b>	<b>122.00</b>	

Other time if appropriate		
---------------------------	--	--

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.14	2.29
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.00	2.14
--	------	------

Urgency of medical decision making	2.00	1.71
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.14	2.14
--------------------------	------	------

Physical effort required	1.86	1.86
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.00	2.00
---	------	------

Outcome depends on the skill and judgment of physician	2.14	2.14
--	------	------

Estimated risk of malpractice suit with poor outcome	1.86	1.71
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.00	2.14
----------------------------------	------	------

Intra-Service intensity/complexity	2.00	2.14
------------------------------------	------	------

Post-Service intensity/complexity	1.86	2.00
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Another repair procedure, CPT 67917 Repair of ectropion; extensive (e.g., tarsal strip operations), was identified in the CY 2013 Final Physician Fee Schedule by CMS as a potentially misvalued service. The Academy submitted an action plan to the RAW in October 2012 identifying the entire family including ectropion procedures of CPT Codes 67914, 67915, 67916 and 67917 as well as entropion procedures of CPT 67921, 67922 67923 and 67924 to survey for consideration at the April 2013 AMA RUC meeting.

**CPT 67915 Survey Analysis**

The AAO survey had 23 respondents reflecting the considerably low volume for this code. The median WRVU was 4.25 and the 25<sup>th</sup> percentile was 4.00. The median IST was 10 minutes. There are two 99212 postoperative visits in the 90-day global period. These are necessary to be certain that punctate keratitis does not develop as the eye heals. The current value of the code is 3.26. Preservice package 6 was chosen. The primary reference code CPT 23075 *Excision, tumor, soft tissue of shoulder area, subcutaneous; less than 3 cm* was RUC reviewed in February 2009. It has an RVU of 4.21. For almost all categories, respondents indicated that the reference code and the surveyed code were similar in intensity and complexity.

**CPT 67915 WRVU Recommendation**

The typical patient has symptomatic eversion of the lower eyelid margin with symptoms of redness, tearing and matting of the lashes. Corneal injury is common from exposure. The surgical techniques to correct this problem have changed little over the years. The volume for this code is low at 500/yr. This surgery is performed primarily in patients who are too frail to undergo a more extensive lid procedure. The code has a 90-day global period and is performed primarily in the office setting.

The AAO expert panel which was familiar with the surgery and the RUC process reviewed the results. The panel felt that the low volume for the code made both the number of respondents and the performance level lower than desired. The panel agreed that the surveyed code was less work than the reference code and a consensus recommendation is being put forward. The surveyed code is less work than the reference code with a shorter IST. The panel believes the current value of the code is too high.

There are very few 90-day global codes with an IST this short. CPT 26600 *Closed treatment of metacarpal fracture, single; without manipulation, each bone* (RUC August 2005) has a WRVU of 2.62 with an IST of 15 minutes. CPT 46930 *Destruction of internal hemorrhoid(s) by thermal energy (e.g., infrared coagulation, cautery, radiofrequency)* (RUC April 2008) has 5 minutes of IST and 1 99213 visit. The WRVU is 1.61. CPT 67915 takes more time and has more postoperative visits. CPT 36589 *Removal of tunneled central venous catheter, without subcutaneous port or pump* (RUC 2003) has a 10-day global with one postoperative visit at the 99211 level, IST of 13 minutes and a WRVU of 2.28. The recommended value of 2.03 WRVU is consistent with the work value, time, intensity and complexity of these codes.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) N/A

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology

How often? Rarely

Specialty Plastic and Reconstructive

How often? Rarely

Specialty

How often?

Estimate the number of times this service might be provided nationally in a one-year period? Medicare population

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 525

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC Database

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States?

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 67915

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A



**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 67916	Tracking Number	Original Specialty Recommended RVU: <b>5.48</b>
		Presented Recommended RVU: <b>5.48</b>
Global Period: 090		RUC Recommended RVU: <b>5.48</b>

CPT Descriptor: Repair of ectropion; excision tarsal wedge

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 65 year old male presents with an out turning segment of central lower eyelid margin six months after excision of a skin cancer from the cheek. He has progressive ocular irritation and redness. His symptoms fail to respond to wound massage and topical lubricants. The examination confirms eversion of the central lower eyelid margin associated with conjunctival epithelial damage, tarsal laxity, normal canthal tendons and breakdown of the ocular surface.

Percentage of Survey Respondents who found Vignette to be Typical: 82%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 11% , In the ASC 64%, In the office 25%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 80%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 40%

Description of Pre-Service Work: The patient history, physical exam and appropriate preoperative tests are reviewed. The preoperative interval history and exam are documented. Photographs are reviewed. The surgical plan is discussed with the patient, all questions are addressed and surgical consent is reviewed. The forehead is marked to indicate the operative eye. The patient is positioned and the surgical eye is confirmed with the patient, surgical and anesthesia team. The eye and periocular area are prepped and draped. After conscious sedation is initiated, the surgeon adds topical anesthesia to both eyes and injects a local anesthetic block to the operative eyelid while the patient is monitored.

Description of Intra-Service Work: A full thickness incision is made through the tarsus at the medial edge of the everted lower eyelid. The edges are pulled over each other to determine the necessary amount of eyelid excision to maximally remove the abnormal eyelid margin and reposition the eyelid without creating retraction. The lateral edge is marked for excision. A full thickness pentagonal wedge resection of the marked central lower eyelid is performed. Absolute hemostasis is achieved with cautery. The lower eyelid retractors are closed with a running 6-0 absorbable suture. The tarsus is closed with two horizontal mattress 6-0 sutures at the inferior tarsal border and the posterior eyelid margin. The eyelid margin is closed with two 6-0 interrupted sutures at the grey line and anterior lash line. The skin is closed with a running 6-0 suture.

Description of Post-Service Work: The eye, incision and eyelids are cleaned and the wounds dressed with antibiotic drops and ointment. Pain management is discussed and the IV removed. The patient and family are given detailed postoperative care instructions and appropriate prescriptions. An operative report is prepared, and required paperwork completed. Follow-up visits are scheduled.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Stephen A. Kamenetzky, M.D./Tamara Fountain, M.D.				
<b>Specialty(s):</b>	AAO and American Society of Ophthalmic Plastic and Reconstructive Surgeons				
<b>CPT Code:</b>	67916				
<b>Sample Size:</b>	368	<b>Resp N:</b>	28	<b>Response:</b> 7.6 %	
<b>Description of Sample:</b>	Random sample of members were pulled from the AAO and American Society of Ophthalmic Plastic and Reconstructive Surgeons membership databases.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	1.75	<b>7.50</b>	25.00	50.00
<b>Survey RVW:</b>	4.90	6.19	<b>6.63</b>	7.11	13.00
<b>Pre-Service Evaluation Time:</b>			<b>25.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>5.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>10.00</b>		
<b>Intra-Service Time:</b>	15.00	20.00	<b>25.00</b>	30.00	45.00
<b>Immediate Post Service-Time:</b>	<b>10.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>38.00</b>	99238x 1.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>69.00</b>	99211x 0.00 12x 0.00 13x 3.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1b-FAC Straightforw Pat Procedure(w sedate/anes)

<b>CPT Code:</b>	67916	<b>Recommended Physician Work RVU: 5.48</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>19.00</b>	<b>19.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>1.00</b>	<b>1.00</b>	<b>0.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>5.00</b>	<b>5.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>25.00</b>		
<b>Immediate Post Service-Time:</b>	<b>10.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>19.00</b>	99238x 0.5 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>55.00</b>	99211x 0.00 12x 2.00 13x 1.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00		

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
15823	090	6.81	RUC Time

CPT Descriptor Blepharoplasty, upper eyelid; with excessive skin weighting down lid**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
64721	090	4.97	RUC Time	000818

CPT Descriptor 1 Neuroplasty and/or transposition; median nerve at carpal tunnel

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
49650	090	6.36	RUC Time	26

CPT Descriptor 2 Laparoscopy, surgical; repair initial inguinal hernia

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
46275	090	5.42	RUC Time

CPT Descriptor Surgical treatment of anal fistula (fistulectomy/fistulotomy); intersphincteric**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 14      % of respondents: 50.0 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 67916</b>	<b>Key Reference CPT Code: 15823</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	25.00	16.00	
Median Intra-Service Time	25.00	45.00	
Median Immediate Post-service Time	10.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	55.0	71.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
<b>Median Total Time</b>	<b>134.00</b>	<b>161.00</b>	
<b>Other time if appropriate</b>			

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.00	3.00
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.79	3.07
--	------	------

Urgency of medical decision making	2.93	2.71
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.64	3.57
--------------------------	------	------

Physical effort required	3.00	3.07
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.00	3.29
---	------	------

Outcome depends on the skill and judgment of physician	3.57	3.79
--	------	------

Estimated risk of malpractice suit with poor outcome	2.93	3.57
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.86	3.36
----------------------------------	------	------

Intra-Service intensity/complexity	2.93	3.29
------------------------------------	------	------

Post-Service intensity/complexity	3.00	2.86
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Another eyelid repair procedure CPT 67917 Repair of ectropion; extensive (eg, tarsal strip operations) was identified in the CY 2013 Final Physician Fee Schedule by CMS as a potentially misvalued service. The Academy submitted an action plan to the RAW in October 2012 identifying the entire family as including the ectropion procedures of CPT Codes 67914, 67915, 67916 and 67917 as well the entropion procedures of CPT 67921, 67922 67923 and 67924 to survey for consideration at the April 2013 AMA RUC meeting.

**CPT 67916 Survey Analysis**

The AAO survey had 28 respondents. The median WRVU was 6.63 and the 25<sup>th</sup> percentile was 6.19. The median IST was 25 minutes. There were three postoperative visits in the 90-day global period. The current value of the code is 5.48. Preservice package 1B was chosen. The primary reference code CPT 15823 *Blepharoplasty, upper eyelid; with excessive skin weighting down lid* was RUC reviewed in February 2010. It has an RVU of 6.81. For most categories, respondents indicated that the reference code was more intense and complex than the surveyed code.

**CPT 67916 Recommendation**

The typical patient has symptomatic eversion of the lower eyelid margin with symptoms of redness, tearing and matting of the lashes. The surgical techniques to correct this problem have changed little over the years. The volume for this code is low at 3143/yr. This surgery is performed for patients who have mild to moderate ectropion. The code has a 90-day global period and is performed primarily in the facility setting.

The AAO expert panel which was familiar with the surgery and the RUC process reviewed the results. The panel felt that it was a good survey although the number of respondents was slightly lower than ideal. This was due to the low performance rate for this procedure. The panel agreed that the surveyed code was less work than the reference code and a consensus recommendation is being put forward. The panel believes that there is no compelling evidence that the code is currently misvalued. Therefore, the panel recommended that the current value of 5.48 WRVU be maintained. This value is less than the 25<sup>th</sup> percentile of the survey.

There are many codes in the database that have similar values to the recommended value for this code. CPT 46275 *Surgical treatment of anal fistula (fistulectomy/fistulotomy); intersphincteric* (RUC reviewed August 2005) has a WRVU of 5.42, 30 minutes of IST and same number of postoperative visits. CPT 28285 *Correction, hammertoe (eg, inter-phalangeal fusion, partial or total phalangectomy* (RUC October 2010) has an RVU of 5.62 with a slightly longer IST and one more postoperative visit. Similarly CPT 28675 *Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed* (RUC February 2007) has a WRVU of 5.62 with 30 minutes IST and one more postoperative visit. CPT 28820 *Amputation, toe; metatarsophalangeal joint* (RUC October 2010) has a WRVU of 5.82 with 30 minutes of IST and 4 postoperative visits. These comparison codes indicate that 67916 is fairly valued at the recommended WRVU of 5.48.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) N/A

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology

How often? Sometimes

Specialty Plastic and Reconstructive

How often? Rarely

Specialty

How often?

Estimate the number of times this service might be provided nationally in a one-year period? This is primarily a Medicare aged population.

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3,143

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC Database

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States? No

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 67916

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 67917	Tracking Number	Original Specialty Recommended RVU: <b>6.19</b>
		Presented Recommended RVU: <b>6.19</b>
Global Period: 090		RUC Recommended RVU: <b>5.93</b>

CPT Descriptor: Repair of ectropion; extensive (eg, tarsal strip operations)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 55 year old female presents with an out turning lateral lower eyelid six months after a fall causing traumatic facial scar near the lateral orbital rim. She has progressive ocular irritation and redness. Her symptoms fail to respond to wound massage, steroid injections to the scar and topical lubricants. The examination confirms a hypertrophic scar of the eyelid skin causing tractional eversion of the lateral lower eyelid and breakdown of the ocular surface.

Percentage of Survey Respondents who found Vignette to be Typical: 41%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 9% , In the ASC 79%, In the office 12%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 77%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 31%

Description of Pre-Service Work: The patient history, physical exam and appropriate preoperative tests are reviewed. The preoperative interval history and exam are documented. Photographs are reviewed. The surgical plan is discussed with the patient, all questions are addressed and surgical consent is reviewed. The forehead is marked to indicate the operative eye. The patient is positioned and the surgical eye is confirmed with the patient, surgical and anesthesia team. The eye and periocular area are prepped and draped. After conscious sedation is initiated, the surgeon adds topical anesthesia to both eyes and injects a local anesthetic block to the operative eyelid while the patient is monitored.

Description of Intra-Service Work: A sharp canthal angle is created with interrupted 6-0 absorbable sutures at the grey line and anterior lash lines.. Electrodissection is used to expose the periosteum of the lateral orbital rim. The lower eyelid is securely grasped with forceps and the lateral canthal tendon is sharply released from the bone. Any attachments to the lower eyelid, particularly those creating inferior traction, are released with sharp dissection in the subcutaneous plane. The lateral tarsal stump is shortened as necessary and mitered 45 degrees to the eyelid margin. A tongue or strip of tarsus is further dissected removing any lashes, epithelial and conjunctival elements. The globe is repositioned away from the orbital rim and protected with Sewall retractors. The tarsal strip is then sutured to the inner orbital rim with permanent 5-0 horizontal mattress sutures. The eyelid tension, contour and position are evaluated and adjusted as needed. Absolute hemostasis is achieved with cautery. The wound is closed, in layers. The subcutaneous tissues are supported to the periosteum of the anterior zygoma with 5-0 permanent sutures. The skin is closed with interrupted 6-0 non-absorbable sutures.

Description of Post-Service Work: The eye and eyelids are cleaned and the wounds dressed with antibiotic drops and ointment. Pain management is discussed and the IV removed. The patient and family are given detailed postoperative care instructions and appropriate prescriptions. An operative report is prepared, and required paperwork completed. Follow-up visits are scheduled.



**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Stephen A. Kamenetzky, M.D./Tamara Fountain, M.D.				
<b>Specialty(s):</b>	AAO and American Society of Ophthalmic Plastic and Reconstructive Surgeons				
<b>CPT Code:</b>	67917				
<b>Sample Size:</b>	368	<b>Resp N:</b>	34	<b>Response:</b> 9.2 %	
<b>Description of Sample:</b>	Random sample of members were pulled from the AAO and American Society of Ophthalmic Plastic and Reconstructive Surgeons membership databases.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	2.00	26.25	<b>40.00</b>	75.00	500.00
<b>Survey RVW:</b>	6.01	6.66	<b>6.86</b>	7.50	18.00
<b>Pre-Service Evaluation Time:</b>			<b>30.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>5.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>10.00</b>		
<b>Intra-Service Time:</b>	10.00	25.00	<b>32.50</b>	40.00	60.00
<b>Immediate Post Service-Time:</b>	<b>10.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>38.00</b>	99238x 1.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>69.00</b>	99211x 0.00 12x 0.00 13x 3.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1b-FAC Straightforw Pat Procedure(w sedate/anes)

<b>CPT Code:</b>	67917	<b>Recommended Physician Work RVU: 5.93</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>19.00</b>	<b>19.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>1.00</b>	<b>1.00</b>	<b>0.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>5.00</b>	<b>5.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>33.00</b>		
<b>Immediate Post Service-Time:</b>	<b>10.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>19.00</b>	99238x 0.5 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>55.00</b>	99211x 0.00 12x 2.00 13x 1.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00		

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
15823	090	6.81	RUC Time

CPT Descriptor Blepharoplasty, upper eyelid; with excessive skin weighting down lid**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
33212	090	5.26	RUC Time	10,897

CPT Descriptor 1 Insertion or replacement of pacemaker pulse generator only; single chamber, atrial or ventricular

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
49650	090	6.36	RUC Time	26,234

CPT Descriptor 2 Repair umbilical hernia, age 5 years or older; reducible

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
46060	090	6.37	RUC Time

CPT Descriptor Incision and drainage of ischiorectal or intramural abscess, with fistulectomy or fistulotomy, submuscular, with or without placement of seton**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 14      % of respondents: 41.1 %

**TIME ESTIMATES (Median)**

	<b>CPT Code:</b> 67917	<b>Key Reference CPT Code:</b> 15823	<b>Source of Time</b> RUC Time
Median Pre-Service Time	25.00	16.00	
Median Intra-Service Time	33.00	45.00	
Median Immediate Post-service Time	10.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	55.0	71.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
<b>Median Total Time</b>	<b>142.00</b>	<b>161.00</b>	

Other time if appropriate		
---------------------------	--	--

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.19	3.19
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.81	3.06
--	------	------

Urgency of medical decision making	2.44	2.38
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.69	3.63
--------------------------	------	------

Physical effort required	3.06	3.13
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.06	3.38
---	------	------

Outcome depends on the skill and judgment of physician	3.75	3.94
--	------	------

Estimated risk of malpractice suit with poor outcome	2.56	3.44
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.06	3.19
----------------------------------	------	------

Intra-Service intensity/complexity	3.19	3.38
------------------------------------	------	------

Post-Service intensity/complexity	3.13	3.19
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

This eyelid repair procedure, CPT 67917 Repair of ectropion; extensive (e.g., tarsal strip operations), was identified in the CY 2013 Final Physician Fee Schedule by CMS as a potentially misvalued service. The Academy submitted an action plan to the RAW in October 2012 identifying the entire family as including

the ectropion procedures of CPT Codes 67914, 67915, 67916 and 67917 as well the entropion procedures of CPT 67921, 67922 67923 and 67924 to survey for consideration at the April 2013 AMA RUC meeting.

### **CPT 67917 Survey Analysis**

The AAO survey had 34 respondents and a tight survey. The median WRVU was 6.86 and the 25<sup>th</sup> percentile was 6.66. The median IST was 32.5 minutes. There were three postoperative visits in the 90-day global period. The current value of the code is 6.19 RVU. Preservice package 1B was chosen. The primary reference code CPT 15823, *Blepharoplasty, upper eyelid; with excessive skin weighting down lid*, was RUC reviewed in February 2010. It has an RVU of 6.81. For most categories, respondents indicated that the reference code and the surveyed code were similar. For a few categories the reference code was higher.

### **CPT 67917 Recommendation**

The typical patient has symptomatic eversion of the lower eyelid margin with symptoms of redness, tearing and matting of the lashes. The surgical techniques to correct this problem have changed little over the years. The volume for this code is 28000/yr. This procedure is the most extensive in the family for correction of ectropion, performed in patients who have the most severe disease. The code has a 90-day global period and is performed primarily in the facility setting.

The AAO expert panel which was familiar with the surgery and the RUC process reviewed the results. The panel felt that it was a good survey with a good reference code. The panel agreed that the surveyed code was less work than the reference code. The panel felt that there is no compelling evidence that the current code is misvalued. Therefore, recommend 5.93 WRVU value, less than the 25<sup>th</sup> percentile of the survey.

There are codes in the database that have similar values to the recommended value for this code. CPT 67912 *Correction of lagophthalmos, with implantation of upper eyelid lid load (eg, gold weight)* (RUC reviewed April 2003) has a WRVU of 6.36, a slightly longer IST and the same number of postoperative visits. CPT 46060, *Incision and drainage of ischiorectal or intramural abscess, with fistulectomy or fistulotomy, submuscular, with or without placement of seton* (RUC August 2005) has an RVU of 6.37, an IST of 40 and the same number of postoperative visits. Similarly CPT 25109 *Excision of tendon, forearm and/or wrist, flexor or extensor, each* (RUC April 2006) has 40 minutes of IST and 3 postoperative visits. These comparison codes indicate that CPT 67917 is fairly valued at the recommended WRVU of 5.93.

## **SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## **FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) N/A

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology

How often? Sometimes

Specialty Plastic and Reconstructive

How often? Rarely

Specialty

How often?

Estimate the number of times this service might be provided nationally in a one-year period? This occurs primarily in a Medicare aged population.

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?  
28,419 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.  
Please explain the rationale for this estimate. RUC Database

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States?

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 67917

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 67921	Tracking Number	Original Specialty Recommended RVU: <b>3.47</b>
		Presented Recommended RVU: <b>3.47</b>
Global Period: 090		RUC Recommended RVU: <b>3.47</b>

CPT Descriptor: Repair of entropion; suture

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 70 year old female presents with intermittent eyelash irritation and redness. Her symptoms fail to respond to eyelid hygiene, lubricants, topical antibiotics, steroids or lateral eyelid taping. The examination confirms intermittent inward rotation of the lower eyelashes with prone positioning or eyelid squeezing. This is associated with breakdown of the ocular surface.

Percentage of Survey Respondents who found Vignette to be Typical: 24%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 7% , In the ASC 33%, In the office 60%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 47%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 14%

Description of Pre-Service Work: The patient history, physical exam and appropriate preoperative tests are reviewed. The preoperative interval history and exam are documented. Photographs are reviewed. The surgical plan is discussed with the patient, all questions are addressed and surgical consent is reviewed. The forehead is marked to indicate the operative eye. The patient is positioned and the surgical eye is confirmed with the patient, surgical and anesthesia team. The eye and periocular area are prepped and draped. After conscious administration is administered, the surgeon adds topical anesthesia to both eyes and injects a local anesthetic block to the operative eyelid while the patient is monitored.

Description of Intra-Service Work: An appropriate higher eyelid crease is marked with methylene blue. A series of double armed 4-0 absorbable horizontal mattress sutures are placed through full thickness eyelid from the conjunctival side just above the lower conjunctival fornix, grasping the lower eyelid retractors and emerging from the marked higher eyelid skin crease. This typically requires four sutures to rotate the lid and lashes, prevent orbicularis override, and provide a stable eyelid margin and crease. The sutures are tied to create a deep cutaneous crease and rotate the eyelid margin a desired amount. The sutures may require removal and/or adjustment to ensure the eyelid margin and lash positions are adequate. Hemostasis is managed with direct pressure.

Description of Post-Service Work: The eye, incision and eyelids are cleaned and the wounds dressed with antibiotic drops and ointment. Pain management is discussed and the IV removed. The patient and family are given detailed postoperative care instructions and appropriate prescriptions. An operative report is produced, and required paperwork completed. Follow-up visits are scheduled.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Stephen A. Kamenetzky, M.D./Tamara Fountain, M.D.				
<b>Specialty(s):</b>	AAO and American Society of Ophthalmic Plastic and Reconstructive Surgeons				
<b>CPT Code:</b>	67921				
<b>Sample Size:</b>	368	<b>Resp N:</b>	34	<b>Response:</b> 9.2 %	
<b>Description of Sample:</b>	Random sample of members were pulled from the AAO and American Society of Ophthalmic Plastic and Reconstructive Surgeons membership databases.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	2.50	10.00	23.75	85.00
<b>Survey RVW:</b>	3.50	4.21	5.03	6.00	12.00
<b>Pre-Service Evaluation Time:</b>			25.00		
<b>Pre-Service Positioning Time:</b>			5.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10.00		
<b>Intra-Service Time:</b>	5.00	10.00	15.00	25.00	45.00
<b>Immediate Post Service-Time:</b>	<b>10.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>38.00</b>	99238x 1.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>69.00</b>	99211x 0.00 12x 0.00 13x 3.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1b-FAC Straightforw Pat Procedure(w sedate/anes)

<b>CPT Code:</b>	67921	<b>Recommended Physician Work RVU: 3.47</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		19.00	19.00	0.00
<b>Pre-Service Positioning Time:</b>		1.00	1.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00
<b>Intra-Service Time:</b>		15.00		
<b>Immediate Post Service-Time:</b>	<b>10.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>19.00</b>	99238x 0.5 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>55.00</b>	99211x 0.00 12x 2.00 13x 1.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00		

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
23075	090	4.21	RUC Time

CPT Descriptor Excision, tumor, soft tissue of shoulder area, subcutaneous; less than 3 cm**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
21031	090	3.30	RUC Time	818

CPT Descriptor 1 Excision of torus mandibularis

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
64721	090	4.97	RUC Time	110,695

CPT Descriptor 2 ,695Neuroplasty and/or transposition; median nerve at carpal tunne

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
26160	090	3.57	RUC Time

CPT Descriptor Excision of lesion of tendon sheath or joint capsule (eg, cyst, mucous cyst, or ganglion)**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 6      % of respondents: 17.6 %

**TIME ESTIMATES (Median)**

	<b>CPT Code:</b> 67921	<b>Key Reference CPT Code:</b> <u>23075</u>	<b>Source of Time</b> RUC Time
Median Pre-Service Time	25.00	34.00	
Median Intra-Service Time	15.00	30.00	
Median Immediate Post-service Time	10.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	55.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
<b>Median Total Time</b>	<b>124.00</b>	<b>142.00</b>	
<b>Other time if appropriate</b>			



**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.50	2.67
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.17	2.33
--	------	------

Urgency of medical decision making	2.33	2.00
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.50	2.33
--------------------------	------	------

Physical effort required	2.00	2.00
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.17	2.00
---	------	------

Outcome depends on the skill and judgment of physician	2.50	2.50
--	------	------

Estimated risk of malpractice suit with poor outcome	2.00	1.83
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.33	2.33
----------------------------------	------	------

Intra-Service intensity/complexity	1.83	2.17
------------------------------------	------	------

Post-Service intensity/complexity	1.83	2.00
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Another eyelid repair procedure CPT 67917 Repair of ectropion; extensive (e.g., tarsal strip operations) was identified in the CY 2013 Final Physician Fee Schedule by CMS as a potentially misvalued service. The Academy submitted an action plan to the RAW in October 2012 identifying the entire family as including the ectropion procedures of CPT Codes 67914, 67915, 67916 and 67917 as well the entropion procedures of CPT 67921, 67922 67923 and 67924 to survey for consideration at the April 2013 AMA RUC meeting.

**CPT 67921 Survey Analysis**

The AAO survey had 34 respondents. The median WRVU was 5.03 and the 25<sup>th</sup> percentile was 4.21. The median IST was 20 minutes. There were three 99212 postoperative visits in the 90-day global period. The current value of the code is 3.47. Preservice package 1B was chosen. The primary reference code CPT 23075 *Excision, tumor, soft tissue of shoulder area, subcutaneous; less than 3 cm* was RUC reviewed in February 2009. It has longer IST and one 99213 and one 99212 visit in the postoperative period. The reference code has an RVU of 4.21. Overall, respondents indicated that the reference code and the surveyed code were about equal in intensity and complexity.

**CPT 67921 Recommendation**

The typical patient has symptomatic inversion of the lower eyelid margin with symptoms of redness, tearing and matting of the lashes. Corneal irritation is common as well. The surgical techniques to correct this problem have changed little over the years. The volume for this code is relatively low at 5000/yr. This surgery is performed primarily in patients who are too frail to undergo a more extensive lid procedure. The code has a 90-day global period. The RUC database indicates that just over 50% of these cases are done in the office.

The AAO expert panel which was familiar with the surgery and the RUC process reviewed the results. The panel felt that it was a good survey and that the reference code was appropriate. The panel felt that there is no compelling evidence which meets the RUC standard for a misvalued code. Therefore, the panel recommended that the current value of 3.47 WRVU be maintained. This value is less than the 25<sup>th</sup> percentile of the survey.

There are many codes in the database that have similar values to the recommended value for this code. CPT 26160 *Excision of lesion of tendon sheath or joint capsule (e.g., cyst, mucous cyst, or ganglion), hand or finger* (RUC reviewed Aug 2005) has a WRVU of 3.57 and the same IST and number of postoperative visits. CPT 25359, *Manipulation, wrist, under anesthesia* (RUC 2001) has an RVU of 4.04, and the same 20 minute IST. Similarly CPT 24300 (RUC 2001), *Manipulation, elbow, under anesthesia* has an identical WRVU of 4.06 and the same IST. CPT 28890, *Extracorporeal shock wave, high energy, performed by a physician or other qualified health care professional, requiring anesthesia other than local, including ultrasound guidance, involving the plantar fascia* (RUC Feb 2005) has an IST of 25 minutes but lower postoperative work and a WRVU of 3.45. CPT 24357, *Tenotomy, elbow, lateral or medial (e.g., epicondylitis, tennis elbow, golfer's elbow); percutaneous* (RUC 2007) has the same IST and a WRVU of 5.44. It has one additional postoperative visit. These comparison codes indicate that 67921 is fairly valued at the recommended WRVU of 3.47.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) N/A

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology How often? Sometimes

Specialty Plastic and Reconstructive Surgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? Primarily Medicare

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 5,072

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC Database

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States? No

**Professional Liability Insurance Information (PLI)**

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 67921

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 67922	Tracking Number	Original Specialty Recommended RVU: <b>2.25</b>
		Presented Recommended RVU: <b>2.25</b>
Global Period: 090		RUC Recommended RVU: <b>2.03</b>

CPT Descriptor: Repair of entropion; thermocauterization

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: An 80 year old male nursing home patient with multiple health co-morbidities develops progressive ocular irritation, redness and daily eyelash matting associated with inward turning of the lower lashes. His symptoms fail to respond to lubricants, topical antibiotics or lateral taping of the eyelid. The examination confirms inversion of the eyelid resulting in medial lower eyelashes touching the cornea and causing breakdown of the ocular surface.

Percentage of Survey Respondents who found Vignette to be Typical: 85%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 5% , In the ASC 25%, In the office 70%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 33%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 10%

Description of Pre-Service Work: The patient history, physical exam and appropriate preoperative tests are reviewed. The preoperative interval history and exam are documented. Photographs are reviewed. The surgical plan is discussed with the patient, all questions are addressed and surgical consent is reviewed. The forehead is marked to indicate the operative eye. The patient is positioned and the surgical eye is confirmed with the patient, surgical and anesthesia team. The eye and periocular area are prepped and draped. The surgeon adds topical anesthesia to both eyes and injects a local anesthetic block to the operative eyelid while the patient is monitored.

Description of Intra-Service Work: A hot temperature cautery unit is inspected and determined to be in working order. A vertical traction suture may be placed with a 4-0 silk suture in the central lower eyelid margin. An appropriate lower eyelid crease is marked with methylene blue. A horizontal line of cauterized spots are created along the marked external skin crease, just beneath the tarsal plate. The depth, number and placement of the cautery are adjusted to provide an appropriate cicatricial outward rotation of the lower eyelid margin.

Description of Post-Service Work: The eye, incision and eyelids are cleaned and the wounds dressed with antibiotic drops. Pain management is discussed. The patient and family are given detailed postoperative care instructions and appropriate prescriptions. An operative report is produced, and required paperwork completed. Follow-up visits are scheduled.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Stephen A. Kamenetzky, M.D./Tamara Fountain, M.D.				
<b>Specialty(s):</b>	AAO and American Society of Ophthalmic Plastic and Reconstructive Surgeons				
<b>CPT Code:</b>	67922				
<b>Sample Size:</b>	368	<b>Resp N:</b>	20	<b>Response:</b> 5.4 %	
<b>Description of Sample:</b>	Random sample of members were pulled from the AAO and American Society of Ophthalmic Plastic and Reconstructive Surgeons membership databases.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	0.00	0.00	2.00	10.00
<b>Survey RVW:</b>	3.00	4.00	4.45	5.00	8.00
<b>Pre-Service Evaluation Time:</b>			20.00		
<b>Pre-Service Positioning Time:</b>			5.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10.00		
<b>Intra-Service Time:</b>	0.00	5.00	10.00	11.25	30.00
<b>Immediate Post Service-Time:</b>	<b>10.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>32.00</b>	99211x 0.00 12x 2.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

6 - NF Procedure with sedation/anesthesia care

<b>CPT Code:</b>	67922	<b>Recommended Physician Work RVU: 2.03</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		17.00	17.00	0.00
<b>Pre-Service Positioning Time:</b>		1.00	1.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00
<b>Intra-Service Time:</b>		10.00		
<b>Immediate Post Service-Time:</b>	<b>10.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>32.00</b>	99211x 0.00 12x 2.00 13x 0.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00		

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
23075	090	4.21	RUC Time

CPT Descriptor Excision, tumor, soft tissue of shoulder area, subcutaneous; less than 3 cm**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
46930	090	1.61	RUC Time	17,848

CPT Descriptor 1 Destruction of internal hemorrhoid(s) by thermal energy (eg, infrared coagulation, cautery, radiofrequency)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
12052	010	2.87	RUC Time	77,119

CPT Descriptor 2 Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
26600	090	2.60	RUC Time

CPT Descriptor Closed treatment of metacarpal fracture, single; without manipulation, each bone**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 8      % of respondents: 40.0 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 67922</b>	<b>Key Reference CPT Code: 23075</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	23.00	25.00	
Median Intra-Service Time	10.00	10.00	
Median Immediate Post-service Time	10.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	19.00	
Median Office Visit Time	32.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
<b>Median Total Time</b>	<b>75.00</b>	<b>113.00</b>	

Other time if appropriate		
---------------------------	--	--

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.63	2.38
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.13	2.38
--	------	------

Urgency of medical decision making	2.63	2.00
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.75	2.13
--------------------------	------	------

Physical effort required	2.13	2.25
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.38	2.00
---	------	------

Outcome depends on the skill and judgment of physician	2.88	2.50
--	------	------

Estimated risk of malpractice suit with poor outcome	2.25	1.88
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.30	2.25
----------------------------------	------	------

Intra-Service intensity/complexity	2.00	2.25
------------------------------------	------	------

Post-Service intensity/complexity	2.00	2.00
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Another procedure, CPT 67917 Repair of ectropion; extensive (e.g., tarsal strip operations), was identified in the CY 2013 Final Physician Fee Schedule by CMS as a potentially misvalued service. The Academy submitted an action plan to the RAW in October 2012 identifying the entire family including the

ectropion procedures of CPT Codes 67914, 67915, 67916 and 67917 as well as the entropion procedures of CPT 67921, 67922 67923 and 67924 to survey for consideration at the April 2013 AMA RUC meeting.

### **CPT 67922 Survey Analysis**

The AAO survey had 23 respondents reflecting the low volume for this code. The median WRVU was 4.25 and the 25<sup>th</sup> percentile was 4.00. The median IST was 10 minutes. There are two 99212 postoperative visits in the 90-day global period. These are necessary to be certain that punctate keratitis does not develop as the eye heals. The current value of the code is 3.26. Preservice package 6 was chosen as this is primarily an office-based procedure. The primary reference code CPT 23075 *Excision, tumor, soft tissue of shoulder area, subcutaneous; less than 3 cm* was RUC reviewed in February 2009. It has an RVU of 4.21. For almost all categories, respondents indicated that the reference code and the surveyed code were similar in intensity and complexity.

### **CPT 67922 WRVU Recommendation**

The typical patient has symptomatic inversion of the lower eyelid margin with symptoms of redness, tearing and matting of the lashes. Corneal injury is common from mechanical irritation from the lashes. The surgical techniques to correct this problem have changed little over the years. The volume for this code is low at 252/yr. This surgery is performed primarily in patients who are too frail to undergo a more extensive lid procedure. The code has a 90-day global period and is performed primarily in the office setting and at the bedside.

The AAO expert panel which was familiar with the surgery and the RUC process reviewed the results. The panel felt that the low volume for the code made both the number of respondents and the performance level lower than desired. The panel agreed that the surveyed code was less work with a shorter IST than the reference code and a consensus recommendation is being put forward. The panel also believes that the current value of the code is too high. After review of RUC codes with similar times and postoperative visits, the Academy consensus panel recommends a value of 2.03 WRVU. This value is less than the 25<sup>th</sup> percentile of the survey.

There are very few 90-day global codes with an IST this short. CPT 26600 *Closed treatment of metacarpal fracture, single; without manipulation, each bone* (RUC August 2005) has a WRVU of 2.62 with an IST of 15 minutes. CPT 46930 *Destruction of internal hemorrhoid(s) by thermal energy (e.g., infrared coagulation, cautery, radiofrequency)* (RUC April 2008) has 5 minutes of IST and one 99213 visit and a WRVU of 1.61. CPT 67915 takes more time and has more postoperative visits. CPT 36589 *Removal of tunneled central venous catheter, without subcutaneous port or pump* (RUC 2003) is a 10-day global with one visit at the 99211 level, IST of 13 minutes and a WRVU of 2.28. The recommended value of 2.03 WRVU is consistent with the work value, time, intensity and complexity of these codes.

### **SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.



**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) N/A

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology How often? Rarely

Specialty Plastic and Reconstructive Surgeons How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 252

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC Database

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States?

**Professional Liability Insurance Information (PLI)**

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 67922

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 67923	Tracking Number	Original Specialty Recommended RVU: <b>6.05</b>
		Presented Recommended RVU: <b>6.05</b>
Global Period: 090		RUC Recommended RVU: <b>5.48</b>

CPT Descriptor: Repair of entropion; excision tarsal wedge

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 65 yo male presents with constant ocular irritation, mattering, and redness three months after a traumatic eyelid laceration. His symptoms fail to respond to topical lubricants, antibiotics and eyelash epilation. The examination confirms thinning of a central segment of the lower eyelid margin with aberrant lashes growing towards the globe. This is associated with tarsal laxity, normal canthal tendons and breakdown of the ocular surface.

Percentage of Survey Respondents who found Vignette to be Typical: 83%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 12% , In the ASC 71%, In the office 17%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 69%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 30%

Description of Pre-Service Work: The patient history, physical exam and appropriate preoperative tests are reviewed. The preoperative interval history and exam are documented. Photographs are reviewed. The surgical plan is discussed with the patient, all questions are addressed and surgical consent is reviewed. The forehead is marked to indicate the operative eye. The patient is positioned and the surgical eye is confirmed with the patient, surgical and anesthesia team. The eye and periocular area are prepped and draped. After conscious sedation is initiated, the surgeon adds topical anesthesia to both eyes and injects a local anesthetic block to the operative eyelid while the patient is monitored.

Description of Intra-Service Work: A full thickness incision is made through the tarsus just medial to the aberrant lower eyelid margin. The edges are overlapped to ensure the aberrant margin can be safely excised. The lateral edge is marked with methylene blue. A full thickness pentagonal wedge resection is removed containing the aberrant eyelid margin. Absolute hemostasis is achieved with handheld cautery. The lower eyelid retractors are closed with a running 6-0 absorbable suture. The tarsus is closed with two horizontal mattress sutures at the inferior tarsal border and the posterior eyelid margin. The eyelid margin is closed with two interrupted sutures at the grey line and anterior lash line. The skin is closed with a running suture, incorporating the ends of the eyelid margin sutures to present contact of the margin sutures with the globe.

Description of Post-Service Work: The eye and eyelids are cleaned and the wounds dressed with antibiotic drops and ointment. Pain management is discussed and the IV removed. The patient and family are given detailed postoperative care instructions and appropriate prescriptions. An operative report is produced, and required paperwork completed. Follow-up visits are scheduled.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Stephen A. Kamenetzky, M.D./Tamara Fountain, M.D.				
<b>Specialty(s):</b>	AAO and American Society of Ophthalmic Plastic and Reconstructive Surgeons				
<b>CPT Code:</b>	67923				
<b>Sample Size:</b>	368	<b>Resp N:</b>	24	<b>Response:</b> 6.5 %	
<b>Description of Sample:</b>	Random sample of members were pulled from the AAO and American Society of Ophthalmic Plastic and Reconstructive Surgeons membership databases.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	1.00	<b>10.00</b>	21.25	100.00
<b>Survey RVW:</b>	5.01	6.23	<b>6.70</b>	7.46	12.00
<b>Pre-Service Evaluation Time:</b>			<b>26.50</b>		
<b>Pre-Service Positioning Time:</b>			<b>6.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>10.00</b>		
<b>Intra-Service Time:</b>	0.00	20.00	<b>25.00</b>	35.00	45.00
<b>Immediate Post Service-Time:</b>	<b>10.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>38.00</b>	99238x 1.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>55.00</b>	99211x 0.00 12x 2.00 13x 1.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1b-FAC Straightforw Pat Procedure(w sedate/anes)

<b>CPT Code:</b>	67923	<b>Recommended Physician Work RVU: 5.48</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>19.00</b>	<b>19.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>1.00</b>	<b>1.00</b>	<b>0.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>5.00</b>	<b>5.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>25.00</b>		
<b>Immediate Post Service-Time:</b>	<b>10.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>19.00</b>	99238x 0.5 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>55.00</b>	99211x 0.00 12x 2.00 13x 1.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00		

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
15823	090	6.81	RUC Time

CPT Descriptor Blepharoplasty, upper eyelid; with excessive skin weighting down lid**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
64721	090	4.97	RUC Time	818

CPT Descriptor 1 Neuroplasty and/or transposition; median nerve at carpal tunnel

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
49650	090	6.36	RUC Time	26,234

CPT Descriptor 2 Laparoscopy, surgical; repair initial inguinal hernia

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
28820	090	5.82	RUC Time

CPT Descriptor Amputation, toe; metatarsophalangeal joint**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 9      % of respondents: 37.5 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 67923</b>	<b>Key Reference CPT Code: 15823</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	25.00	16.00	
Median Intra-Service Time	25.00	45.00	
Median Immediate Post-service Time	10.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	55.0	71.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
<b>Median Total Time</b>	<b>134.00</b>	<b>161.00</b>	
<b>Other time if appropriate</b>			

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.89	3.00
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.56	2.89
--	------	------

Urgency of medical decision making	3.22	3.44
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.67	3.00
--------------------------	------	------

Physical effort required	2.67	3.00
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.67	3.11
---	------	------

Outcome depends on the skill and judgment of physician	3.11	3.56
--	------	------

Estimated risk of malpractice suit with poor outcome	2.67	3.44
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.89	3.33
----------------------------------	------	------

Intra-Service intensity/complexity	2.78	3.11
------------------------------------	------	------

Post-Service intensity/complexity	2.56	2.89
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Another eyelid repair procedure CPT 67917 Repair of ectropion; extensive (eg, tarsal strip operations) was identified in the CY 2013 Final Physician Fee Schedule by CMS as a potentially misvalued service. The Academy submitted an action plan to the RAW in October 2012 identifying the entire family as including the ectropion procedures of CPT Codes 67914, 67915, 67916 and 67917 as well the entropion procedures of CPT 67921, 67922 67923 and 67924 to survey for consideration at the April 2013 AMA RUC meeting.

**CPT 67923 Survey Analysis**

The AAO survey had 24 respondents, reflecting the low volume of the code. The median WRVU was 6.70 and the 25<sup>th</sup> percentile was 6.23. The median IST was 25 minutes. There were three postoperative visits in the 90-day global period. The current value of the code is 6.05. Preservice package 1B was chosen. The primary reference code CPT 15823 *Blepharoplasty, upper eyelid; with excessive skin weighting down lid* was RUC reviewed in February 2010. It has an RVU of 6.81. For all categories, respondents indicated that the reference code was more intense and complex than the surveyed code.

**CPT 67923 Recommendation**

The typical patient for CPT 67923 has symptomatic inversion of the lower eyelid margin with symptoms of redness, tearing and mattering of the lashes. The surgical techniques to correct this problem have changed little over the years. The volume for this code is low at 2615/yr. This surgery is performed for patients who have mild to moderate entropion. The code has a 90-day global period and is performed primarily in the facility setting.

The AAO expert panel which was familiar with the surgery and the RUC process reviewed the results. The panel felt that it was a good survey although the number of respondents was lower than ideal. This was due to the low performance rate for this procedure. The panel agreed that the surveyed code was less work than the reference code and a consensus recommendation is being put forward. The panel felt that there is no compelling evidence that the currently the code is misvalued. Therefore, the panel recommended that the current value of 6.05 WRVU be maintained. This value is less than the 25<sup>th</sup> percentile of the survey.

There are several codes in the database that have similar values to the recommended value for this code. CPT 28820 *Amputation, toe; metatarsophalangeal joint* (RUC October 2010) has a WRVU of 5.82 with 30 minutes of IST and 4 postoperative visits. CPT 26951, *Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure* (RUC August 2005) has a WRVU of 6.04, 30 min IST and more post-operative visits. CPT 25605 *Closed treatment of distal radial fracture (e.g., Colles or Smith type) or epiphyseal separation, includes closed treatment of fracture of ulnar styloid, when performed; with manipulation* has 30 minutes of IST and a work value of 6.25. Another orthopedic code CPT 25520 *Closed treatment of radial shaft fracture and closed treatment of dislocation of distal radioulnar joint (Galeazzi fracture/dislocation)* has an IST of 30 minutes, WRVU of 6.5 and slightly more postoperative care. These comparison codes indicate that 67923 is fairly valued at the recommended WRVU of 6.05.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) N/A

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology

How often? Sometimes

Specialty Plastic and Reconstructive Surgery

How often? Rarely

Specialty

How often?

Estimate the number of times this service might be provided nationally in a one-year period? Primarily a Medicare pop.  
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,615  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC Database

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States? No

**Professional Liability Insurance Information (PLI)**

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 67923

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 67924      Tracking Number

Original Specialty Recommended RVU: **5.93**Presented Recommended RVU: **5.93**

Global Period: 090

RUC Recommended RVU: **5.93**

CPT Descriptor: Repair of entropion; extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 75 year old female presents with progressive ocular irritation, mattering, and redness. Her symptoms fail to respond to topical lubricants and antibiotics. The examination confirms the entire lower eyelid margin rolled inward with lashes touching the globe. This is associated with a complete dehiscence of the lower eyelid retractors, tarsal/canthal tendon laxity and breakdown of the ocular surface.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 9% , In the ASC 79%, In the office 12%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 70%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 31%

Description of Pre-Service Work: The patient history, physical exam and appropriate preoperative tests are reviewed. The preoperative interval history and exam are documented. Photographs are reviewed. The surgical plan is discussed with the patient, all questions are addressed and surgical consent is reviewed. The forehead is marked to indicate the operative eye. The patient is positioned and the surgical eye is confirmed with the patient, surgical and anesthesia team. The eye and periocular area are prepped and draped. After conscious sedation is initiated, the surgeon adds topical anesthesia to both eyes and injects a local anesthetic block to the operative eyelid while the patient is monitored.

Description of Intra-Service Work: The lower eyelid is supported with two 4-0 silk vertical traction sutures placed in the medial and lateral eyelid margin. A lower eyelid crease incision is marked and later incised 5mm inferior to the punctum tapering to 7mm laterally. Electrodissection is used to expose the orbital septum which is incised. The capsulopalpebral fascia (CPF) is exposed with blunt and sharp dissection. Any significant fat present within the wound is clamped, cut, cauterized and observed for hemostasis prior to allowing it to retract into the orbit. A solid portion of the CPF is sutured to the inferior tarsal border with five or more interrupted 6-0 permanent sutures across the entire lower tarsus. The eyelid position is inspected for remaining laxity and the degree of marginal retraction. The sutures removed and adjusted, if necessary. The inferior lower eyelid skin is draped over the wound and any excess skin is excised. Absolute hemostasis is achieved with cautery. An eyelid crease closure is achieved with interrupted 6-0 absorbable sutures grasping the CPF with each bite.

Description of Post-Service Work: The eye and eyelids are cleaned and the wounds dressed with antibiotic drops and ointment. Pain management is discussed and IV removed. The patient and family are given detailed postoperative care



instructions and appropriate prescriptions. An operative report is produced, and required paperwork completed. Follow-up visits are scheduled.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2013				
<b>Presenter(s):</b>	Stephen A. Kamenetzky, M.D./Tamara Fountain, M.D.					
<b>Specialty(s):</b>	AAO and American Society of Ophthalmic Plastic and Reconstructive Surgeons					
<b>CPT Code:</b>	67924					
<b>Sample Size:</b>	368	<b>Resp N:</b>	33	<b>Response:</b> 8.9 %		
<b>Description of Sample:</b>	Random sample of members were pulled from the AAO and American Society of Ophthalmic Plastic and Reconstructive Surgeons membership databases.					
		<b><u>Low</u></b>	<b><u>25<sup>th</sup> pctl</u></b>	<b><u>Median*</u></b>	<b><u>75<sup>th</sup> pctl</u></b>	<b><u>High</u></b>
<b>Service Performance Rate</b>		1.00	20.00	<b>30.00</b>	50.00	200.00
<b>Survey RVW:</b>		6.00	6.75	<b>7.30</b>	8.00	22.00
<b>Pre-Service Evaluation Time:</b>				<b>35.00</b>		
<b>Pre-Service Positioning Time:</b>				<b>10.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>10.00</b>		
<b>Intra-Service Time:</b>		10.00	30.00	<b>40.00</b>	45.00	90.00
<b>Immediate Post Service-Time:</b>	<b><u>10.00</u></b>					
<b><u>Post Operative Visits</u></b>	<b><u>Total Min**</u></b>	<b><u>CPT Code and Number of Visits</u></b>				
<b>Critical Care time/visit(s):</b>	<b><u>0.00</u></b>	99291x 0.00	99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b><u>0.00</u></b>	99231x 0.00	99232x 0.00	99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b><u>38.00</u></b>	99238x 1.00	99239x 0.00	99217x 0.00		
<b>Office time/visit(s):</b>	<b><u>69.00</u></b>	99211x 0.00	12x 0.00	13x 3.00	14x 0.00	15x 0.00
<b>Prolonged Services:</b>	<b><u>0.00</u></b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00	
<b>Sub Obs Care:</b>	<b><u>0.00</u></b>	99224x 0.00	99225x 0.00	99226x 0.00		

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

1b-FAC Straightforw Pat Procedure(w sedate/anes)

CPT Code:	67924	Recommended Physician Work RVU: 5.93			
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:		19.00	19.00	0.00	
Pre-Service Positioning Time:		1.00	1.00	0.00	
Pre-Service Scrub, Dress, Wait Time:		5.00	5.00	0.00	
Intra-Service Time:		40.00			
Immediate Post Service-Time:	10.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	19.00	99238x 0.5	99239x 0.0	99217x 0.00	
Office time/visit(s):	55.00	99211x 0.00	12x 2.00	13x 1.00	14x 0.00 15x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	0.00	99224x 0.00	99225x 0.00	99226x 0.00	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
67911	090	7.50	RUC Time

CPT Descriptor Correction of lid retraction**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
33212	090	5.26	RUC Time	10,897

CPT Descriptor 1 Insertion of pacemaker pulse generator only; with existing single lead

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
49650	090	6.36	RUC Time	26,234

CPT Descriptor 2 Laparoscopy, surgical; repair initial inguinal hernia

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
46060	090	6.37	RUC Time

CPT Descriptor Incision and drainage of ischiorectal or intramural abscess, with fistulectomy or fistulotomy, submuscular, with or without placement of seton**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 15      % of respondents: 45.4 %

**TIME ESTIMATES (Median)**

	<u>CPT Code:</u> 67924	<u>Key Reference CPT Code:</u> 67911	<u>Source of Time</u> RUC Time
Median Pre-Service Time	25.00	35.00	
Median Intra-Service Time	40.00	50.00	
Median Immediate Post-service Time	10.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	55.0	64.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
<b>Median Total Time</b>	<b>149.00</b>	<b>183.00</b>	

Other time if appropriate		
---------------------------	--	--

**INTENSITY/COMPLEXITY MEASURES (Mean)** (of those that selected Key Reference code)

**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.40	3.47
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.07	3.13
--	------	------

Urgency of medical decision making	3.67	3.07
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.27	3.93
--------------------------	------	------

Physical effort required	3.67	3.53
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.73	3.47
---	------	------

Outcome depends on the skill and judgment of physician	4.13	3.93
--	------	------

Estimated risk of malpractice suit with poor outcome	3.00	3.20
--	------	------

**INTENSITY/COMPLEXITY MEASURES** **CPT Code** **Reference Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	3.33	3.27
----------------------------------	------	------

Intra-Service intensity/complexity	3.93	3.73
------------------------------------	------	------

Post-Service intensity/complexity	3.13	3.07
-----------------------------------	------	------

---

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Another eyelid repair procedure CPT 67917 Repair of ectropion; extensive (e.g., tarsal strip operation) was identified in the CY 2013 Final Physician Fee Schedule by CMS as a potentially misvalued service. The Academy submitted an action plan to the RAW in October 2012 identifying the entire family including

the ectropion procedures of CPT Codes 67914, 67915, 67916 and 67917 and the entropion procedures of CPT 67921, 67922 67923 and 67924 to survey for consideration at the April 2013 AMA RUC meeting.

### **CPT 67924 Survey Analysis**

The AAO survey had 33 respondents and a tight survey. The median WRVU was 7.3 and the 25<sup>th</sup> percentile was 6.75. The median IST was 40 minutes. There were three postoperative visits in the 90-day global period. The current value of the code is 5.93 RVU. Preservice package 1B was chosen. The primary reference code CPT 67911 *Correction of lid retraction* was RUC reviewed in August 2005. It has an RVU of 7.50. Across all categories, respondents indicated that the reference code and the surveyed code were similar in intensity and complexity.

### **CPT 67924 Recommendation**

The typical patient treated for entropion has symptomatic inversion of the lower eyelid margin with symptoms of redness, tearing and matting of the lashes. The cornea is also subject to irritation from in-turned lashes. The surgical techniques to correct this problem have changed little over the years. The volume for this code is 12924/yr. This procedure is the most complex in the family for correction of entropion, performed in patients who have the most severe disease. The code has a 90-day global period and is performed primarily in the facility setting.

The AAO expert panel which was familiar with the surgery and the RUC process reviewed the results. The panel felt that it was a good survey. The reference code has a longer intraservice time but similar postoperative care. The panel felt, however, that there is no compelling evidence that the current code is misvalued using RUC-approved criteria. Therefore, the panel recommended that the current value of 5.93 WRVU be maintained. This value is less than the 25<sup>th</sup> percentile of the survey.

There are codes in the database that have similar values to the recommended value for this code. CPT 67912 *Correction of lagophthalmos, with implantation of upper eyelid lid load (eg, gold weight)* (RUC reviewed April 2003) has a WRVU of 6.36, a slightly longer IST and the same number of postoperative visits. CPT 46060, *Incision and drainage of ischiorectal or intramural abscess, with fistulectomy or fistulotomy, submuscular, with or without placement of seton* (RUC August 2005) has an RVU of 6.37, an IST of 40 and the same number of postoperative visits. Similarly CPT 25109 *Excision of tendon, forearm and/or wrist, flexor or extensor, each* (RUC April 2006) has WRVU of 6.94, 40 minutes of IST and 3 postoperative visits. These comparison codes indicate that 67924 is certainly not overvalued at the recommended WRVU of 5.93.

## **SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) N/A

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology                      How often? Sometimes

Specialty Plastic and Reconstructive How often? Rarely

Specialty	How often?
-----------	------------

Estimate the number of times this service might be provided nationally in a one-year period? Primarily Medicare pop. If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?  
12,594 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.  
Please explain the rationale for this estimate. RUC Database

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States? No

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 67924

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN	
12	ISSUE: Eyelid Repair Codes																																								
13	TAB: 24																																								
14						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day					FAC-obs				Office					Prolonged						
15	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	
16	REF	67911	Correction of lid retraction		0.081			7.50			183	10	10	15			50			15						0.5						4									
17	CURRENT	67914	Repair of ectropion; suture	33	0.114			3.75			79	9		15			22			9												1.5									
18	SVY	67914	Repair of ectropion;		0.080	0.90	4.22	5.25	6.80	12.00	149	30	5	10	3	15	20	25	45	10						0.5						1	2								
19	REC				0.023	3.75					129	19	1	5			20			10						0.5						1	2								
20																																									
21						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day					FAC-obs				Office					Prolonged						
22	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	
23	REF	23075	Excision, tumor, soft tissue of		0.035			4.21			142	14	10	10			30			20						0.5						1	1								
24	CURRENT	67915	Repair of Ectropion; thermocauterization		0.119			3.26			60	9					18			9												1.5									
25	SVY	67915	Repair of Ectropion; thermocauterization	23	0.245	3.30	4.00	4.25	4.90	9.00	84	20	5	7	8	10	15	45	10													2									
26	REC				0.051	2.03					70	17	1	5			10			5												2									
27																																									
28						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day					FAC-obs				Office					Prolonged						
29	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	
30	REF	15823	Blepharoplasty		0.072			6.81			161	10	1	5			45			10						0.5						1	3								
31	CURRENT	67916	Repair of ectropion; excision tarsal wedge		0.079			5.48			141	18		15			37			15												3.5									
32	SVY	67916	Repair of ectropion; excision tarsal wedge	28	0.158	4.90	6.19	7.50	7.11	13.00	149	25	5	10	15	20	25	30	45	10						0.5						1	2								
33	REC				0.088	5.48					134	19	1	5			25			10						0.5						1	2								
34																																									
35						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day					FAC-obs				Office					Prolonged						
36	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	
37	REF	15823	Blepharoplasty		0.072			6.81			161	10	1	5			45			10						0.5						1	3								
38	CURRENT	67917	Repair of ectropion; extensive		0.072			6.19			159	20		15			49			19												3.5									
39	SVY	67917	Repair of ectropion; extensive	34	0.098	6.01	6.66	6.86	7.50	18.00	162	30	5	10	10	25	33	40	60	10						0.5						1	2								
40	REC				0.080	5.93					142	19	1	5			33			10						0.5						1	2								
41																																									
42						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day					FAC-obs				Office					Prolonged						
43	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN	
14						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day					FAC-obs				Office					Prolonged						
15	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	
44	REF	23075	Excision, tumor, soft tissue of shoulder area, subcutaneous; less than 3 cm		0.035			4.21			142	14	10	10			30			20					0.5							1	1								
45	CURRENT	67921	Repair of entropion; suture		0.107			3.47			64	9					22			9												1.5									
46	SVY	67921	Repair of entropion; suture	30	0.099	3.50	4.21	5.03	6.00	12.00	139	25	5	10	5	10	15	25	45	10					0.5							1	2								
47	REC				0.013	3.47					124	19	1	5			15			10					0.5						1	2									
48																																									
49						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day					FAC-obs				Office					Prolonged						
50	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	
51	REF	23075	Excision, tumor, soft tissue of shoulder area, subcutaneous; less than 3 cm		0.035			4.21			142	14	10	10			30			20					0.5							1	1								
52	CURRENT	67922	Repair of entropion; thermocauterization		0.131			3.14			59	10					15			10												1.5									
53	SVY	67922	Repair of entropion; thermocauterization	20	0.263	3.00	4.00	4.45	5.00	8.00	87	20	5	10	0	9	10	20	30	10												2									
54	REC				0.063	2.03					65	17	1	5			10															2									
55																																									
56						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day					FAC-obs				Office					Prolonged						
57	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	
58	REF	15823	Blepharoplasty		0.072			6.81			161	10	1	5			45			10					0.5							1	3								
59	CURRENT	67923	Repair of entropion; excision of tarsal wedge		0.096			6.05			142	19		15			36			16												3.5									
60	SVY	67923	Repair of entropion; excision of tarsal wedge	24	0.124	5.01	6.23	6.70	7.46	12.00	152	26.5	6	10	0	20	25	35	45	10						0.5						1	2								
61	REC				0.088	5.48					134	19	1	5			25			10						0.5					1	2									
62																																									
63						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day					FAC-obs				Office					Prolonged						
64	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	
65	REF	67911	Correction of lid retraction		0.081			7.50			183	10	10	15			50			15					0.5							4									
66	CURRENT	67924	Repair of entropion; extensive		0.052			5.93			177	21		15			54			20					0.5							3									
67	SVY	67924	Repair of entropion; extensive	33	0.085	6.00	6.75	7.30	8.00	22.00	179	35	10	10	10	30	40	45	90	10						0.5						1	2								
68	REC				0.066	5.93					149	19	1	5			40			10						0.5					1	2									



**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor: 67914 Repair of ectropion; suture

Global Period: 090

Meeting Date: 4/2013

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Academy convenes a Consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. Additionally we use other physicians who have the appropriate expertise. The consensus committee reviewed the current PE details and made the appropriate changes to clinical time in order to match the survey results and any standard packages that are now applicable as compared to the current facility input. The existing supplies and equipment were also reviewed and any needed adjustments were also applied

If you have provided any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:

This code is an existing code being evaluated per CMS request in the 2013 NPRM Table 7.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Standard 90-day global times to: Complete pre-service diagnostic & referral forms; Coordinate pre-surgery services; Schedule space and equipment in facility; Provide pre-service education/obtain consent, and follow-up phone calls & prescriptions.

Intra-Service Clinical Labor Activities:

Standard 6 minutes for discharge day management coordination.

Post-Service Clinical Labor Activities:

Standard times for post-operative office visits at the appropriate levels.

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor: 67914 Repair of Ectropion; suture

Global Period: 090 Meeting Date: April 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Academy convenes a Consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. Additionally we use other physicians who have the appropriate expertise. The consensus committee reviewed the current PE details and made the appropriate changes to clinical time in order to match the survey results and any standard packages that are now applicable as compared to the current facility input. The existing supplies and equipment were also reviewed and any needed adjustments were also applied

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

This code is an existing code being evaluated per CMS request in the 2013 NPRM Table 7.

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time: N/A

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence: N/A

5. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Standard 90-day global times to: Complete pre-service diagnostic & referral forms; Coordinate pre-surgery services; Schedule space and equipment in facility; Provide pre-service education/obtain consent, and follow-up phone calls & prescriptions.

Intra-Service Clinical Labor Activities:

Standard 6 minutes for discharge day management coordination.

Post-Service Clinical Labor Activities:

Standard times for post-operative office visits at the appropriate levels.

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor: 67915 Repair of ectropion; thermocauterization

Global Period: 090

Meeting Date: 4/2013

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Academy convenes a Consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. Additionally we use other physicians who have the appropriate expertise. The consensus committee reviewed the current PE details and made the appropriate changes to clinical time in order to match the survey results and any standard packages that are now applicable as compared to the current facility input. The existing supplies and equipment were also reviewed and any needed adjustments were also applied

If you have provided any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:

This code is an existing code being evaluated per CMS request in the 2013 NPRM Table 7.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Standard 90-day global times to: Complete pre-service diagnostic & referral forms; Coordinate pre-surgery services; Schedule space and equipment in facility; Provide pre-service education/obtain consent, and follow-up phone calls & prescriptions.

Intra-Service Clinical Labor Activities:

Standard 6 minutes for discharge day management coordination.

Post-Service Clinical Labor Activities:

Standard times for post-operative office visits at the appropriate levels.

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor: 67915 Repair of Ectropion; thermocauterization

Global Period: 090 Meeting Date: April 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Academy convenes a Consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. Additionally we use other physicians who have the appropriate expertise. The consensus committee reviewed the current PE details and made the appropriate changes to clinical time in order to match the survey results and any standard packages that are now applicable as compared to the current facility input. The existing supplies and equipment were also reviewed and any needed adjustments were also applied

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

This code is an existing code being evaluated per CMS request in the 2013 NPRM Table 7.

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time: N/A

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence: N/A

5. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Standard 90-day global times to: Complete pre-service diagnostic & referral forms; Coordinate pre-surgery services; Schedule space and equipment in facility; Provide pre-service education/obtain consent, and follow-up phone calls & prescriptions.

Intra-Service Clinical Labor Activities:

Standard 6 minutes for discharge day management coordination.

Post-Service Clinical Labor Activities:

Standard times for post-operative office visits at the appropriate levels.

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor: 67916 Repair of ectropion; excision tarsal wedge

Global Period: 090

Meeting Date: 4/2013

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Academy convenes a Consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. Additionally we use other physicians who have the appropriate expertise. The consensus committee reviewed the current PE details and made the appropriate changes to clinical time in order to match the survey results and any standard packages that are now applicable as compared to the current facility input. The existing supplies and equipment were also reviewed and any needed adjustments were also applied

If you have provided any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:

This code is an existing code being evaluated per CMS request in the 2013 NPRM Table 7.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Standard 90-day global times to: Complete pre-service diagnostic & referral forms; Coordinate pre-surgery services; Schedule space and equipment in facility; Provide pre-service education/obtain consent, and follow-up phone calls & prescriptions.

Intra-Service Clinical Labor Activities:

Standard 6 minutes for discharge day management coordination.

Post-Service Clinical Labor Activities:

Standard times for post-operative office visits at the appropriate levels.

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor: 67916 Repair of Ectropion; excision tarsal wedge

Global Period: 090 Meeting Date: April 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Academy convenes a Consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. Additionally we use other physicians who have the appropriate expertise. The consensus committee reviewed the current PE details and made the appropriate changes to clinical time in order to match the survey results and any standard packages that are now applicable as compared to the current facility input. The existing supplies and equipment were also reviewed and any needed adjustments were also applied

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

This code is an existing code being evaluated per CMS request in the 2013 NPRM Table 7.

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time: N/A

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence: N/A

5. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Standard 90-day global times to: Complete pre-service diagnostic & referral forms; Coordinate pre-surgery services; Schedule space and equipment in facility; Provide pre-service education/obtain consent, and follow-up phone calls & prescriptions.

Intra-Service Clinical Labor Activities:

Standard 6 minutes for discharge day management coordination.

Post-Service Clinical Labor Activities:

Standard times for post-operative office visits at the appropriate levels.

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor: 67917 Repair of ectropion; extensive (eg, tarsal strip operations)

Global Period: 090

Meeting Date: 4/2013

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Academy convenes a Consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. Additionally we use other physicians who have the appropriate expertise. The consensus committee reviewed the current PE details and made the appropriate changes to clinical time in order to match the survey results and any standard packages that are now applicable as compared to the current facility input. The existing supplies and equipment were also reviewed and any needed adjustments were also applied

If you have provided any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:

This code is an existing code being evaluated per CMS request in the 2013 NPRM Table 7.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Standard 90-day global times to: Complete pre-service diagnostic & referral forms; Coordinate pre-surgery services; Schedule space and equipment in facility; Provide pre-service education/obtain consent, and follow-up phone calls & prescriptions.

Intra-Service Clinical Labor Activities:

Standard 6 minutes for discharge day management coordination.

Post-Service Clinical Labor Activities:

Standard times for post-operative office visits at the appropriate levels.

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor: 67917 Repair of Ectropion; (e.g., tarsal strip operations)

Global Period: 090 Meeting Date: April 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Academy convenes a Consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. Additionally we use other physicians who have the appropriate expertise. The consensus committee reviewed the current PE details and made the appropriate changes to clinical time in order to match the survey results and any standard packages that are now applicable as compared to the current facility input. The existing supplies and equipment were also reviewed and any needed adjustments were also applied

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

This code is an existing code being evaluated per CMS request in the 2013 NPRM Table 7.

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time: N/A

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence: N/A

5. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Standard 90-day global times to: Complete pre-service diagnostic & referral forms; Coordinate pre-surgery services; Schedule space and equipment in facility; Provide pre-service education/obtain consent, and follow-up phone calls & prescriptions.

Intra-Service Clinical Labor Activities:

Standard 6 minutes for discharge day management coordination.

Post-Service Clinical Labor Activities:

Standard times for post-operative office visits at the appropriate levels.



**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor: 67921 Repair of entropion; suture

Global Period: 090

Meeting Date: 4/2013

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Academy convenes a Consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. Additionally we use other physicians who have the appropriate expertise. The consensus committee reviewed the current PE details and made the appropriate changes to clinical time in order to match the survey results and any standard packages that are now applicable as compared to the current facility input. The existing supplies and equipment were also reviewed and any needed adjustments were also applied

If you have provided any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:

This code is an existing code being evaluated per CMS request in the 2013 NPRM Table 7.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Standard 90-day global times to: Complete pre-service diagnostic & referral forms; Coordinate pre-surgery services; Schedule space and equipment in facility; Provide pre-service education/obtain consent, and follow-up phone calls & prescriptions.

Intra-Service Clinical Labor Activities:

Standard 6 minutes for discharge day management coordination.

Post-Service Clinical Labor Activities:

Standard times for post-operative office visits at the appropriate levels.

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor: 67921 Repair of Entropion; suture

Global Period: 090 Meeting Date: April 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Academy convenes a Consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. Additionally we use other physicians who have the appropriate expertise. The consensus committee reviewed the current PE details and made the appropriate changes to clinical time in order to match the survey results and any standard packages that are now applicable as compared to the current facility input. The existing supplies and equipment were also reviewed and any needed adjustments were also applied

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

This code is an existing code being evaluated per CMS request in the 2013 NPRM Table 7.

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time: N/A

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence: N/A

5. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Standard 90-day global times to: Complete pre-service diagnostic & referral forms; Coordinate pre-surgery services; Schedule space and equipment in facility; Provide pre-service education/obtain consent, and follow-up phone calls & prescriptions.

Intra-Service Clinical Labor Activities:

Standard 6 minutes for discharge day management coordination.

Post-Service Clinical Labor Activities:

Standard times for post-operative office visits at the appropriate levels.

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor: 67922 Repair of entropion; thermocauterization

Global Period: 090

Meeting Date: 4/2013

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Academy convenes a Consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. Additionally we use other physicians who have the appropriate expertise. The consensus committee reviewed the current PE details and made the appropriate changes to clinical time in order to match the survey results and any standard packages that are now applicable as compared to the current facility input. The existing supplies and equipment were also reviewed and any needed adjustments were also applied

If you have provided any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:

This code is an existing code being evaluated per CMS request in the 2013 NPRM Table 7.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Standard 90-day global times to: Complete pre-service diagnostic & referral forms; Coordinate pre-surgery services; Schedule space and equipment in facility; Provide pre-service education/obtain consent, and follow-up phone calls & prescriptions.

Intra-Service Clinical Labor Activities:

Standard 6 minutes for discharge day management coordination.

Post-Service Clinical Labor Activities:

Standard times for post-operative office visits at the appropriate levels.

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor: 67922 Repair of Entropion; thermocauterization

Global Period: 090 Meeting Date: April 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Academy convenes a Consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. Additionally we use other physicians who have the appropriate expertise. The consensus committee reviewed the current PE details and made the appropriate changes to clinical time in order to match the survey results and any standard packages that are now applicable as compared to the current facility input. The existing supplies and equipment were also reviewed and any needed adjustments were also applied

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

This code is an existing code being evaluated per CMS request in the 2013 NPRM Table 7.

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time: N/A

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence: N/A

5. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Standard 90-day global times to: Complete pre-service diagnostic & referral forms; Coordinate pre-surgery services; Schedule space and equipment in facility; Provide pre-service education/obtain consent, and follow-up phone calls & prescriptions.

Intra-Service Clinical Labor Activities:

Standard 6 minutes for discharge day management coordination.

Post-Service Clinical Labor Activities:

Standard times for post-operative office visits at the appropriate levels.

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor: 67923 Repair of entropion; excision tarsal wedge

Global Period: 090

Meeting Date: 4/2013

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Academy convenes a Consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. Additionally we use other physicians who have the appropriate expertise. The consensus committee reviewed the current PE details and made the appropriate changes to clinical time in order to match the survey results and any standard packages that are now applicable as compared to the current facility input. The existing supplies and equipment were also reviewed and any needed adjustments were also applied

If you have provided any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:

This code is an existing code being evaluated per CMS request in the 2013 NPRM Table 7.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Standard 90-day global times to: Complete pre-service diagnostic & referral forms; Coordinate pre-surgery services; Schedule space and equipment in facility; Provide pre-service education/obtain consent, and follow-up phone calls & prescriptions.

Intra-Service Clinical Labor Activities:

Standard 6 minutes for discharge day management coordination.

Post-Service Clinical Labor Activities:

Standard times for post-operative office visits at the appropriate levels.

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor: 67923 Repair of Entropion; excision of tarsal wedge

Global Period: 090 Meeting Date: April 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Academy convenes a Consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. Additionally we use other physicians who have the appropriate expertise. The consensus committee reviewed the current PE details and made the appropriate changes to clinical time in order to match the survey results and any standard packages that are now applicable as compared to the current facility input. The existing supplies and equipment were also reviewed and any needed adjustments were also applied

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

This code is an existing code being evaluated per CMS request in the 2013 NPRM Table 7.

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time: N/A

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence: N/A

5. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Standard 90-day global times to: Complete pre-service diagnostic & referral forms; Coordinate pre-surgery services; Schedule space and equipment in facility; Provide pre-service education/obtain consent, and follow-up phone calls & prescriptions.

Intra-Service Clinical Labor Activities:

Standard 6 minutes for discharge day management coordination.

Post-Service Clinical Labor Activities:

Standard times for post-operative office visits at the appropriate levels.

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor: 67924 Repair of entropion; extensive (eg, tarsal strip operations)

Global Period: 090

Meeting Date: 4/2013

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Academy convenes a Consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. Additionally we use other physicians who have the appropriate expertise. The consensus committee reviewed the current PE details and made the appropriate changes to clinical time in order to match the survey results and any standard packages that are now applicable as compared to the current facility input. The existing supplies and equipment were also reviewed and any needed adjustments were also applied

If you have provided any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:

This code is an existing code being evaluated per CMS request in the 2013 NPRM Table 7.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Standard 90-day global times to: Complete pre-service diagnostic & referral forms; Coordinate pre-surgery services; Schedule space and equipment in facility; Provide pre-service education/obtain consent, and follow-up phone calls & prescriptions.

Intra-Service Clinical Labor Activities:

Standard 6 minutes for discharge day management coordination.

Post-Service Clinical Labor Activities:

Standard times for post-operative office visits at the appropriate levels.

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor: 67924 Repair of Entropion; extensive (eg, tarsal strip operations)

Global Period: 090 Meeting Date: April 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Academy convenes a Consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. Additionally we use other physicians who have the appropriate expertise. The consensus committee reviewed the current PE details and made the appropriate changes to clinical time in order to match the survey results and any standard packages that are now applicable as compared to the current facility input. The existing supplies and equipment were also reviewed and any needed adjustments were also applied

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

This code is an existing code being evaluated per CMS request in the 2013 NPRM Table 7.

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time: N/A

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence: N/A

5. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Standard 90-day global times to: Complete pre-service diagnostic & referral forms; Coordinate pre-surgery services; Schedule space and equipment in facility; Provide pre-service education/obtain consent, and follow-up phone calls & prescriptions.

Intra-Service Clinical Labor Activities:

Standard 6 minutes for discharge day management coordination.

Post-Service Clinical Labor Activities:

Standard times for post-operative office visits at the appropriate levels.



	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI
1	REVISED			REF CODE				REF CODE				REF CODE			ociety Recommendation	REF CODE				REF CODE				REF CODE				REF CODE				REF CODE			
2	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.			67914		67914		67915		67915		67916		67916		67917		67917		67921		67921		67922		67922		67923		67923		67924		67924	
3	Meeting Date: 4/25/13 (PEAC REVISED) Tab: 24 Specialty:Ophthalmology	CMS Code	Staff Type	Repair of ectropion; suture		Repair of ectropion; suture		Repair of ectropion; thermo-cauterization		Repair of ectropion; thermo-cauterization		Repair of ectropion, excision of tarsal wedge		Repair of ectropion, excision of tarsal wedge		Repair of ectropion, extensive (eg Tarsal strip operations)		Repair of ectropion, extensive (eg Tarsal strip operations)		Repair of entropion; suture		Repair of entropion; suture		Repair of entropion; thermo-cauterization		Repair of entropion; thermo-cauterization		Repair of entropion; excision tarsal wedge		Repair of entropion; excision tarsal wedge		Repair of entropion, extensive (eg Tarsal strip operations)		Repair of entropion, extensive (eg Tarsal strip operations)	
4	LOCATION			Non Fac	Facilit y	Non Fac	Facilit y	Non Fac	Facilit y	Non Fac	Facilit y	Non Fac	Facilit y	Non Fac	Facility	Non Fac	Facilit y	Non Fac	Facilit y	Non Fac	Facility	Non Fac	Facilit y	Non Fac	Facilit y	Non Fac	Facilit y	Non Fac	Facilit y	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
10	PRE-SERVICE																																		
11	Start: Following visit when decision for surgery or procedure made																																		
12	Complete pre-service diagnostic & referral forms	L038A	COMT/COT/RN/CST	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	
13	Coordinate pre-surgery services	L038A	COMT/COT/RN/CST	10	20	10	20	10	20	10	20	10	20	10	20	10	20	10	20	10	20	10	20	10	20	10	20	10	20	10	20	10	20	10	20
14	Schedule space and equipment in facility	L038A	COMT/COT/RN/CST	0	8	0	8	0	8	0	8	0	8	0	8	0	8	0	8	0	8	0	8	0	8	0	8	0	8	0	8	0	8	0	8
15	Provide pre-service education/obtain consent	L038A	COMT/COT/RN/CST	10	20	10	20	10	20	10	20	10	20	10	20	10	20	10	20	10	20	10	20	10	20	10	20	10	20	10	20	10	20	10	20
16	Follow-up phone calls & prescriptions	L038A	COMT/COT/RN/CST	10	7	10	7	10	7	10	7	10	7	10	7	10	7	10	7	10	7	10	7	10	7	10	7	10	7	10	7	10	7	10	7
17	*Other Clinical Activity - specify:																																		
18	End: When patient enters office/facility for surgery/procedure																																		
19	SERVICE PERIOD																																		
20	Start: When patient enters office/facility for surgery/procedure:																																		
21	Greet patient, provide gowning, ensure appropriate medical records are available	L038A	COMT/COT/RN/CST	3		3		3		3		3		3		3		3		3		3		3		3		3		3		3		3	
22	Obtain vital signs	L038A	COMT/COT/RN/CST	3		3		3		3		3		3		3		3		3		3		3		3		3		3		3		3	
23	Provide pre-service education/obtain consent																																		
24	Prepare room, equipment, supplies					2				2				2				2				2				2				2				2	
25	Setup scope (non facility setting only)																																		
26	Prepare and position patient/ monitor patient/ set up IV																																		
27	Sedate/apply anesthesia																																		
28	*Other Clinical Activity - specify:																																		
29	Intra-service																																		
30	Assist physician in performing procedure	L038A	COMT/COT/RN/CST	15		20		12		10		37		25		49		32.5		15		15		10		10		36		25		54		40	

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI		
1	REVISED			REF CODE				REF CODE				REF CODE		ociety Recommendation		REF CODE				REF CODE				REF CODE				REF CODE				REF CODE					
	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.																																				
2				67914		67914		67915		67915		67916		67916		67917		67917		67921		67921		67922		67922		67923		67923		67924		67924			
3	Meeting Date: 4/25/13 (PEAC REVISED) Tab: 24 Specialty:Ophthalmology	CMS Code	Staff Type	Repair of ectropion; suture		Repair of ectropion; suture		Repair of ectropion; thermo-cauterization		Repair of ectropion; thermo-cauterization		Repair of ectropion, excision of tarsal wedge		Repair of ectropion, excision of tarsal wedge		Repair of ectropion, estensive (eg Tarsal strip operations)		Repair of ectropion, estensive (eg Tarsal strip operations)		Repair of entropion; suture		Repair of entropion; suture		Repair of entropion; thermo-cauterization		Repair of entropion; thermo-cauterization		Repair of entropion; excision tarsal wedge		Repair of entropion; excision tarsal wedge		Repair of entropion, estensive (eg Tarsal strip operations)		Repair of entropion, estensive (eg Tarsal strip operations)			
4	LOCATION			Non Fac	Facilit y	Non Fac	Facilit y	Non Fac	Facilit y	Non Fac	Facilit y	Non Fac	Facilit y	Non Fac	Facility	Non Fac	Facilit y	Non Fac	Facilit y	Non Fac	Facility	Non Fac	Facilit y	Non Fac	Facilit y	Non Fac	Facilit y	Non Fac	Facilit y	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
31	Post-Service																																				
32	Monitor pt. following service/check tubes, monitors, drains																																				
33	Clean room/equipment by physician staff	L038A	COMT/COT/RN/CST	3		3		3		3		3		3		3		3		3		3		3		3		3		3		3		3		3	
34	Clean Scope																																				
35	Clean Surgical Instrument Package	L038A	COMT/COT/RN/CST	10		10						10		10		10		10		10		10		10		10		10		10		10		10		10	
36	Complete diagnostic forms, lab & X-ray requisitions																																				
37	Review/read X-ray, lab, and pathology reports																																				
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions																																				
39	*Other Clinical Activity - specify:																																				
40	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			n/a		n/a	6	n/a		n/a	6	n/a		n/a	6	n/a		n/a	6	n/a		n/a	6	n/a		n/a	6	n/a		n/a		n/a		n/a		6	
41	Dischrg mgmt (1.0 x 99238) (enter 12 min)			n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a			
42	Dischrg mgmt (1.0 x 99239) (enter 15 min)			n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a			
43	End: Patient leaves office																																				
44	POST-SERVICE Period																																				
45	Start: Patient leaves office/facility																																				
46	Conduct phone calls/call in prescriptions																																				
47	Office visits: List Number and Level of Office Visits			# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	
48	99211 16 minutes		16																																		
49	99212 27 minutes		27	1.5	1.5	2	2	1.5	1.5	2	2	3.5	3.5	2	2	3.5	3.5	2	2	1.5	1.5	2	2	1.5	1.5	2	2	3.5	3.5	2	2	3	3	2	2		
50	99213 36 minutes		36			1	1							1	1			1	1			1	1							1	1			1	1		
51	99214 53 minutes		53																																		
52	99215 63 minutes		63																																		
53	Total Office Visit Time			40.5	40.5	90.0	90.0	40.5	40.5	54.0	54.0	94.5	94.5	90.0	90.0	94.5	94.5	90.0	90.0	40.5	40.5	90.0	90.0	40.5	40.5	54.0	54.0	94.5	94.5	90.0	90.0	81.0	81.0	90.0	90.0		
54	*Other Clinical Activity - specify:																																				
55	End: with last office visit before end of global period																																				

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI		
1	REVISED			REF CODE				REF CODE				REF CODE				REF CODE				REF CODE				REF CODE				REF CODE				REF CODE					
2	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the PE Spreadsheet Instructions document for an example.			67914		67914		67915		67915		67916		67916		67917		67917		67921		67921		67922		67922		67923		67923		67924		67924			
3	Meeting Date: 4/25/13 (PEAC REVISED) Tab: 24 Specialty:Ophthalmology	CMS Code	Staff Type	Repair of ectropion; suture		Repair of ectropion; suture		Repair of ectropion; thermo-cauterization		Repair of ectropion; thermo-cauterization		Repair of ectropion, excision of tarsal wedge		Repair of ectropion, excision of tarsal wedge		Repair of ectropion, extensive (eg Tarsal strip operations)		Repair of ectropion, extensive (eg Tarsal strip operations)		Repair of entropion; suture		Repair of entropion; suture		Repair of entropion; thermo-cauterization		Repair of entropion; thermo-cauterization		Repair of entropion; excision tarsal wedge		Repair of entropion; excision tarsal wedge		Repair of entropion, extensive (eg Tarsal strip operations)		Repair of entropion, extensive (eg Tarsal strip operations)			
4	LOCATION			Non Fac	Facilit y	Non Fac	Facilit y	Non Fac	Facilit y	Non Fac	Facilit y	Non Fac	Facilit y	Non Fac	Facility	Non Fac	Facilit y	Non Fac	Facilit y	Non Fac	Facility	Non Fac	Facilit y	Non Fac	Facilit y	Non Fac	Facilit y	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
56	MEDICAL SUPPLIES**	CODE	UNIT																																		
57	pack, ophthalmology visit-no dilation	SA050	pack	2.5	1.5	4	3	2.5	1.5	3	2	4.5	3.5	4	3	4.5	3.5	4	3	2.5	1.5	4	3	2.5	1.5	3	2	4.5	3.5	4	3	4	3	4	3	4	3
58	Betadine	SJ041	ml	5		5		5		5		5		5		5		5		5		5		5		5		5		5		5		5		5	
59	needle, 18-19g, filter	SC027	ea	2		2		2		2		2		2		2		2		2		2		2		2		2		2		2		2		2	
60	surgical cap	SB001	ea	2		2		2		2		2		2		2		2		2		2		2		2		2		2		2		2		2	
61	gloves, sterile	SB024	pair	2		2		2		2		2		2		2		2		2		2		2		2		2		2		2		2		2	
62	shoe covers	SB039	pair	2		2		2		2		2		2		2		2		2		2		2		2		2		2		2		2		2	
63	drape, sterile, mayo stand	SB012	ea	1		1		1		1		1		1		1		1		1		1		1		1		1		1		1		1		1	
64	drape, sterile, U	SB015	ea	1		1		1		1		1		1		1		1		1		1		1		1		1		1		1		1		1	
65	drape/cover, sterile, For O.R. light handle	11106	ea	1				1				1				1				1				1				1				1					
66	Marking pen	SK075	ea	1		1		1		1		1		1		1		1		1		1		1		1		1		1		1		1		1	
67	syringe 5-6ml	SC057	ea	1		1		1		1		1		1		1		1		1		1		1		1		1		1		1		1		1	
68	needle, 18 to 24g	SC029	ea	1		1		1		1		1		1		1		1		1		1		1		1		1		1		1		1		1	
69	needle, 27 to 30g	SC031	ea	1		1		1		1		1		1		1		1		1		1		1		1		1		1		1		1		1	
70	Lidocaine 2% w/ epi	SH049	ml	20		10		20		10		20		10		20		20		20		10		20		10		20		10		20		20		20	
71	BSS irrigation	SH078	15ml	1		1		1		1		1		1		1		1		1		1		1		1		1		1		1		1		1	
72	Blade, scalpel #11,15,20	SF047	ea									1		1		1		1										1		1		1		1		1	
73	Gauze, sterile 4"x4"	SG056	10pack	1		1		1		1		1		1		1		1		1		1		1		1		1		1		1		1		1	
74	applicators, cotton-tipped, sterile, 6in	SG081	ea	10		10		10		10		20		20		20		20		10		10		10		10		20		20		20		20		20	
75	Suture, silk, 4-0	SF039	ea			1				1		1		1		1		1		1		1		1		1		1		1		1		1		1	
76	Suture, nylon, 6-0	SF037	ea									1		1		1		1									1		1		1		1		1		
77	Suture, Vicryl, 5-0	SF040	ea			3						1		3		1		1		3		4						1		3		3		3		3	
78	Pack, cleaning instruments	SA043	ea			1				1		1		1		1		1		1		1				0		1		1				1		1	
79	erythromycin ophthalmic ointment	SH032	ea	0.5		1		0.5		1		0.5		1		0.5		1		0.5		1		0.5		1		0.5		1		0.5		1		1	
80	Tape, Surgical 1" width (eg, Micropore)	SG079	in	12		12		12		12		12		12		12		12		12		12		12		12		12		12		12		12		12	
81	Strabismus Eye pads	SG046	ea	4		2		4		2		4		2		4		2		4		2		4		2		4		2		4		2		2	
82	Eye Shield	SG047	ea									1		1		1		1									1		1		1		1		1		
83	Cautery cord	SF012	ea			1		12		1				1				1				1		10		1			1					1		1	
84	Bipolar hand piece	SF013	ea			1		12		1				1				1				1		10		1			1					1		1	
85	EQUIPMENT	CODE																																			
86	Lane, screening	EL006	ea	55.5	40.5	110.0	90.0	52.5	40.5	64.0	54.0	131.5	94.5	115.0	90.0	143.5	94.5	122.5	90.0	55.5	40.5	105.0	90.0	50.5	40.5	64.0	54.0	130.5	94.5	115.0	90.0	135.0	81.0	130.0	90.0		
87	pack, medium surgical	EQ138	ea			20						37		25				32.5				15							25						40		
88	pack, basic surgical	EQ137	ea	15												49		32.5		15				10		10		36				54					
89	Loupes	EQ176	pair	15		20		12		10		37		25		49		32.5		15		15		10		10		36		25		54		40			
90	Cautery power source	EQ114	ea			20		12		10				25				32.5				15		10		10				25				40			
91																																					
92																																					
93	Stand, Mayo	EF015	ea			20				10				25				32.5				15		10		10				25					40		

AMA/Specialty Society RVS Update Committee Summary of Recommendations  
*CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes*

April 2013

**MRI-Spine**

CPT codes 72141 and 72148 were identified through the CMS High Expenditure Procedural Codes screen. The RUC recommended a survey of physician work and review of practice expense for this family of services at the April 2013 RUC meeting. The specialties added additional codes to survey as part of this family of services. The RUC agreed that the work and intensity of spine codes are similar across lumbar, thoracic and cervical regions. The RUC also discussed that the MRI brain CPT codes were recently reviewed at the January 2013 RUC meeting. The MRI spine codes have similar work and intensity and should maintain rank order with the MRI brain codes.

***72141 Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material***

The RUC reviewed the survey results from 52 radiologists and neuroradiologists and recommends the following physician time components: pre-service time of 5 minutes, intra-service time of 20 minutes and post-service time of 5 minutes. The RUC noted that all services in the family that do not require contrast material have the same amount of pre, intra and post service time and the same level of intensity, and therefore, should be valued the same. The RUC reviewed the survey 25<sup>th</sup> percentile work RVU of 1.60 and determined that the respondents overestimated the physician work required to perform this service. The RUC determined that a work value of 1.48, which is the lowest current RVU out of the three without contrast material codes in the family (CPT code 72148), is the appropriate value for all codes without contrast materials across the lumbar, thoracic and cervical regions. It also maintains relativity with similar CPT code 70551 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material* (RUC recommended work RVU=1.48, 5 minutes pre-time, 18 minutes intra-time, 5 minutes post-time), which the RUC reviewed in January 2013 and recommended the current value.

The RUC also compared the surveyed code to CPT code 70336 *Magnetic resonance (eg, proton) imaging, temporomandibular joint(s)* (work RVU=1.48, 20 minutes intra-time) and noted that the codes have the same intra-service time and should be valued the same. For additional support the RUC compared the surveyed code to CPT code 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family* (work RVU=1.42, 4 minutes pre-time, 20 minutes intra-time, 5 minutes post-time) and 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the*

*patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family (work RVU=1.50, 5 minutes pre-time, 25 minutes intra-time, 10 minutes post-time. The RUC noted that 99203 and the surveyed code have identical intra-service time and similar pre- and post-service time, justifying the similar work value. The RUC also noted that 99214 has slightly more intra-service time but is less intense to perform, justifying the similar work value. **The RUC recommends a work RVU of 1.48 for CPT code 72141.***

***72142 Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; with contrast material(s)***

The RUC reviewed the survey results from 52 radiologists and neuroradiologists and recommend the following physician time components: pre-service time of 5 minutes, intra-service time of 23 minutes and post-service time of 5 minutes. The RUC noted that all services in the family that require contrast materials have the same amount of pre, intra and post service time and the same level of intensity, and therefore, should be valued the same. The RUC reviewed the survey median work RVU of 2.00 and determined that the respondents overestimated the physician work required to perform this service. The RUC determined that a work value of 1.78, which is the lowest current RVU out of the three with contrast material(s) codes in the family (CPT code 72149), is the appropriate value for all codes with contrast material(s) across the lumbar, thoracic and cervical regions. Additionally, the value is between the survey 25<sup>th</sup> and median for this service. It also maintains relativity with similar CPT code 70552 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s)* (RUC recommended work RVU=1.78, 5 minutes pre-time, 20 minutes intra-time and 7 minutes post-time), which the RUC reviewed in January 2013 and recommended the current value. The RUC also compared the surveyed code to CPT code 70498 *Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU=1.75, 7 minutes pre-time, 20 minutes intra-time and 10 minutes post-time) and noted that both services are with contrast material(s) and agreed that 72142 should be valued slightly higher because it has slightly more intra-service time. **The RUC recommends a work RVU of 1.78 for CPT code 72142.**

***72146 Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material***

The RUC reviewed the survey results from 46 radiologists and neuroradiologists and recommend the following physician time components: pre-service time of 5 minutes, intra-service time of 20 minutes and post-service time of 5 minutes. The RUC noted that all services in the family that do not require contrast material have the same amount of pre, intra and post service time and the same level of intensity and should be valued the same. The RUC reviewed the survey 25<sup>th</sup> percentile work RVU of 1.61 and determined that the respondents overestimated the physician work required to perform this service. The RUC determined that a work value of 1.48, which is the lowest current RVU out of the three without contrast material codes in the family (CPT code 72148), is the appropriate value for all codes without contrast materials across the lumbar, thoracic and cervical regions. It also maintains relativity with similar CPT code 70551 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material* (RUC recommended work RVU=1.48, 5 minutes pre-time, 18 minutes intra-time, 5 minutes post-time), which the RUC reviewed in January 2013 and recommended the current value.

The RUC also compared the surveyed code to CPT code 70336 *Magnetic resonance (eg, proton) imaging, temporomandibular joint(s)* (work RVU=1.48, 20 minutes intra-time) and noted that the codes have the same intra-service time and should be valued the same. For additional support

the RUC compared the surveyed code to CPT code 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family* (work RVU=1.42, 4 minutes pre-time, 20 minutes intra-time, 5 minutes post-time) and 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family* (work RVU=1.50, 5 minutes pre-time, 25 minutes intra-time, 10 minutes post-time). The RUC noted that 99203 and the surveyed code have identical intra-service time and similar pre- and post-service time, justifying the similar work value. The RUC also noted that 99214 has slightly more intra-service time but is less intense to perform, justifying the similar work value. **The RUC recommends a work RVU of 1.48 for CPT code 72146.**

***72147 Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; with contrast material(s)***

The RUC reviewed the survey results from 46 radiologists and neuroradiologists and recommend the following physician time components: pre-service time of 5 minutes, intra-service time of 23 minutes and post-service time of 5 minutes. The RUC noted that all services in the family that require contrast materials have the same amount of pre, intra and post service time and the same level of intensity, and therefore, should be valued the same. The RUC reviewed the survey median work RVU of 2.00 and determined that the respondents overestimated the physician work required to perform this service. The RUC determined that a work value of 1.78, which is the lowest current RVU out of the three with contrast material(s) codes in the family (CPT code 72149), is the appropriate value for all codes with contrast material(s) across the lumbar, thoracic and cervical regions. Additionally, the value is between the survey 25<sup>th</sup> and median for this service. It also maintains relativity with similar CPT code 70552 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s)* (RUC recommended work RVU=1.78, 5 minutes pre-time, 20 minutes intra-time and 7 minutes post-time), which the RUC reviewed in January 2013 and recommended the current value. The RUC also compared the surveyed code to CPT code 70498 *Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU=1.75, 7 minutes pre-time, 20 minutes intra-time and 10 minutes post-time) and noted that both services are with contrast material(s) and agreed that 72147 should be valued slightly higher because it has slightly more intra-service time. **The RUC recommends a work RVU of 1.78 for CPT code 72147.**

***72148 Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material***

The RUC reviewed the survey results from 49 radiologists and neuroradiologists and recommend the following physician time components: pre-service time of 5 minutes, intra-service time of 20 minutes and post-service time of 5 minutes. The RUC noted that all services in the family that do not require contrast material have the same amount of pre, intra and post service time and the same level of intensity, and therefore, should be valued the same. The RUC reviewed the survey 25<sup>th</sup> percentile work RVU of 1.60 and determined that the respondents overestimated the physician



work required to perform this service. Therefore, the current value of 1.48 is appropriate for this service. Additionally, the RUC determined that a work value of 1.48, which is lowest current RVU out of the three without contrast material codes in the family, is the appropriate value for all codes without contrast materials across the lumbar, thoracic and cervical regions. It also maintains relativity with similar CPT code 70551 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material* (RUC recommended work RVU=1.48, 5 minutes pre-time, 18 minutes intra-time, 5 minutes post-time), which the RUC reviewed in January 2013 and recommended the current value.

The RUC also compared the surveyed code to CPT code 70336 *Magnetic resonance (eg, proton) imaging, temporomandibular joint(s)* (work RVU=1.48, 20 minutes intra-time) and noted that the codes have the same intra-service time and should be valued the same. For additional support the RUC compared the surveyed code to CPT code 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family* (work RVU=1.42, 4 minutes pre-time, 20 minutes intra-time, 5 minutes post-time) and 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family* (work RVU=1.50, 5 minutes pre-time, 25 minutes intra-time, 10 minutes post-time). The RUC noted that 99203 and the surveyed code have identical intra-service time and similar pre- and post-service time, justifying the similar work value. The RUC also noted that 99214 has slightly more intra-service time but is less intense to perform, justifying the similar work value. **The RUC recommends a work RVU of 1.48 for CPT code 72148.**

#### **72149 Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; with contrast material(s)**

The RUC reviewed the survey results from 49 radiologists and neuroradiologists and recommend the following physician time components: pre-service time of 5 minutes, intra-service time of 23 minutes and post-service time of 5 minutes. The RUC noted that all services in the family that require contrast materials have the same amount of pre, intra and post service time and the same level of intensity, and therefore, should be valued the same. The RUC reviewed the survey 25<sup>th</sup> percentile work RVU of 1.75 and agreed with the specialty societies that the current value of 1.78 is appropriate for this service. Additionally, the RUC determined that a work value of 1.78, which is the lowest current RVU out of the three with contrast material(s) codes in the family, is the appropriate value for all codes with contrast material(s) across the lumbar, thoracic and cervical regions. It also maintains relativity with similar CPT code 70552 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s)* (RUC recommended work RVU=1.78, 5 minutes pre-time, 20 minutes intra-time and 7 minutes post-time), which the RUC reviewed in January 2013 and recommended the current value. The RUC also compared the surveyed code to CPT code 70498 *Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU=1.75, 7 minutes pre-time, 20 minutes intra-time and 10 minutes post-time) and noted that both services are with contrast material(s) and agreed that 72149 should be valued slightly higher because it has slightly more intra-service time. **The RUC recommends a work RVU of 1.78 for CPT code 72149.**

***72156 Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical***

The RUC reviewed the survey results from 52 radiologists and neuroradiologists and recommend the following physician time components: pre-service time of 5 minutes, intra-service time of 25 minutes and post-service time of 5 minutes. The specialty noted and the RUC agreed that all services in the family that are performed without contrast material, followed by with contrast material(s) have the same amount of pre, intra and post service time and the same level of intensity and should be valued the same. The RUC reviewed the survey median work RVU of 2.29 and determined it appropriately accounts for the work required to perform this service. The RUC determined that a work value of 2.29, which is the median survey value for this procedure and the lowest survey median RVU out of the three without and with contrast material(s) codes in the family, is the appropriate value for all codes without and with contrast material(s) across the lumbar, thoracic and cervical regions. Additionally, it is lower than the current value. It also maintains relativity with similar CPT code 70553 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences* (RUC recommended work RVU=2.36, 5 minutes pre-time, 25 minutes intra-time and 7 minutes post-time), which the RUC reviewed in January 2013 and recommended the current value. The RUC noted that the lower work value for 72156 is justified because an MRI of the spine without and with contrast requires slightly less time and intensity than the brain MRI codes without and with contrast. The RUC also compared the surveyed code to CPT code 72197 *Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s), followed by contrast material(s) and further sequences* (work RVU=2.26, 10 minutes pre-time, 25 minutes intra-time and 10 minutes post-time) and noted that both codes are without and with contrast. The RUC agreed that while 72197 and the surveyed code have identical intra-service time, the spine is a more complex region of the body and should be valued slightly higher. Additionally, the RUC compared the surveyed code to key reference service 74261 *Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material* (work RVU=2.40, 5 minutes pre-time, 40 minutes intra-time and 5 minutes post-time) and noted that the lower intensity image processing for CT colonography requires more time, but the higher intensity and complexity for a spine MRI supports the only slightly lower work value of 2.29. **The RUC recommends a work RVU of 2.29 for CPT code 72156.**

***72157 Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic***

The RUC reviewed the survey results from 46 radiologists and neuroradiologists and recommend the following physician time components: pre-service time of 5 minutes, intra-service time of 25 minutes and post-service time of 5 minutes. The specialty noted and the RUC agreed that all services in the family that are performed without contrast material, followed by with contrast material(s) have the same amount of pre, intra and post service time and the same level of intensity and should be valued the same. The specialty societies indicated and the RUC agreed that a work RVU of 2.29, between the survey 25<sup>th</sup> percentile and median, is appropriate for this service. The RUC determined that a work value of 2.29, the survey median work RVU for 72156, which is the lowest survey median RVU out of the three without and with contrast material(s) codes in the family, is the appropriate value for all codes without and with contrast material(s) across the lumbar, thoracic and cervical regions. Additionally, it is lower than the current value. It also maintains relativity with similar CPT code 70553 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences* (RUC recommended work RVU=2.36, 5 minutes pre-time, 25 minutes intra-time and 7 minutes post-time), which the RUC reviewed in January 2013 and recommended the current value.



The RUC noted that the lower work value for 72157 is justified because an MRI of the spine without and with contrast requires slightly less time and intensity than the brain MRI codes without and with contrast. The RUC also compared the surveyed code to CPT code 72197 *Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s), followed by contrast material(s) and further sequences* (work RVU=2.26, 10 minutes pre-time, 25 minutes intra-time and 10 minutes post-time) and noted that both codes are without and with contrast. The RUC agreed that while 72197 and the surveyed code have identical intra-service time, the spine is a more complex region of the body and should be valued slightly higher. Additionally, the RUC compared the surveyed code to key reference service 74261 *Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material* (work RVU=2.40, 5 minutes pre-time, 40 minutes intra-time and 5 minutes post-time) and noted that the lower intensity image processing for CT colonography requires more time, but the higher intensity and complexity for a spine MRI supports the only slightly lower work value of 2.29. **The RUC recommends a work RVU of 2.29 for CPT code 72157.**

***72158 Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar***

The RUC reviewed the survey results from 49 radiologists and neuroradiologists and recommend the following physician time components: pre-service time of 5 minutes, intra-service time of 25 minutes and post-service time of 5 minutes. The specialty noted and the RUC agreed that all services in the family that are performed without contrast material, followed by with contrast material(s) have the same amount of pre, intra and post service time and the same level of intensity and should be valued the same. The specialty societies indicated and the RUC agreed that a work RVU of 2.29, between the survey 25<sup>th</sup> percentile and median, is appropriate for this service. The RUC determined that a work value of 2.29, the survey median work RVU for 72156, which is the lowest survey median RVU out of the three without and with contrast material(s) codes in the family, is the appropriate value for all codes without and with contrast material(s) across the lumbar, thoracic and cervical regions. Additionally, it is lower than the current value. It also maintains relativity with similar CPT code 70553 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences* (RUC recommended work RVU=2.36, 5 minutes pre-time, 25 minutes intra-time and 7 minutes post-time), which the RUC reviewed in January 2013 and recommended the current value. The RUC noted that the lower work value for 72158 is justified because an MRI of the spine without and with contrast requires slightly less time and intensity than the brain MRI codes without and with contrast. The RUC also compared the surveyed code to CPT code 72197 *Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s), followed by contrast material(s) and further sequences* (work RVU=2.26, 10 minutes pre-time, 25 minutes intra-time and 10 minutes post-time) and noted that both codes are without and with contrast. The RUC agreed that while 72197 and the surveyed code have identical intra-service time, the spine is a more complex region of the body and should be valued slightly higher. Additionally, the RUC compared the surveyed code to key reference service 74261 *Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material* (work RVU=2.40, 5 minutes pre-time, 40 minutes intra-time and 5 minutes post-time) and noted that the lower intensity image processing for CT colonography requires more time, but the higher intensity and complexity for a spine MRI supports the only slightly lower work value of 2.29. **The RUC recommends a work RVU of 2.29 for CPT code 72158.**

Code	Short Desc	Pre-	Intra-	Post-	Work RVU
------	------------	------	--------	-------	----------

72141	MRI C-Spine w/o	5	20	5	1.48
72146	MRI T-Spine w/o	5	20	5	1.48
72148	MRI L-Spine w/o	5	20	5	1.48
72142	MRI C-Spine w/	5	23	5	1.78
72147	MRI T-Spine w/	5	23	5	1.78
72149	MRI L-Spine w/	5	23	5	1.78
72156	MRI C-Spine w/o&w/	5	25	5	2.29
72157	MRI T-Spine w/o&w/	5	25	5	2.29
72158	MRI L-Spine w/o&w/	5	25	5	2.29

### Practice Expense:

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

### Work Neutrality

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

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
72141		Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material	XXX	1.48
72142		with contrast material(s)  (For cervical spinal canal imaging without contrast material followed by contrast material, use 72156)	XXX	1.78
72146		Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material	XXX	1.48

72147		with contrast material(s)  (For thoracic spinal canal imaging without contrast material followed by contrast material, use 72157)	XXX	1.78
72148		Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material	XXX	1.48 (No Change)
72149		with contrast material(s)  (For lumbar spinal canal imaging without contrast material followed by contrast material, use 72158)	XXX	1.78 (No Change)
72156		Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical	XXX	2.29
72157		thoracic	XXX	2.29
72158		lumbar	XXX	2.29

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 72141	Tracking Number	Original Specialty Recommended RVU: <b>1.60</b>
		Presented Recommended RVU: <b>1.60</b>
Global Period: XXX		RUC Recommended RVU: <b>1.48</b>

CPT Descriptor: Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: 50-year-old male with acute onset neck pain and left arm weakness.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 19%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 7%

**Description of Pre-Service Work:**

- Review the request for appropriateness, review clinical history.
- Confirm no contraindication for MRI.
- Review any prior applicable studies.
- Communicate protocol to technologist.

**Description of Intra-Service Work:**

- Obtain/interpret scout views of area to be imaged.
- Obtain/review axial and sagittal planes of T1, T2, STIR, and T2 MEDIC pulse sequences and determine whether contrast enhanced sequences or coronal sequences are necessary.
- Interpret the axial and sagittal planes of T1, T2, STIR, and T2 MEDIC pulse sequences of cervical spine. Evaluate vertebral bodies, pedicles, posterior elements, vertebral alignment, and the skull base. Evaluate spinal cord, spinal nerve roots, spinal arteries and veins, thecal sac, epidural space, epidural venous plexus. Evaluate disk spaces, annulus fibrosis, nucleus pulposus, vertebral endplates, anterior longitudinal ligament, posterior longitudinal ligament, transverse/cruciform ligaments, interspinous ligaments, ligamenta flava, paraspinal muscles, prevertebral muscles. Evaluate facet joints and uncovertebral joints. Evaluate spinal canal, lateral recesses, foramina, and extra-foraminal regions. Evaluate proximal aspects of the brachial plexus. Evaluate vertebral arteries and visible anterior neck soft tissues. Evaluate images for degenerative disease, stenoses, tumor, infection, congenital anomalies, demyelination, cord compression, cord ischemia, trauma, and nerve root thickening or nerve root compression.
- Compare to all pertinent available prior studies.
- Dictate report.

**Description of Post-Service Work:**

- Review and sign the final report.

- Communicate findings with referring physician/emergency department.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Zeke Silva, MD; Kurt Schoppe, MD; Joshua Hirsch, MD; Gregory Nicola, MD				
<b>Specialty(s):</b>	American College of Radiology and American Society of Neuroradiology				
<b>CPT Code:</b>	72141				
<b>Sample Size:</b>	1853	<b>Resp N:</b>	52	<b>Response:</b> 2.8 %	
<b>Description of Sample:</b>	Random Sample				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	120.00	200.00	350.00	2000.00
<b>Survey RVW:</b>	1.00	1.60	1.75	1.80	2.30
<b>Pre-Service Evaluation Time:</b>			5.00		
<b>Pre-Service Positioning Time:</b>			0.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.00		
<b>Intra-Service Time:</b>	5.00	10.00	20.00	25.00	27.00
<b>Immediate Post Service-Time:</b>	5.00				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	0.00	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	0.00	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	0.00	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	0.00	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

<b>CPT Code:</b>	72141	<b>Recommended Physician Work RVU: 1.48</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		5.00	0.00	5.00
<b>Pre-Service Positioning Time:</b>		0.00	0.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	0.00	0.00
<b>Intra-Service Time:</b>		20.00		
<b>Immediate Post Service-Time:</b>	5.00			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	0.00	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	0.00	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	0.00	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	0.00	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	0.00	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	0.00	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
70496	XXX	1.75	RUC Time

CPT Descriptor Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
93351	XXX	1.75	RUC Time	253,648

CPT Descriptor 1 Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
-----------------------	---------------	-----------------	--------------------	---

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
---------------------------------	---------------	-----------------	--------------------

CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 17      % of respondents: 32.6 %**

**TIME ESTIMATES (Median)**

	<b>CPT Code: 72141</b>	<b>Key Reference CPT Code: 70496</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	5.00	8.00	
Median Intra-Service Time	20.00	20.00	
Median Immediate Post-service Time	5.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>30.00</b>	<b>38.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.71	3.24
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.88	2.94
--	------	------

Urgency of medical decision making	3.82	3.18
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.88	3.12
--------------------------	------	------

Physical effort required	3.88	3.12
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.53	2.88
---	------	------

Outcome depends on the skill and judgment of physician	3.94	3.18
--	------	------

Estimated risk of malpractice suit with poor outcome	3.71	3.24
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.71	3.00
----------------------------------	------	------

Intra-Service intensity/complexity	3.76	3.12
------------------------------------	------	------

Post-Service intensity/complexity	3.76	3.06
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**



CPT Code 72141 [Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material] was identified on the CMS' High Expenditure Procedural Codes Screen. The American College of Radiology (ACR) and American Society of Neuroradiology (ASNR) surveyed 72141, 72142, and 72156 (code family), and convened an expert panel of physicians familiar with the services to review the survey data.

### Work RVU Recommendations

The expert panel recommends maintaining current value for 72141 and 72142. The panel recommends the median survey RVU of 2.29 for 72156, below the existing value of 2.57 RVU.

### Pre, Intra, and Post Service Times

The panel recommends the median survey service period times for all three codes as summarized in the following table:

CPT Code	Short Descriptor	Work RVU	Pre-Service	Intra-Service	Post-Service	Total Time	IWPUT
72141	MR C-spine W/O DYE	1.60	5	20	5	30	0.069
72142	MR C-spine W DYE	1.92	5	23	5	33	0.074
72156	MR C-spine W/O & W DYE	2.29	5	25	5	35	0.083

### Compelling Evidence

While our societies are not submitting arguments for compelling evidence for an increase in value, we would point out that there have been revolutionary changes in MR technology since this procedure was originally valued. Modern pulse sequences have allowed thinner slice profiles, leading to an increase in the number of images typically acquired. The thinner slice profile has led to the detection of subtle abnormalities not visible on old techniques. This includes detection of disk herniations, facet cysts, cord demyelination, tumors, dural arteriovenous fistulas, and arachnoid cysts/adhesions.

Codes 72141, 72142, and 72156 [*Magnetic resonance (eg, Proton) imaging of cervical spine family*] are invaluable tools in investigating a diverse set of pathologies which range from minor to life threatening. They are pivotal tools in investigating back pain, radiculopathy, myelopathy, trauma, tumor, metastatic disease, demyelination, vascular malformations, vascular insults, and infection, among many other central nervous system pathologies. Not only is a positive result significant, a negative result is also pertinent in patient management, in relieving patient anxiety, and in providing assurance to ordering physicians. They are technically challenging examinations to interpret. Subtle findings, combined with pulsation artifact created by CSF flow, require meticulous attention to detail in order to provide proper interpretation. Each MR pulse sequence is interpreted in conjunction with the other sequences, as the differential diagnosis will drastically change depending on how pathology looks on each sequence (no one sequence is diagnostic in isolation). A combination of its utility (as a positive and negative predictor of pathology), intensity, and the amount of technical training necessary to accurately interpret led us to believe that this procedure is appropriately valued as above.

### Comparison to other RUC reviewed MR codes

CPT Code	Short Descriptor	Work RVU	Pre Time	Intra Time	Post Time	Total Time	IWPUT
70547	MR ANGIOGRAPHY NECK W/O DYE	1.20	5	10	10	25	0.086

CPT Code: 72141							
70336	MAGNETIC IMAGE JAW JOINT	1.48		20		20	0.074
<b>72141</b>	<b>MRI CERVICAL SPINE W/O DYE</b>	<b>1.60</b>	<b>5</b>	<b>20</b>	<b>5</b>	<b>30</b>	<b>0.069</b>
70542	MRI ORBIT/FACE/NECK W/DYE	1.62	8	15	10	33	0.081
73222	MRI JOINT UPR EXTREM W/DYE	1.62	5	20	8	33	0.066
70546	MR ANGIOGRAPH HEAD W/O&W/DYE	1.80	6	15	10	31	0.096
72198	MR ANGIO PELVIS W/O & W/DYE	1.80	5	25	8	38	0.06
<b>72142</b>	<b>MRI CERVICAL SPINE W/DYE</b>	<b>1.92</b>	<b>5</b>	<b>23</b>	<b>5</b>	<b>33</b>	<b>0.074</b>
73220	MRI UPPR EXTREMITY W/O&W/DYE	2.15	10	25	10	45	0.068
71552	MRI CHEST W/O & W/DYE	2.26	7.5	24	10	41.5	0.078
<b>72156</b>	<b>MRI CERVICAL SPINE W/O &amp; W/DYE</b>	<b>2.29</b>	<b>5</b>	<b>25</b>	<b>5</b>	<b>35</b>	<b>0.083</b>
70555	FMRI BRAIN BY PHYS/PSYCH	2.54	10	45	10	65	0.047
75561	CARDIAC MRI FOR MORPH W/DYE	2.60	10	45	10	65	0.048

**Summary of Recommendation for CPT Code 72141 [Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material]**

Our expert panel recommends maintaining the current value of 72141 at 1.60 RVU with median service period times of 5, 20, and 5 minutes. The current and recommended work RVU value of 1.60 is equal to the 25th percentile reported by our survey participants, supporting maintaining current value.

*Key Reference Service for (KRS) 72141:*

Our recommended work RVU of 1.60 is 0.15 RVU less than the most commonly chosen KRS, 70496 (*Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image post processing*). Our intra-service time recommendation of 20 minutes is identical to the KRS. The difference in total time is entirely secondary to the additional pre and post service time allotted to 70496. Intensity and complexity measures were all higher for 72141 vs. 70496, supporting the slightly higher IWP/UT. The identical intra-service times and similar IWP/UTs support a work RVU value similar to the KRS. The slightly higher work RVU for 70496 is supported by the longer total time.

CPT Code	Short Descriptor	Work RVU	Pre-Service	Intra-Service	Post-Service	Total Time	IWP/UT
<b>72141</b>	<b>MR C-spine W/O DYE</b>	<b>1.60</b>	<b>5</b>	<b>20</b>	<b>5</b>	<b>30</b>	<b>0.069</b>
<b>70496</b>	CTA angiogram Head W/DYE	1.75	8	20	10	38	0.067

*MPC Code for 72141:*

Our recommendation is compared to MPC code 93351 (*Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional*), demonstrating identical intra service times and nearly identical IWP/UTs. Total time difference is solely secondary to the post service period. This difference in time supports the subtle difference in RVU.

CPT Code	Short Descriptor	Work RVU	Pre-Service	Intra-Service	Post-Service	Total Time	IWP/UT
<b>72141</b>	<b>MR C-spine W/O DYE</b>	<b>1.60</b>	<b>5</b>	<b>20</b>	<b>5</b>	<b>30</b>	<b>0.069</b>
<b>93351</b>	Transthoracic echo rest and stress	1.75	5	20	10	35	0.071

**Summary**

Our expert panel recommends maintaining the current value of 72141 at 1.60 RVU with median service period times of 5, 20, and 5 minutes. We believe this compares favorably with the key reference service, 70496, and MPC code, 93351. Relativity is also appropriate across the 3 codes for MR of the cervical spine as well as across the larger family of MR codes.

### Summary Table

Code	Short Desc	Proposed RVU	Pre-	Intra-	Post-	IWPUT
72148	MRI L-Spine w/o	1.48	5	20	5	0.063
72141	MRI C-Spine w/o	1.60	5	20	5	0.069
72146	MRI T-Spine w/o	1.60	5	20	5	0.069
72149	MRI L-Spine w/	1.78	5	23	5	0.068
72142	MRI C-Spine w/	1.92	5	23	5	0.074
72147	MRI T-Spine w/	1.92	5	23	5	0.074
72156	MRI C-Spine w/o&w/	2.29	5	25	5	0.083
72157	MRI T-Spine w/o&w/	2.29	5	25	5	0.083
72158	MRI L-Spine w/o&w/	2.29	5	25	5	0.083

### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

### FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 72141

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology

How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1531080

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The overall number of services described by 72141 provided nationally in a one-year period is estimated to be 1,531,080

Specialty Diagnostic Radiology	Frequency 1271000	Percentage 83.01 %
--------------------------------	-------------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

510,360 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2011 Medicare data estimates that CPT code 72141 was billed approximately 510,360 times for Medicare patients nationally in a one-year period.

Specialty Diagnostic Radiology	Frequency 423700	Percentage 83.01 %
--------------------------------	------------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 72141

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 72142	Tracking Number	Original Specialty Recommended RVU: <b>1.92</b>
		Presented Recommended RVU: <b>1.92</b>
Global Period: XXX		RUC Recommended RVU: <b>1.78</b>

CPT Descriptor: Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; with contrast material(s)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: 30-year-old female with multiple sclerosis on therapy presents with new right hand numbness.

Percentage of Survey Respondents who found Vignette to be Typical: 82%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 21%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 7%

**Description of Pre-Service Work:**

- Review the request for appropriateness, review clinical history.
- Confirm no contraindication for MRI.
- Review lab studies to assess renal function. Review medical record for allergy history, absence of contraindications to contrast injection, factors predisposing to contrast-induced Nephrogenic Systemic Fibrosis, and adjust contrast product and amount to be injected. Request renal consult if necessary.
- Review the nature and risks of contrast reaction with the patient and obtain informed consent where applicable. Supervise IV placement.
- Review any prior applicable studies.
- Communicate protocol to technologist.

**Description of Intra-Service Work:**

- Obtain/interpret scout views of area to be imaged.
- Supervise Gadolinium contrast injection, supervise monitoring for contrast reaction and extravasation.
- Obtain the contrast-phase MR images and review, consider obtaining delayed-phase MR images. Also consider obtaining coronal sequences.
- Obtain/review axial and sagittal planes of T1, T2, STIR, and T2 MEDIC pulse sequences after contrast.
- Interpret the axial and sagittal planes of T1, T2, STIR, and T2 MEDIC pulse sequences of cervical spine. Evaluate vertebral bodies, pedicles, posterior elements, vertebral alignment, and the skull base. Evaluate spinal cord, spinal nerve roots, spinal arteries and veins, thecal sac, epidural space, epidural venous plexus. Evaluate disk spaces, annulus fibrosis, nucleus pulposus, vertebral endplates, anterior longitudinal ligament, posterior longitudinal ligament, transverse/cruciform ligaments, interspinous ligaments, ligamenta flava, paraspinal muscles, prevertebral muscles. Evaluate facet joints and uncovertebral joints. Evaluate spinal canal, lateral recesses, foramina, and extra-foraminal regions. Evaluate proximal aspects of the brachial plexus. Evaluate vertebral arteries and visible anterior neck soft tissues. Evaluate images for

degenerative disease, stenoses, tumor, infection, congenital anomalies, demyelination, cord compression, cord ischemia, trauma, and nerve root thickening or nerve root compression. Count neoplastic, infectious, or demyelinating lesions and measure in two dimensions, if applicable.

- Compare to all pertinent available prior studies.
- Dictate report.

Description of Post-Service Work:

- Confirm lack of complication from contrast agent such as allergic reaction or extravasation of contrast.
- Review and sign the final report.
- Communicate findings with referring physician/emergency department.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Zeke Silva, MD; Kurt Schoppe, MD; Joshua Hirsch, MD; Gregory Nicola, MD				
<b>Specialty(s):</b>	American College of Radiology and American Society of Neuroradiology				
<b>CPT Code:</b>	72142				
<b>Sample Size:</b>	1853	<b>Resp N:</b>	52	<b>Response:</b> 2.8 %	
<b>Description of Sample:</b>	Random Sample				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	14.00	40.00	60.00	1000.00
<b>Survey RVW:</b>	1.10	1.75	2.00	2.10	2.50
<b>Pre-Service Evaluation Time:</b>			5.00		
<b>Pre-Service Positioning Time:</b>			0.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.00		
<b>Intra-Service Time:</b>	8.00	11.00	23.00	28.00	35.00
<b>Immediate Post Service-Time:</b>	5.00				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	0.00	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

<b>CPT Code:</b>	72142	<b>Recommended Physician Work RVU: 1.78</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		5.00	0.00	5.00
<b>Pre-Service Positioning Time:</b>		0.00	0.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	0.00	0.00
<b>Intra-Service Time:</b>		23.00		
<b>Immediate Post Service-Time:</b>	5.00			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	0.00	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	0.00	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	0.00	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		
<b>Sub Obs Care:</b>	0.00	99224x 0.00 99225x 0.00 99226x 0.00		

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
74177	XXX	1.82	RUC Time

CPT Descriptor Computed tomography, abdomen and pelvis; with contrast material(s)**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
92004	XXX	1.82	RUC Time	2,180,149

CPT Descriptor 1 Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
-----------------------	---------------	-----------------	--------------------	---

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
74178	XXX	2.01	RUC Time

CPT Descriptor Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 13      % of respondents: 25.0 %

**TIME ESTIMATES (Median)**

	<b>CPT Code:</b> 72142	<b>Key Reference CPT Code:</b> 74177	<b>Source of Time</b> RUC Time
Median Pre-Service Time	5.00	5.00	
Median Intra-Service Time	23.00	25.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
<b>Median Total Time</b>	<b>33.00</b>	<b>35.00</b>	



Other time if appropriate		
---------------------------	--	--

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.38
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.69	3.23
--	------	------

Urgency of medical decision making	3.77	3.00
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.00	3.23
--------------------------	------	------

Physical effort required	3.38	2.77
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.92	3.46
---	------	------

Outcome depends on the skill and judgment of physician	3.77	3.31
--	------	------

Estimated risk of malpractice suit with poor outcome	3.92	3.46
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.38	2.69
----------------------------------	------	------

Intra-Service intensity/complexity	3.85	3.38
------------------------------------	------	------

Post-Service intensity/complexity	3.23	2.77
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**

CPT Code 72141 [Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material] was identified on the CMS' High Expenditure Procedural Codes Screen. The American College of Radiology (ACR) and

American Society of Neuroradiology (ASNR) surveyed 72141, 72142, and 72156 (code family), and convened an expert panel of physicians familiar with the services to review the survey data.

### Work RVU Recommendations

The expert panel recommends maintaining current value for 72141 and 72142. The panel recommends the median survey RVU of 2.29 for 72156, below the existing value of 2.57 RVU.

### Pre, Intra, and Post Service Times

The panel recommends the median survey service period times for all three codes as summarized in the following table:

CPT Code	Short Descriptor	Work RVU	Pre-Service	Intra-Service	Post-Service	Total Time	IWPUT
72141	MR C-spine W/O DYE	1.60	5	20	5	30	0.069
72142	MR C-spine W DYE	1.92	5	23	5	33	0.074
72156	MR C-spine W/O & W DYE	2.29	5	25	5	35	0.083

### Compelling Evidence

While our societies are not submitting arguments for compelling evidence for an increase in value, we would point out that there have been revolutionary changes in MR technology since this procedure was originally valued. Modern pulse sequences have allowed thinner slice profiles, leading to an increase in the number of images typically acquired. The thinner slice profile has led to the detection of subtle abnormalities not visible on old techniques. This includes detection of disk herniations, facet cysts, cord demyelination, tumors, dural arteriovenous fistulas, and arachnoid cysts/adhesions.

Codes 72141, 72142, and 72156 [*Magnetic resonance (eg. Proton) imaging of cervical spine family*] are invaluable tools in investigating a diverse set of pathologies which range from minor to life threatening. They are pivotal tools in investigating back pain, radiculopathy, myelopathy, trauma, tumor, metastatic disease, demyelination, vascular malformations, vascular insults, and infection, among many other central nervous system pathologies. Not only is a positive result significant, a negative result is also pertinent in patient management, in relieving patient anxiety, and in providing assurance to ordering physicians. They are technically challenging examinations to interpret. Subtle findings, combined with pulsation artifact created by CSF flow, require meticulous attention to detail in order to provide proper interpretation. Each MR pulse sequence is interpreted in conjunction with the other sequences, as the differential diagnosis will drastically change depending on how pathology looks on each sequence (no one sequence is diagnostic in isolation). A combination of its utility (as a positive and negative predictor of pathology), intensity, and the amount of technical training necessary to accurately interpret led us to believe that this procedure is appropriately valued as above.

### Comparison to other RUC reviewed MR codes

CPT Code	Short Descriptor	Work RVU	Pre Time	Intra Time	Post Time	Total Time	IWPUT
----------	------------------	----------	----------	------------	-----------	------------	-------

CPT Code: 72142							
70547	MR ANGIOGRAPHY NECK W/O DYE	1.20	5	10	10	25	0.086
70336	MAGNETIC IMAGE JAW JOINT	1.48		20		20	0.074
<b>72141</b>	<b>MRI CERVICAL SPINE W/O DYE</b>	<b>1.60</b>	<b>5</b>	<b>20</b>	<b>5</b>	<b>30</b>	<b>0.069</b>
70542	MRI ORBIT/FACE/NECK W/DYE	1.62	8	15	10	33	0.081
73222	MRI JOINT UPR EXTREM W/DYE	1.62	5	20	8	33	0.066
70546	MR ANGIOGRAPH HEAD W/O&W/DYE	1.80	6	15	10	31	0.096
72198	MR ANGIO PELVIS W/O & W/DYE	1.80	5	25	8	38	0.06
<b>72142</b>	<b>MRI CERVICAL SPINE W/DYE</b>	<b>1.92</b>	<b>5</b>	<b>23</b>	<b>5</b>	<b>33</b>	<b>0.074</b>
73220	MRI UPPR EXTREMITY W/O&W/DYE	2.15	10	25	10	45	0.068
71552	MRI CHEST W/O & W/DYE	2.26	7.5	24	10	41.5	0.078
<b>72156</b>	<b>MRI CERVICAL SPINE W/O &amp; W/DYE</b>	<b>2.29</b>	<b>5</b>	<b>25</b>	<b>5</b>	<b>35</b>	<b>0.083</b>
70555	FMRI BRAIN BY PHYS/PSYCH	2.54	10	45	10	65	0.047
75561	CARDIAC MRI FOR MORPH W/DYE	2.60	10	45	10	65	0.048

**Summary of Recommendation for CPT Code 72142 [Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; with contrast material]**

Our expert panel recommends current value of 72142 at 1.92 RVU with median service period times of 5, 23, and 5 minutes. The current and recommended work RVU of 1.92 is between the 25th and 50<sup>th</sup> percentiles reported by our survey participants. The work RVU incremental increase between 72141 (without contrast) and 72142 (with contrast), equal to 0.32 (20%) RVU, is consistent with other RUC reviewed MRI code families (chart below). Both these factors support maintaining the current work value.

CPT code	Description	Work RVU	Percent Change
70540	MRI ORBIT/FACE/NECK W/O DYE	1.35	
70542	MRI ORBIT/FACE/NECK W/DYE	1.62	20%
70543	MRI ORBT/FAC/NCK W/O &W/DYE	2.15	33%
70551	MRI BRAIN STEM W/O DYE	1.48	
70552	MRI BRAIN STEM W/DYE	1.78	20%
70553	MRI BRAIN STEM W/O & W/DYE	2.36	33%
72195	MRI PELVIS W/O DYE	1.46	
72196	MRI PELVIS W/DYE	1.73	18%
72197	MRI PELVIS W/O & W/DYE	2.26	31%

*Key Reference Service (KRS) for 72142:*

Our recommended work RVU of 1.92 is very similar to the most commonly chosen KRS, 74177 (*Computed tomography, abdomen and pelvis; with contrast material(s)*). The pre, intra, and post service times are virtually identical. Survey respondents felt the intensity and complexity measures for 72142 were all higher than the KRS, supporting a higher IWPOT and work RVU value.

CPT Code	Short Descriptor	Work RVU	Pre-Service	Intra-Service	Post-Service	Total Time	IWPUT
72142	MR C-spine W DYE	1.92	5	23	5	33	0.074
74177	CT AB/PEL W/DYE	1.82	5	25	5	35	0.064

#### MPC Code for 72142:

Our recommendation is compared to MPC code 92004 (*Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits*), demonstrating nearly identical intra service times. 72142 is a contrast enhanced exam which, by nature, typically means a complex patient with prior surgery, multiple sclerosis, tumor, etc. This is reflected in the higher IWPUT. Contrast exams are also very rarely performed as a first line examination; therefore, a prior comparison study will frequently be available.

CPT Code	Short Descriptor	Work RVU	Pre-Service	Intra-Service	Post-Service	Total Time	IWPUT
72142	MR C-spine W DYE	1.92	5	23	5	33	0.074
92004	Ophth. E&M. New Patient	1.82	5	25	10	40	0.059

#### Summary

Our expert panel recommends maintaining the current value of 72142 at 1.92 RVU with median service period times of 5, 23, and 5 minutes. We believe this compares favorably with the key reference service, 74177, and MPC code, 92004. Relativity is also appropriate across the 3 codes for MR of the cervical spine as well as across the larger family of MR codes.

#### Summary Table

Code	Short Desc	Proposed RVU	Pre-	Intra-	Post-	IWPUT
72148	MRI L-Spine w/o	1.48	5	20	5	0.063
72141	MRI C-Spine w/o	1.60	5	20	5	0.069
72146	MRI T-Spine w/o	1.60	5	20	5	0.069
72149	MRI L-Spine w/	1.78	5	23	5	0.068
72142	MRI C-Spine w/	1.92	5	23	5	0.074
72147	MRI T-Spine w/	1.92	5	23	5	0.074
72156	MRI C-Spine w/o&w/	2.29	5	25	5	0.083
72157	MRI T-Spine w/o&w/	2.29	5	25	5	0.083
72158	MRI L-Spine w/o&w/	2.29	5	25	5	0.083

#### SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.

- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 72142

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology                      How often? Commonly

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 13104

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The overall number of services described by 72142 provided nationally in a one-year period is estimated to be 13104

Specialty Diagnostic Radiology                      Frequency 11535                      Percentage 88.02 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 4,368

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2011 Medicare data estimates that CPT code 72142 was billed approximately 4,368 times for Medicare patients nationally in a one-year period.

Specialty Diagnostic Radiology                      Frequency 3845                      Percentage 88.02 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

## Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 72142

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 72146	Tracking Number	Original Specialty Recommended RVU: <b>1.60</b>
		Presented Recommended RVU: <b>1.60</b>
Global Period: XXX		RUC Recommended RVU: <b>1.48</b>

CPT Descriptor: Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: 75-year-old female presents with severe back pain after fall. X-rays of thoracic spine are normal, but patient has persistent intractable pain.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 21%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 3%

**Description of Pre-Service Work:**

- Review the request for appropriateness, review clinical history.
- Confirm no contraindication for MRI.
- Review any prior applicable studies.
- Communicate protocol to technologist.

**Description of Intra-Service Work:**

- Obtain/interpret scout views of area to be imaged.
- Obtain/review axial and sagittal planes of T1, T2, and STIR pulse sequences and determine whether contrast enhanced sequences or coronal sequences are necessary.
- Interpret the axial and sagittal planes of T1, T2, and STIR pulse sequences of thoracic spine. Evaluate vertebral bodies, pedicles, posterior elements and alignment. Evaluate spinal cord, spinal nerve roots, spinal arteries and veins, thecal sac, epidural space, epidural venous plexus. Evaluate disk spaces, annulus fibrosis, nucleus pulposus, vertebral endplates, anterior longitudinal ligament, posterior longitudinal ligament, interspinous ligaments, ligamenta flava, paraspinal muscles, prevertebral muscles. Evaluate facet joints. Evaluate the spinal canal, lateral recesses, foramina, and extra-foraminal regions. Evaluate visible paraspinal soft tissues, including aortic contours. Evaluate images for degenerative disease, stenoses, tumor, infection, congenital anomalies, demyelination, cord compression, cord ischemia, trauma, and nerve root thickening or nerve root compression.
- Compare to all pertinent available prior studies.
- Dictate report.

**Description of Post-Service Work:**

- Review and sign the final report.

- Communicate findings with referring physician/emergency department.



**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Zeke Silva, MD; Kurt Schoppe, MD; Joshua Hirsch, MD; Gregory Nicola, MD				
<b>Specialty(s):</b>	American College of Radiology and American Society of Neuroradiology				
<b>CPT Code:</b>	72146				
<b>Sample Size:</b>	1853	<b>Resp N:</b>	46	<b>Response:</b> 2.4 %	
<b>Description of Sample:</b>	Random Sample				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	75.00	100.00	200.00	800.00
<b>Survey RVW:</b>	1.00	1.61	1.75	1.80	2.30
<b>Pre-Service Evaluation Time:</b>			5.00		
<b>Pre-Service Positioning Time:</b>			0.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.00		
<b>Intra-Service Time:</b>	8.00	12.00	20.00	25.00	26.00
<b>Immediate Post Service-Time:</b>	<u>5.00</u>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

<b>CPT Code:</b>	72146	<b>Recommended Physician Work RVU: 1.48</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		5.00	0.00	5.00
<b>Pre-Service Positioning Time:</b>		0.00	0.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	0.00	0.00
<b>Intra-Service Time:</b>		20.00		
<b>Immediate Post Service-Time:</b>	<u>5.00</u>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
70496	XXX	1.75	RUC Time

CPT Descriptor Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
93351	XXX	1.75	RUC Time	253,648

CPT Descriptor 1 Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
-----------------------	---------------	-----------------	--------------------	---

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
---------------------------------	---------------	-----------------	--------------------

CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 18      % of respondents: 39.1 %**

**TIME ESTIMATES (Median)**

	<b>CPT Code: 72146</b>	<b>Key Reference CPT Code: 70496</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	5.00	8.00	
Median Intra-Service Time	20.00	20.00	
Median Immediate Post-service Time	5.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>30.00</b>	<b>38.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.72	3.00
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.67	3.06
--	------	------

Urgency of medical decision making	3.67	3.11
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.78	3.11
--------------------------	------	------

Physical effort required	3.83	3.11
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.67	3.17
---	------	------

Outcome depends on the skill and judgment of physician	3.83	3.22
--	------	------

Estimated risk of malpractice suit with poor outcome	3.67	3.00
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.28	2.83
----------------------------------	------	------

Intra-Service intensity/complexity	3.67	3.28
------------------------------------	------	------

Post-Service intensity/complexity	3.33	3.06
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**

CPT Code 72146 [Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material] is being brought to the RUC for work evaluation as part of a series of spine codes. The American College of Radiology (ACR) and American Society of Neuroradiology (ASNR) surveyed 72146, 72147, and 72157 (code family), and convened an expert panel of physicians familiar with the services to review the survey data.

### Work RVU Recommendations

The expert panel recommends maintaining current value for 72146 and 72147. The panel is recommending a work RVU of 2.29 for code 72157 which is below the existing value of 2.57.

### Pre, Intra, and Post Service Times

The panel recommends the median survey service period times for all three codes as summarized in the following table:

CPT Code	Short Descriptor	Work RVU	Pre-Service	Intra-Service	Post-Service	Total Time	IWPUT
<b>72146</b>	<b>MR T-spine W/O DYE</b>	<b>1.60</b>	<b>5</b>	<b>20</b>	<b>5</b>	<b>30</b>	<b>0.069</b>
<b>72147</b>	MR T-spine W DYE	1.92	5	23	5	33	0.074
<b>72157</b>	MR T-spine W/O & W DYE	2.29	5	25	5	35	0.083

### Compelling Evidence

While our societies are not submitting arguments for compelling evidence for an increase in value, we would point out that there have been revolutionary changes in MR technology since this procedure was originally valued. Modern pulse sequences have allowed thinner slice profiles, leading to an increase in the number of images typically acquired. The thinner slice profile has led to the detection of subtle abnormalities not visible on old techniques. This includes detection of disk herniations, facet cysts, cord demyelination, tumors, dural arteriovenous fistulas, and arachnoid cysts/adhesions.

Codes 72146, 72147, and 72157 [*Magnetic resonance (eg, Proton) imaging of thoracic spine family*] are invaluable tools in investigating a diverse set of pathologies, which range from minor to life threatening. They are pivotal tools in investigating back pain, radiculopathy, myelopathy, trauma, tumor, metastatic disease, demyelination, vascular malformations, vascular insults, and infection, among many other central nervous system pathologies. Not only is a positive result significant, a negative result is also pertinent in patient management, in relieving patient anxiety, and in providing assurance to ordering physicians. They are technically challenging examinations to interpret. Subtle findings, combined with pulsation artifact created by CSF flow, require meticulous attention to detail in order to provide proper interpretation. Each MR pulse sequence is interpreted in conjunction with the other sequences, as the differential diagnosis will drastically change depending on how pathology looks on each sequence (no one sequence is diagnostic in isolation). A combination of its utility (as a positive and negative predictor of pathology), intensity, and the amount of technical training necessary to accurately interpret led us to believe that this procedure is appropriately valued as above.

### Comparison to other RUC reviewed MR codes

CPT Code	Short Descriptor	Work RVU	Pre Time	Intra Time	Post Time	Total Time	IWPUT
70547	MR ANGIOGRAPHY NECK W/O DYE	1.2	5	10	10	25	0.086

CPT Code: 72146							
70336	MAGNETIC IMAGE JAW JOINT	1.48		20		20	0.074
<b>72141</b>	<b>MRI CERVICAL SPINE W/O DYE</b>	<b>1.6</b>	<b>5</b>	<b>20</b>	<b>5</b>	<b>30</b>	<b>0.069</b>
70542	MRI ORBIT/FACE/NECK W/DYE	1.62	8	15	10	33	0.081
73222	MRI JOINT UPR EXTREM W/DYE	1.62	5	20	8	33	0.066
70546	MR ANGIOGRAPH HEAD W/O&W/DYE	1.8	6	15	10	31	0.096
72198	MR ANGIO PELVIS W/O & W/DYE	1.8	5	25	8	38	0.06
<b>72142</b>	<b>MRI CERVICAL SPINE W/DYE</b>	<b>1.92</b>	<b>5</b>	<b>23</b>	<b>5</b>	<b>33</b>	<b>0.074</b>
73220	MRI UPPR EXTREMITY W/O&W/DYE	2.15	10	25	10	45	0.068
71552	MRI CHEST W/O & W/DYE	2.26	7.5	24	10	41.5	0.078
<b>72156</b>	<b>MRI CERVICAL SPINE W/O &amp; W/DYE</b>	<b>2.29</b>	<b>5</b>	<b>25</b>	<b>5</b>	<b>35</b>	<b>0.083</b>
70555	FMRI BRAIN BY PHYS/PSYCH	2.54	10	45	10	65	0.047
75561	CARDIAC MRI FOR MORPH W/DYE	2.6	10	45	10	65	0.048

### Summary of Recommendation for CPT Code 72146 [Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material]

Our expert panel recommends maintaining the current value of 72146 at 1.60 RVU with median service period times of 5, 20, and 5 minutes. The current and recommended work RVU value of 1.60 is slightly less than the 25th percentile reported by our survey participants, supporting maintaining current value.

#### Key Reference Service (KRS) for 72146:

Our recommended work RVU of 1.60 is 0.15 RVU less than the most commonly chosen KRS, 70496 (*Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image post processing*). Our intra-service time recommendation of 20 minutes is identical to the KRS. The difference in total time is entirely secondary to the additional pre and post service work required for 70496. Intensity and complexity measures were all higher for 72146 vs. 70496, supporting the slightly higher IWPUT. The identical intra-service times and similar IWPUTs support a work RVU value similar to the KRS. The slightly higher work RVU for 70496 is supported by the longer total time.

CPT Code	Short Descriptor	Work RVU	Pre-Service	Intra-Service	Post-Service	Total Time	IWPUT
<b>72146</b>	<b>MR T-spine W/O DYE</b>	<b>1.60</b>	<b>5</b>	<b>20</b>	<b>5</b>	<b>30</b>	<b>0.069</b>
<b>70496</b>	CTA angiogram Head W/DYE	1.75	8	20	10	38	0.067

#### MPC Code for 72146:

Our recommendation is compared to MPC code 93351 (*Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional*), demonstrating identical intra service times and nearly identical IWPUTs. Total time difference is solely secondary to the post service period. This difference in time supports the subtle difference in RVU.

CPT Code	Short Descriptor	Work RVU	Pre-Service	Intra-Service	Post-Service	Total Time	IWPUT
<b>72146</b>	<b>MR T-spine W/O DYE</b>	<b>1.60</b>	<b>5</b>	<b>20</b>	<b>5</b>	<b>30</b>	<b>0.069</b>
<b>93351</b>	Transthoracic echo rest and stress	1.75	5	20	10	35	0.071

### Summary

Our expert panel recommends maintaining the current value of 72146 at 1.60 RVU with median service period times of 5, 20, and 5 minutes. We believe this compares favorably with the key reference service, 70496, and

MPC code, 93351. Relativity is also appropriate across the 3 codes for MR of the thoracic spine as well as across the larger family of MR codes.

### Summary Table

Code	Short Desc	Proposed RVU	Pre-	Intra-	Post-	IWPUT
72148	MRI L-Spine w/o	1.48	5	20	5	0.063
72141	MRI C-Spine w/o	1.60	5	20	5	0.069
72146	MRI T-Spine w/o	1.60	5	20	5	0.069
72149	MRI L-Spine w/	1.78	5	23	5	0.068
72142	MRI C-Spine w/	1.92	5	23	5	0.074
72147	MRI T-Spine w/	1.92	5	23	5	0.074
72156	MRI C-Spine w/o&w/	2.29	5	25	5	0.083
72157	MRI T-Spine w/o&w/	2.29	5	25	5	0.083
72158	MRI L-Spine w/o&w/	2.29	5	25	5	0.083

---

### SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

---

### FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 72146

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology

How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 557277

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The overall number of services described by 72146 provided nationally in a one-year period is estimated to be 557,277

Specialty Diagnostic Radiology	Frequency 482000	Percentage 86.49 %
--------------------------------	------------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

185,759 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2011 Medicare data estimates that CPT code 72146 was billed approximately 185759 times for Medicare patients nationally in a one-year period.

Specialty Diagnostic Radiology	Frequency 160700	Percentage 86.50 %
--------------------------------	------------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 72146

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 72147	Tracking Number	Original Specialty Recommended RVU: <b>1.92</b>
		Presented Recommended RVU: <b>1.92</b>
Global Period: XXX		RUC Recommended RVU: <b>1.78</b>

CPT Descriptor: Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; with contrast material(s)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: 46-year-old female with multiple sclerosis on therapy presents with worsening lower extremity numbness and tingling. Brain MRI did not show any new demyelinating plaques.

Percentage of Survey Respondents who found Vignette to be Typical: 82%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 24%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 5%

**Description of Pre-Service Work:**

- Review the request for appropriateness, review clinical history.
- Confirm no contraindication for MRI.
- Review lab studies to assess renal function. Review medical record for allergy history, absence of contraindications to contrast injection, factors predisposing to contrast-induced Nephrogenic Systemic Fibrosis, and adjust contrast product and amount to be injected. Request renal consult if necessary.
- Review the nature and risks of contrast reaction with the patient and obtain informed consent where applicable. Supervise IV placement.
- Review any prior applicable studies.
- Communicate protocol to technologist.

**Description of Intra-Service Work:**

- Obtain/interpret scout views of area to be imaged.
- Supervise Gadolinium contrast injection, supervise monitoring for contrast reaction and extravasation.
- Obtain the contrast-phase MR images and review, consider obtaining delayed-phase MR images.
- Obtain/review axial and sagittal planes of T1, T2, and STIR sequences after contrast. Also consider obtaining coronal sequences.
- Interpret the axial and sagittal planes of T1, T2, and STIR pulse sequences of thoracic spine. Evaluate vertebral bodies, pedicles, posterior elements and alignment. Evaluate spinal cord, spinal nerve roots, spinal arteries and veins, thecal sac, epidural space, epidural venous plexus. Evaluate disk spaces, annulus fibrosis, nucleus pulposus, vertebral endplates, anterior longitudinal ligament, posterior longitudinal ligament, interspinous ligaments, ligamenta flava, paraspinal muscles, prevertebral muscles. Evaluate facet joints. Evaluate the spinal canal, lateral recesses, foramina, and extra-foraminal regions. Evaluate visible paraspinal soft tissues, including aortic contours. Evaluate images for degenerative disease,



stenoses, tumor, infection, congenital anomalies, demyelination, cord compression, cord ischemia, trauma, and nerve root thickening or nerve root compression. Count neoplastic, infectious, or demyelinating lesions and measure in two dimensions, if applicable.

- Compare to all pertinent available prior studies.
- Dictate report.

Description of Post-Service Work:

- Confirm lack of complication from contrast agent such as allergic reaction or extravasation of contrast.
- Review and sign the final report.
- Communicate findings with referring physician/emergency department.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Zeke Silva, MD; Kurt Schoppe, MD; Joshua Hirsch, MD; Gregory Nicola, MD				
<b>Specialty(s):</b>	American College of Radiology and American Society of Neuroradiology				
<b>CPT Code:</b>	72147				
<b>Sample Size:</b>	1853	<b>Resp N:</b>	46	<b>Response:</b> 2.4 %	
<b>Description of Sample:</b>	Random Sample				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	10.00	40.00	50.00	600.00
<b>Survey RVW:</b>	1.00	1.75	2.00	2.10	3.00
<b>Pre-Service Evaluation Time:</b>			6.00		
<b>Pre-Service Positioning Time:</b>			0.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.00		
<b>Intra-Service Time:</b>	10.00	14.00	23.00	28.00	35.00
<b>Immediate Post Service-Time:</b>	6.00				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	0.00	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

<b>CPT Code:</b>	72147	<b>Recommended Physician Work RVU: 1.78</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		5.00	0.00	5.00
<b>Pre-Service Positioning Time:</b>		0.00	0.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	0.00	0.00
<b>Intra-Service Time:</b>		23.00		
<b>Immediate Post Service-Time:</b>	5.00			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	0.00	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	0.00	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	0.00	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		
<b>Sub Obs Care:</b>	0.00	99224x 0.00 99225x 0.00 99226x 0.00		

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
74178	XXX	2.01	RUC Time

CPT Descriptor Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
92004	XXX	1.82	RUC Time	2,180,149

CPT Descriptor 1 Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
-----------------------	---------------	-----------------	--------------------	---

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
---------------------------------	---------------	-----------------	--------------------

CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 11      % of respondents: 23.9 %**

**TIME ESTIMATES (Median)**

	<b>CPT Code: 72147</b>	<b>Key Reference CPT Code: 74178</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	5.00	5.00	
Median Intra-Service Time	23.00	30.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
<b>Median Total Time</b>	<b>33.00</b>	<b>40.00</b>	

Other time if appropriate		
---------------------------	--	--

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.36
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.91	3.27
--	------	------

Urgency of medical decision making	3.82	3.45
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.18	3.55
--------------------------	------	------

Physical effort required	3.36	2.82
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.09	3.27
---	------	------

Outcome depends on the skill and judgment of physician	4.18	3.55
--	------	------

Estimated risk of malpractice suit with poor outcome	3.82	3.36
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.55	3.00
----------------------------------	------	------

Intra-Service intensity/complexity	3.82	3.36
------------------------------------	------	------

Post-Service intensity/complexity	3.45	2.91
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**

CPT Code 72146 [Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material] is being brought to the RUC for work evaluation as part of a series of spine codes. The American College of Radiology (ACR) and American Society of Neuroradiology (ASNR) surveyed 72146, 72147, and 72157 (code family), and convened an expert panel of physicians familiar with the services to review the survey data.

**Work RVU Recommendations**

The expert panel recommends maintaining current value for 72146 and 72147. The panel is recommending a work RVU of 2.29 for code 72157 which is below the existing value of 2.57.

**Pre, Intra, and Post Service Times**

The panel recommends the median survey service period times for all three codes as summarized in the following table:

CPT Code	Short Descriptor	Work RVU	Pre-Service	Intra-Service	Post-Service	Total Time	IWPUT
72146	MR T-spine W/O DYE	1.60	5	20	5	30	0.069
72147	MR T-spine W DYE	1.92	5	23	5	33	0.074
72157	MR T-spine W/O & W DYE	2.29	5	25	5	35	0.083

**Compelling Evidence**

While our societies are not submitting arguments for compelling evidence for an increase in value, we would point out that there have been revolutionary changes in MR technology since this procedure was originally valued. Modern pulse sequences have allowed thinner slice profiles, leading to an increase in the number of images typically acquired. The thinner slice profile has led to the detection of subtle abnormalities not visible on old techniques. This includes detection of disk herniations, facet cysts, cord demyelination, tumors, dural arteriovenous fistulas, and arachnoid cysts/adhesions.

Codes 72146, 72147, and 72157 [*Magnetic resonance (eg. Proton) imaging of thoracic spine family*] are invaluable tools in investigating a diverse set of pathologies, which range from minor to life threatening. They are pivotal tools in investigating back pain, radiculopathy, myelopathy, trauma, tumor, metastatic disease, demyelination, vascular malformations, vascular insults, and infection, among many other central nervous system pathologies. Not only is a positive result significant, a negative result is also pertinent in patient management, in relieving patient anxiety, and in providing assurance to ordering physicians. They are technically challenging examinations to interpret. Subtle findings, combined with pulsation artifact created by CSF flow, require meticulous attention to detail in order to provide proper interpretation. Each MR pulse sequence is interpreted in conjunction with the other sequences, as the differential diagnosis will drastically change depending on how pathology looks on each sequence (no one sequence is diagnostic in isolation). A combination of its utility (as a positive and negative predictor of pathology), intensity, and the amount of technical training necessary to accurately interpret led us to believe that this procedure is appropriately valued as above.

**Comparison to other RUC reviewed MR codes**

CPT Code	Short Descriptor	Work RVU	Pre Time	Intra Time	Post Time	Total Time	IWPUT
70547	MR ANGIOGRAPHY NECK W/O	1.20	5	10	10	25	0.086

CPT Code: 72147							
	DYE						
70336	MAGNETIC IMAGE JAW JOINT	1.48		20		20	0.074
<b>72141</b>	<b>MRI CERVICAL SPINE W/O DYE</b>	<b>1.60</b>	<b>5</b>	<b>20</b>	<b>5</b>	<b>30</b>	<b>0.069</b>
70542	MRI ORBIT/FACE/NECK W/DYE	1.62	8	15	10	33	0.081
73222	MRI JOINT UPR EXTREM W/DYE	1.62	5	20	8	33	0.066
70546	MR ANGIOGRAPH HEAD W/O&W/DYE	1.80	6	15	10	31	0.096
72198	MR ANGIO PELVIS W/O & W/DYE	1.80	5	25	8	38	0.06
<b>72142</b>	<b>MRI CERVICAL SPINE W/DYE</b>	<b>1.92</b>	<b>5</b>	<b>23</b>	<b>5</b>	<b>33</b>	<b>0.074</b>
73220	MRI UPPR EXTREMITY W/O&W/DYE	2.15	10	25	10	45	0.068
71552	MRI CHEST W/O & W/DYE	2.26	7.5	24	10	41.5	0.078
<b>72156</b>	<b>MRI CERVICAL SPINE W/O &amp; W/DYE</b>	<b>2.29</b>	<b>5</b>	<b>25</b>	<b>5</b>	<b>35</b>	<b>0.083</b>
70555	FMRI BRAIN BY PHYS/PSYCH	2.54	10	45	10	65	0.047
75561	CARDIAC MRI FOR MORPH W/DYE	2.60	10	45	10	65	0.048

**Summary of Recommendation for CPT Code 72147 [Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; with contrast material]**

Our expert panel recommends current value of 72147 at 1.92 RVU with median service period times of 5, 23, and 5 minutes. The current and recommended work RVU of 1.92 is between the 25<sup>th</sup> and median 50<sup>th</sup> percentiles reported by our survey participants. The work RVU incremental increase between 72146 (without contrast) and 72147 (with contrast) equal to 0.32 (20%) RVU is consistent with other RUC reviewed MRI code families (chart below). Both these factors support maintaining the current work value.

CPT code	Description	Work RVU	Percent Change
70540	MRI ORBIT/FACE/NECK W/O DYE	1.35	
70542	MRI ORBIT/FACE/NECK W/DYE	1.62	20%
70543	MRI ORBT/FAC/NCK W/O &W/DYE	2.15	33%
70551	MRI BRAIN STEM W/O DYE	1.48	
70552	MRI BRAIN STEM W/DYE	1.78	20%
70553	MRI BRAIN STEM W/O & W/DYE	2.36	33%
72195	MRI PELVIS W/O DYE	1.46	
72196	MRI PELVIS W/DYE	1.73	18%
72197	MRI PELVIS W/O & W/DYE	2.26	31%

**Key Reference Service (KRS) for 72147:**

Our recommended work RVU of 1.92 is 0.09 RVU lower than the most commonly chosen KRS, 74178 (*Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions*). The intra service time for the KRS is longer; however, survey respondents felt the intensity and complexity measures for 72147 were all higher, supporting a higher IWPOT. The longer total time of the KRS justifies the higher work RVU.

CPT Code	Short Descriptor	Work RVU	Pre-Service	Intra-Service	Post-Service	Total Time	IWPUT
72147	MR T-spine W DYE	1.92	5	23	5	33	0.074
74178	CT AB/PEL W/O & W DYE	2.01	5	30	5	40	0.060

#### MPC Code for 72147:

Our recommendation is compared to MPC code 92004 (*Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits*), demonstrating nearly identical intra service times. 72147 is a contrast enhanced exam which, by nature, typically means a complex patient with prior surgery, multiple sclerosis, tumor, etc. This is reflected in the higher IWPUT. Contrast exams are also very rarely performed as a first line examination; therefore, a prior comparison study will frequently be available.

CPT Code	Short Descriptor	Work RVU	Pre-Service	Intra-Service	Post-Service	Total Time	IWPUT
72147	MR T-spine W DYE	1.92	5	23	5	33	0.074
92004	Ophth. E&M. New Patient	1.82	5	25	10	40	0.059

#### Summary

Our expert panel recommends maintaining the current value of 72147 at 1.92 RVU with median service period times of 5, 23, and 5 minutes. We believe this compares favorably with the key reference service, 74178, and MPC code, 92004. Relativity is also appropriate across the 3 codes for MR of the thoracic spine as well as across the larger family of MR codes.

#### Summary Table

Code	Short Desc	Proposed RVU	Pre-	Intra-	Post-	IWPUT
72148	MRI L-Spine w/o	1.48	5	20	5	0.063
72141	MRI C-Spine w/o	1.60	5	20	5	0.069
72146	MRI T-Spine w/o	1.60	5	20	5	0.069
72149	MRI L-Spine w/	1.78	5	23	5	0.068
72142	MRI C-Spine w/	1.92	5	23	5	0.074
72147	MRI T-Spine w/	1.92	5	23	5	0.074
72156	MRI C-Spine w/o&w/	2.29	5	25	5	0.083
72157	MRI T-Spine w/o&w/	2.29	5	25	5	0.083
72158	MRI L-Spine w/o&w/	2.29	5	25	5	0.083

#### SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.

- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 72147

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology                      How often? Commonly

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 11085

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The overall number of services described by 72147 provided nationally in a one-year period is estimated to be 11085

Specialty Diagnostic Radiology                      Frequency 9832                      Percentage 88.69 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3,695

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2011 Medicare data estimates that CPT code 72147 was billed approximately 3695 times for Medicare patients nationally in a one-year period.

Specialty Diagnostic Radiology                      Frequency 3278                      Percentage 88.71 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

## Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 72147



If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 72148	Tracking Number	Original Specialty Recommended RVU: <b>1.48</b>
		Presented Recommended RVU: <b>1.48</b>
Global Period: XXX		RUC Recommended RVU: <b>1.48</b>

CPT Descriptor: Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: 75-year-old male presents with back pain and spinal claudication.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 18%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 7%

**Description of Pre-Service Work:**

- Review the request for appropriateness, review clinical history.
- Confirm no contraindication for MRI.
- Review any prior applicable studies.
- Communicate protocol to technologist.

**Description of Intra-Service Work:**

- Obtain/interpret scout views of area to be imaged.
- Obtain/review axial, coronal, sagittal planes of T1, T2, and STIR pulse sequences and determine whether contrast enhanced sequences or coronal sequences are necessary.
- Interpret the axial and sagittal planes of T1, T2, and STIR pulse sequences of lumbar spine. Evaluate vertebral bodies, pedicles, posterior elements, vertebral alignment, sacral ala, and visualized iliac bones. Evaluate spinal cord/conus medullaris, spinal nerve roots, spinal arteries and veins, thecal sac, epidural space, epidural venous plexus. Evaluate disk spaces, annulus fibrosis, nucleus pulposus, vertebral endplates, anterior longitudinal ligament, posterior longitudinal ligament, interspinous ligaments, ligamenta flava, paraspinal muscles, prevertebral muscles. Evaluate facet joints and sacroiliac joints. Evaluate the spinal canal, lateral recesses, foramina, and extra-foraminal regions. Evaluate visible paraspinal soft tissues, including aortic contours. Evaluate images for degenerative disease, stenoses, tumor, infection, congenital anomalies, demyelination, cord compression, cord ischemia, trauma, and nerve root thickening or nerve root compression.
- Compare to all pertinent available prior studies.
- Dictate report.

**Description of Post-Service Work:**

- Review and sign the final report.

- Communicate findings with referring physician/emergency department.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Zeke Silva, MD; Kurt Schoppe, MD; Joshua Hirsch, MD; Gregory Nicola, MD				
<b>Specialty(s):</b>	American College of Radiology and American Society of Neuroradiology				
<b>CPT Code:</b>	72148				
<b>Sample Size:</b>	1853	<b>Resp N:</b>	49	<b>Response:</b> 2.6 %	
<b>Description of Sample:</b>	Random Sample				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	138.00	<b>230.00</b>	500.00	4000.00
<b>Survey RVW:</b>	1.00	1.60	<b>1.75</b>	1.82	2.30
<b>Pre-Service Evaluation Time:</b>			<b>5.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>0.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>0.00</b>		
<b>Intra-Service Time:</b>	6.00	12.00	<b>20.00</b>	25.00	28.00
<b>Immediate Post Service-Time:</b>	<b>5.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

<b>CPT Code:</b>	72148	<b>Recommended Physician Work RVU: 1.48</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>5.00</b>	<b>0.00</b>	<b>5.00</b>
<b>Pre-Service Positioning Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>20.00</b>		
<b>Immediate Post Service-Time:</b>	<b>5.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
70496	XXX	1.75	RUC Time

CPT Descriptor Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
93351	XXX	1.75	RUC Time	253,648

CPT Descriptor 1 Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
-----------------------	---------------	-----------------	--------------------	---

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
---------------------------------	---------------	-----------------	--------------------

CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 18      % of respondents: 36.7 %**

**TIME ESTIMATES (Median)**

	<b>CPT Code: 72148</b>	<b>Key Reference CPT Code: 70496</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	5.00	8.00	
Median Intra-Service Time	20.00	20.00	
Median Immediate Post-service Time	5.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>30.00</b>	<b>38.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.78	3.11
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.78	3.11
Urgency of medical decision making	3.67	3.17

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.83	2.94
Physical effort required	3.78	3.06

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.72	3.06
Outcome depends on the skill and judgment of physician	3.78	3.00
Estimated risk of malpractice suit with poor outcome	3.72	3.11

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.61	2.72
Intra-Service intensity/complexity	3.78	3.00
Post-Service intensity/complexity	3.67	3.06

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUR analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**

CPT Code 72148 [Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material] was identified on the CMS' High Expenditure Procedural Codes Screen. The American College of Radiology (ACR) and American Society of Neuroradiology (ASNR) surveyed 72148, 72149, and 72158 (code family), and convened an expert panel of physicians familiar with the services to review the survey data.

### Work RVU Recommendations

The expert panel recommends maintaining current value for 72148 and 72149. The panel is recommending a work RVU of RVU of 2.29 for code 72158, which is below the existing value of 2.36.

### Pre, Intra, and Post Service Times

The panel recommends the median survey service period times for all three codes as summarized in the following table:

CPT Code	Short Descriptor	Work RVU	Pre-Service	Intra-Service	Post-Service	Total Time	IWPUT
72148	MR L-spine W/O DYE	1.48	5	20	5	30	0.063
72149	MR L-spine W DYE	1.78	5	23	5	33	0.068
72158	MR L-spine W/O & W DYE	2.29	5	25	5	35	0.083

### Compelling Evidence

While our societies are not submitting arguments for compelling evidence for an increase in value, we would point out that there have been revolutionary changes in MR technology since this procedure was originally valued. Modern pulse sequences have allowed thinner slice profiles, leading to an increase in the number of images typically acquired. The thinner slice profile has led to the detection of subtle abnormalities not visible on old techniques. This includes detection of disk herniations, facet cysts, cord demyelination, tumors, dural arteriovenous fistulas, and arachnoid cysts/adhesions.

Codes 72148, 72149, and 72158 [*Magnetic resonance (eg, proton) imaging of lumbar spine family*] are invaluable tools in investigating a diverse set of pathologies which range from minor to life threatening. They are pivotal tools in investigating back pain, radiculopathy, myelopathy, trauma, tumor, metastatic disease, demyelination, vascular malformations, vascular insults, and infection, among many other central nervous system pathologies. Not only is a positive result significant, a negative result is also pertinent in patient management, in relieving patient anxiety, and in providing assurance to ordering physicians. They are technically challenging examinations to interpret. Subtle findings, combined with pulsation artifact created by CSF flow, require meticulous attention to detail in order to provide proper interpretation. Each MR pulse sequence is interpreted in conjunction with the other sequences, as the differential diagnosis will drastically change depending on how pathology looks on each sequence (no one sequence is diagnostic in isolation). A combination of its utility (as a positive and negative predictor of pathology), intensity, and the amount of technical training necessary to accurately interpret led us to believe that this procedure is appropriately valued as above.

### Comparison to other RUC reviewed MR codes

CPT Code	Short Descriptor	Work RVU	Pre Time	Intra Time	Post Time	Total Time	IWPUT
70547	MR ANGIOGRAPHY NECK W/O DYE	1.20	5	10	10	25	0.086

CPT Code: 72148							
70336	MAGNETIC IMAGE JAW JOINT	1.48		20		20	0.074
<b>72141</b>	<b>MRI CERVICAL SPINE W/O DYE</b>	<b>1.60</b>	<b>5</b>	<b>20</b>	<b>5</b>	<b>30</b>	<b>0.069</b>
70542	MRI ORBIT/FACE/NECK W/DYE	1.62	8	15	10	33	0.081
73222	MRI JOINT UPR EXTREM W/DYE	1.62	5	20	8	33	0.066
70546	MR ANGIOGRAPH HEAD W/O&W/DYE	1.80	6	15	10	31	0.096
72198	MR ANGIO PELVIS W/O & W/DYE	1.80	5	25	8	38	0.06
<b>72142</b>	<b>MRI CERVICAL SPINE W/DYE</b>	<b>1.92</b>	<b>5</b>	<b>23</b>	<b>5</b>	<b>33</b>	<b>0.074</b>
73220	MRI UPPR EXTREMITY W/O&W/DYE	2.15	10	25	10	45	0.068
71552	MRI CHEST W/O & W/DYE	2.26	7.5	24	10	41.5	0.078
<b>72156</b>	<b>MRI CERVICAL SPINE W/O &amp; W/DYE</b>	<b>2.29</b>	<b>5</b>	<b>25</b>	<b>5</b>	<b>35</b>	<b>0.083</b>
70555	FMRI BRAIN BY PHYS/PSYCH	2.54	10	45	10	65	0.047
75561	CARDIAC MRI FOR MORPH W/DYE	2.60	10	45	10	65	0.048

**Summary of Recommendation for CPT Code 72148 [Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material]**

Our expert panel recommends maintaining the current value of 72148 at 1.48 RVU with median service period times of 5, 20, and 5 minutes. The current and recommended work RVU value of 1.48 is less than the 25th percentile reported by our survey participants, supporting maintaining current value.

*Key Reference Service (KRS) for 72148:*

Our recommended work RVU of 1.48 is 0.27 RVU less than the most commonly chosen KRS, 70496 (*Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image post processing*). Our intra-service time recommendation of 20 minutes is identical to the KRS. The difference in total time is entirely secondary to the additional pre and post service time allotted to 70496. Intensity and complexity measures were all higher for 72148 vs. 70496, yet 72148 has a lower, but similar, IWPUT. The lower RVU for 72148 is justified based on the shorter total time.

CPT Code	Short Descriptor	Work RVU	Pre-Service	Intra-Service	Post-Service	Total Time	IWPUT
<b>72148</b>	<b>MR L-spine W/O DYE</b>	<b>1.48</b>	<b>5</b>	<b>20</b>	<b>5</b>	<b>30</b>	<b>0.063</b>
<b>70496</b>	CTA angiogram Head W/DYE	1.75	8	20	10	38	0.067

*MPC Code for 72148:*

Our recommendation is compared to MPC code 93351 (*Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional*), demonstrating identical intra service times. Total time difference is solely secondary to the post service period. This difference in time supports the difference in RVU.

CPT Code	Short Descriptor	Work RVU	Pre-Service	Intra-Service	Post-Service	Total Time	IWPUT
<b>72148</b>	<b>MR L-spine W/O DYE</b>	<b>1.48</b>	<b>5</b>	<b>20</b>	<b>5</b>	<b>30</b>	<b>0.063</b>
<b>93351</b>	Transthoracic echo rest and stress	1.75	5	20	10	35	0.071

**Summary**

Our expert panel recommends maintaining the current value of 72148 at 1.48 RVU with median service period times of 5, 20, and 5 minutes. We believe this compares favorably with the key reference service, 70496, and MPC code, 93351.



Relativity is also appropriate across the 3 codes for MR of the lumbar spine as well as across the larger family of MR codes.

### Summary Table

Code	Short Desc	Proposed RVU	Pre-	Intra-	Post-	IWPUT
72148	MRI L-Spine w/o	1.48	5	20	5	0.063
72141	MRI C-Spine w/o	1.60	5	20	5	0.069
72146	MRI T-Spine w/o	1.60	5	20	5	0.069
72149	MRI L-Spine w/	1.78	5	23	5	0.068
72142	MRI C-Spine w/	1.92	5	23	5	0.074
72147	MRI T-Spine w/	1.92	5	23	5	0.074
72156	MRI C-Spine w/o&w/	2.29	5	25	5	0.083
72157	MRI T-Spine w/o&w/	2.29	5	25	5	0.083
72158	MRI L-Spine w/o&w/	2.29	5	25	5	0.083

---

### SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

---

### FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 72148

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology

How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 3518787

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The overall number of services described by 72148 provided nationally in a one-year period is estimated to be 3518787

Specialty Diagnostic Radiology	Frequency 2914000	Percentage 82.81 %
--------------------------------	-------------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

1,172,929 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2011 Medicare data estimates that CPT code 72148 was billed approximately 1,172,929 times for Medicare patients nationally in a one-year period.

Specialty Diagnostic Radiology	Frequency 971250	Percentage 82.80 %
--------------------------------	------------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 72148

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 72149	Tracking Number	Original Specialty Recommended RVU: <b>1.78</b>
		Presented Recommended RVU: <b>1.78</b>
Global Period: XXX		RUC Recommended RVU: <b>1.78</b>

CPT Descriptor: Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; with contrast material(s)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: 30-year-old male with lymphoma presents with gait ataxia, sensory abnormalities, and headache. Evaluate for leptomeningeal tumor.

Percentage of Survey Respondents who found Vignette to be Typical: 83%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 22%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 5%

**Description of Pre-Service Work:**

- Review the request for appropriateness, review clinical history.
- Confirm no contraindication for MRI.
- Review lab studies to assess renal function. Review medical record for allergy history, absence of contraindications to contrast injection, factors predisposing to contrast-induced Nephrogenic Systemic Fibrosis, and adjust contrast product and amount to be injected. Request renal consult if necessary.
- Review the nature and risks of contrast reaction with the patient and obtain informed consent where applicable. Supervise IV placement.
- Review any prior applicable studies.
- Communicate protocol to technologist.

**Description of Intra-Service Work:**

- Obtain/interpret scout views of area to be imaged.
- Supervise Gadolinium contrast injection, supervise monitoring for contrast reaction and extravasation.
- Obtain the contrast-phase MR images and review, consider obtaining delayed-phase MR images. Also consider obtaining coronal sequences.
- Obtain/review axial and sagittal planes of T1, T2, and STIR sequences after contrast.
- Interpret the axial and sagittal planes of T1, T2, and STIR pulse sequences of lumbar spine. Evaluate vertebral bodies, pedicles, posterior elements, vertebral alignment, sacral ala, and visualized iliac bones. Evaluate spinal cord/conus medullaris, spinal nerve roots, spinal arteries and veins, thecal sac, epidural space, epidural venous plexus. Evaluate disk spaces, annulus fibrosis, nucleus pulposus, vertebral endplates, anterior longitudinal ligament, posterior longitudinal ligament, interspinous ligaments, ligamenta flava, paraspinal muscles, prevertebral muscles. Evaluate facet joints and sacroiliac joints. Evaluate the spinal canal, lateral recesses, foramen, and extra-foraminal regions. Evaluate visible

paraspinal soft tissues, including aortic contours. Evaluate images for degenerative disease, stenoses, tumor, infection, congenital anomalies, demyelination, cord compression, cord ischemia, trauma, and nerve root thickening or nerve root compression. Count neoplastic, infectious, or demyelinating lesions and measure in two dimensions, if applicable.

- Compare to all pertinent available prior studies.
- Dictate report.

Description of Post-Service Work:

- Confirm lack of complication from contrast agent such as allergic reaction or extravasation of contrast.
- Review and sign the final report.
- Communicate findings with referring physician/emergency department.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Zeke Silva, MD; Kurt Schoppe, MD; Joshua Hirsch, MD; Gregory Nicola, MD				
<b>Specialty(s):</b>	American College of Radiology and American Society of Neuroradiology				
<b>CPT Code:</b>	72149				
<b>Sample Size:</b>	1853	<b>Resp N:</b>	49	<b>Response:</b> 2.6 %	
<b>Description of Sample:</b>	Random Sample				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	15.00	50.00	71.00	900.00
<b>Survey RVW:</b>	1.10	1.75	2.00	2.10	3.00
<b>Pre-Service Evaluation Time:</b>			6.00		
<b>Pre-Service Positioning Time:</b>			0.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.00		
<b>Intra-Service Time:</b>	10.00	14.00	23.00	28.00	35.00
<b>Immediate Post Service-Time:</b>	6.00				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	0.00	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

<b>CPT Code:</b>	72149	<b>Recommended Physician Work RVU: 1.78</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		5.00	0.00	5.00
<b>Pre-Service Positioning Time:</b>		0.00	0.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	0.00	0.00
<b>Intra-Service Time:</b>		23.00		
<b>Immediate Post Service-Time:</b>	5.00			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	0.00	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	0.00	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	0.00	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		
<b>Sub Obs Care:</b>	0.00	99224x 0.00 99225x 0.00 99226x 0.00		

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
74177	XXX	1.82	RUC Time

CPT Descriptor Computed tomography, abdomen and pelvis; with contrast material(s)**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
92004	XXX	1.82	RUC Time	2,180,149

CPT Descriptor 1 Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11      % of respondents: 22.4 %

**TIME ESTIMATES (Median)**

	CPT Code: 72149	Key Reference CPT Code: 74177	Source of Time RUC Time
Median Pre-Service Time	5.00	5.00	
Median Intra-Service Time	23.00	25.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
<b>Median Total Time</b>	<b>33.00</b>	<b>35.00</b>	
<b>Other time if appropriate</b>			

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered

3.82

3.27

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed

3.82

3.27

Urgency of medical decision making

3.64

3.00

**Technical Skill/Physical Effort (Mean)**

Technical skill required

4.00

3.36

Physical effort required

3.82

3.09

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality

3.91

3.09

Outcome depends on the skill and judgment of physician

4.09

3.36

Estimated risk of malpractice suit with poor outcome

4.18

3.27

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity

3.36

2.55

Intra-Service intensity/complexity

3.55

3.09

Post-Service intensity/complexity

3.36

2.82

---

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**

CPT Code 72148 [Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material] was identified on the CMS' High Expenditure Procedural Codes Screen. The American College of Radiology (ACR) and American Society of Neuroradiology (ASNR) surveyed 72148, 72149, and 72158 (code family), and convened an expert panel of physicians familiar with the services to review the survey data.

**Work RVU Recommendations**

The expert panel recommends maintaining current value for 72148 and 72149. The panel is recommending a work RVU of RVU of 2.29 for code 72158, which is below the existing value of 2.36.

**Pre, Intra, and Post Service Times**

The panel recommends the median survey service period times for all three codes as summarized in the following table:

CPT Code	Short Descriptor	Work RVU	Pre-Service	Intra-Service	Post-Service	Total Time	IWPUT
72148	MR L-spine W/O DYE	1.48	5	20	5	30	0.063
72149	MR L-spine W DYE	1.78	5	23	5	33	0.068
72158	MR L-spine W/O & W DYE	2.29	5	25	5	35	0.083

**Compelling Evidence**

While our societies are not submitting arguments for compelling evidence for an increase in value, we would point out that there have been revolutionary changes in MR technology since this procedure was originally valued. Modern pulse sequences have allowed thinner slice profiles, leading to an increase in the number of images typically acquired. The thinner slice profile has led to the detection of subtle abnormalities not visible on old techniques. This includes detection of disk herniations, facet cysts, cord demyelination, tumors, dural arteriovenous fistulas, and arachnoid cysts/adhesions.

Codes 72148, 72149, and 72158 [*Magnetic resonance (eg. proton) imaging of lumbar spine family*] are invaluable tools in investigating a diverse set of pathologies which range from minor to life threatening. They are pivotal tools in investigating back pain, radiculopathy, myelopathy, trauma, tumor, metastatic disease, demyelination, vascular malformations, vascular insults, and infection, among many other central nervous system pathologies. Not only is a positive result significant, a negative result is also pertinent in patient management, in relieving patient anxiety, and in providing assurance to ordering physicians. They are technically challenging examinations to interpret. Subtle findings, combined with pulsation artifact created by CSF flow, require meticulous attention to detail in order to provide proper interpretation. Each MR pulse sequence is interpreted in conjunction with the other sequences, as the differential diagnosis will drastically change depending on how pathology looks on each sequence (no one sequence is diagnostic in isolation). A combination of its utility (as a positive and negative predictor of pathology), intensity, and the amount of technical training necessary to accurately interpret led us to believe that this procedure is appropriately valued as above.

**Comparison to other RUC reviewed MR codes**

CPT Code	Short Descriptor	Work RVU	Pre Time	Intra Time	Post Time	Total Time	IWPUT
70547	MR ANGIOGRAPHY NECK W/O	1.20	5	10	10	25	0.086



CPT Code: 72149							
	DYE						
70336	MAGNETIC IMAGE JAW JOINT	1.48		20		20	0.074
<b>72141</b>	<b>MRI CERVICAL SPINE W/O DYE</b>	<b>1.60</b>	<b>5</b>	<b>20</b>	<b>5</b>	<b>30</b>	<b>0.069</b>
70542	MRI ORBIT/FACE/NECK W/DYE	1.62	8	15	10	33	0.081
73222	MRI JOINT UPR EXTREM W/DYE	1.62	5	20	8	33	0.066
70546	MR ANGIOGRAPH HEAD W/O&W/DYE	1.80	6	15	10	31	0.096
72198	MR ANGIO PELVIS W/O & W/DYE	1.80	5	25	8	38	0.06
<b>72142</b>	<b>MRI CERVICAL SPINE W/DYE</b>	<b>1.92</b>	<b>5</b>	<b>23</b>	<b>5</b>	<b>33</b>	<b>0.074</b>
73220	MRI UPPR EXTREMITY W/O&W/DYE	2.15	10	25	10	45	0.068
71552	MRI CHEST W/O & W/DYE	2.26	7.5	24	10	41.5	0.078
<b>72156</b>	<b>MRI CERVICAL SPINE W/O &amp; W/DYE</b>	<b>2.29</b>	<b>5</b>	<b>25</b>	<b>5</b>	<b>35</b>	<b>0.083</b>
70555	FMRI BRAIN BY PHYS/PSYCH	2.54	10	45	10	65	0.047
75561	CARDIAC MRI FOR MORPH W/DYE	2.60	10	45	10	65	0.048

**Summary of Recommendation for CPT Code 72149 [Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; with contrast material]**

Our expert panel recommends current value of 72149 at 1.78 RVU with median service period times of 5, 23, and 5 minutes. The current and recommended work RVU of 1.78 is between the 25th and 50<sup>th</sup> percentiles reported by our survey participants. The work RVU incremental increase between 72148 (without contrast) and 72149 (with contrast) equal to 0.30 (20%) RVU, is consistent with other RUC reviewed MRI code families (chart below). Both these factors support maintaining the current work value.

CPT code	Description	Work RVU	Percent Change
70540	MRI ORBIT/FACE/NECK W/O DYE	1.35	
70542	MRI ORBIT/FACE/NECK W/DYE	1.62	20%
70543	MRI ORBT/FAC/NCK W/O &W/DYE	2.15	33%
70551	MRI BRAIN STEM W/O DYE	1.48	
70552	MRI BRAIN STEM W/DYE	1.78	20%
70553	MRI BRAIN STEM W/O & W/DYE	2.36	33%
72195	MRI PELVIS W/O DYE	1.46	
72196	MRI PELVIS W/DYE	1.73	18%
72197	MRI PELVIS W/O & W/DYE	2.26	31%

**Key Reference Service (KRS) for 72149:**

Our recommended work RVU of 1.78 is very similar to the most commonly chosen KRS, 74177 (*Computed tomography, abdomen and pelvis; with contrast material(s)*). The pre, intra, and post service times are virtually identical. Survey respondents felt the intensity and complexity measures for 72149 were all higher than the KRS. The slightly higher intra service time for the KRS justifies the higher RVU.

CPT Code	Short Descriptor	Work RVU	Pre-Service	Intra-Service	Post-Service	Total Time	IWPUT
----------	------------------	----------	-------------	---------------	--------------	------------	-------

<b>72149</b>	<b>MR L-spine W DYE</b>	<b>1.78</b>	<b>5</b>	<b>23</b>	<b>5</b>	<b>33</b>	<b>0.068</b>
<b>74177</b>	CT AB/PEL W/DYE	1.82	5	25	5	35	0.064

**MPC Code for 72149:**

Our recommendation is compared to MPC code 92004 (*Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits*), demonstrating nearly identical intra service times. 72149 is a contrast enhanced exam which, by nature, typically means a complex patient with prior surgery, multiple sclerosis, tumor, etc. This is reflected in the higher IWP/UT. Contrast exams are also very rarely performed as a first line examination; therefore, a prior comparison study will frequently be available.

<b>CPT Code</b>	<b>Short Descriptor</b>	<b>Work RVU</b>	<b>Pre-Service</b>	<b>Intra-Service</b>	<b>Post-Service</b>	<b>Total Time</b>	<b>IWP/UT</b>
<b>72149</b>	<b>MR L-spine W DYE</b>	<b>1.78</b>	<b>5</b>	<b>23</b>	<b>5</b>	<b>33</b>	<b>0.068</b>
<b>92004</b>	Ophth. E&M. New Patient	1.82	5	25	10	40	0.059

**Summary**

Our expert panel recommends maintaining the current value of 72149 at 1.78 RVU with median service period times of 5, 23, and 5 minutes. We believe this compares favorably with the key reference service, 74177, and MPC code, 92004. Relativity is also appropriate across the 3 codes for MR of the lumbar spine as well as across the larger family of MR codes.

**Summary Table**

<b>Code</b>	<b>Short Desc</b>	<b>Proposed RVU</b>	<b>Pre-</b>	<b>Intra-</b>	<b>Post-</b>	<b>IWP/UT</b>
72148	MRI L-Spine w/o	1.48	5	20	5	0.063
72141	MRI C-Spine w/o	1.60	5	20	5	0.069
72146	MRI T-Spine w/o	1.60	5	20	5	0.069
72149	MRI L-Spine w/	1.78	5	23	5	0.068
72142	MRI C-Spine w/	1.92	5	23	5	0.074
72147	MRI T-Spine w/	1.92	5	23	5	0.074
72156	MRI C-Spine w/o&w/	2.29	5	25	5	0.083
72157	MRI T-Spine w/o&w/	2.29	5	25	5	0.083
72158	MRI L-Spine w/o&w/	2.29	5	25	5	0.083

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 72149

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology                      How often? Commonly

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 22086

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The overall number of services described by 72149 provided nationally in a one-year period is estimated to be 22086

Specialty Diagnostic Radiology                      Frequency 19085                      Percentage 86.41 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 7,362

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2011 Medicare data estimates that CPT code 72149 was billed approximately 7362 times for Medicare patients nationally in a one-year period.

Specialty Diagnostic Radiology                      Frequency 6361                      Percentage 86.40 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

## Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 72149

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.



**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 72156	Tracking Number	Original Specialty Recommended RVU: <b>2.29</b>
		Presented Recommended RVU: <b>2.29</b>
Global Period: XXX		RUC Recommended RVU: <b>2.29</b>

CPT Descriptor: Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: 67-year-old female two weeks status post C5-6 discectomy and fusion presents with fevers, difficulty swallowing, and neck tenderness.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 21%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 7%

**Description of Pre-Service Work:**

- Review the request for appropriateness, review clinical history.
- Confirm no contraindication for MRI.
- Review lab studies to assess renal function. Review medical record for allergy history, absence of contraindications to contrast injection, factors predisposing to contrast-induced Nephrogenic Systemic Fibrosis, and adjust contrast product and amount to be injected. Request renal consult if necessary.
- Review the nature and risks of contrast reaction with the patient and obtain informed consent where applicable. Supervise IV placement.
- Review any prior applicable studies.
- Communicate protocol to technologist.

**Description of Intra-Service Work:**

- Obtain/interpret scout views of area to be imaged.
- Supervise Gadolinium contrast injection, supervise monitoring for contrast reaction and extravasation.
- Obtain the contrast-phase MR images and review, consider obtaining delayed-phase MR images. Also consider obtaining coronal sequences.
- Obtain/review axial and sagittal planes of T1, T2, STIR, and T2 MEDIC pulse sequences before contrast. Obtain/review sagittal and axial images after contrast.
- Interpret the axial and sagittal planes of T1, T2, STIR, and T2 MEDIC pulse sequences of cervical spine. Evaluate vertebral bodies, pedicles, posterior elements, vertebral alignment, and the skull base. Evaluate spinal cord, spinal nerve roots, spinal arteries and veins, thecal sac, epidural space, epidural venous plexus. Evaluate disk spaces, annulus fibrosis, nucleus pulposus, vertebral endplates, anterior longitudinal ligament, posterior longitudinal ligament, transverse/cruciform

ligaments, interspinous ligaments, ligamenta flava, paraspinal muscles, prevertebral muscles. Evaluate facet joints and uncovertebral joints. Evaluate spinal canal, lateral recesses, foramina, and extra-foraminal regions. Evaluate proximal aspects of the brachial plexus. Evaluate vertebral arteries and visible anterior neck soft tissues. Evaluate images for degenerative disease, stenoses, tumor, infection, congenital anomalies, demyelination, cord compression, cord ischemia, trauma, and nerve root thickening or nerve root compression. Count neoplastic, infectious, or demyelinating lesions and measure in two dimensions, if applicable.

- Compare to all pertinent available prior studies.
- Dictate report.

Description of Post-Service Work:

- Confirm lack of complication from contrast agent such as allergic reaction or extravasation of contrast.
- Review and sign the final report.
- Communicate findings with referring physician/emergency department.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Zeke Silva, MD; Kurt Schoppe, MD; Joshua Hirsch, MD; Gregory Nicola, MD				
<b>Specialty(s):</b>	American College of Radiology and American Society of Neuroradiology				
<b>CPT Code:</b>	72156				
<b>Sample Size:</b>	1853	<b>Resp N:</b>	52	<b>Response:</b> 2.8 %	
<b>Description of Sample:</b>	Random Sample				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	50.00	100.00	200.00	2000.00
<b>Survey RVW:</b>	1.10	2.01	2.29	2.75	3.00
<b>Pre-Service Evaluation Time:</b>			5.00		
<b>Pre-Service Positioning Time:</b>			0.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.00		
<b>Intra-Service Time:</b>	5.00	15.00	25.00	38.00	40.00
<b>Immediate Post Service-Time:</b>	<b>5.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

XXX Global Code

<b>CPT Code:</b>	72156	<b>Recommended Physician Work RVU: 2.29</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		5.00	0.00	5.00
<b>Pre-Service Positioning Time:</b>		0.00	0.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	0.00	0.00
<b>Intra-Service Time:</b>		25.00		
<b>Immediate Post Service-Time:</b>	<b>5.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00		

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
74261	XXX	2.40	RUC Time

CPT Descriptor Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99284	XXX	2.56	RUC Time	5,747,289

CPT Descriptor 1 Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician physicians, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
-----------------------	---------------	-----------------	--------------------	---

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
---------------------------------	---------------	-----------------	--------------------

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 13      % of respondents: 25.0 %

**TIME ESTIMATES (Median)**

	CPT Code: 72156	Key Reference CPT Code: 74261	Source of Time RUC Time
Median Pre-Service Time	5.00	5.00	
Median Intra-Service Time	25.00	40.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	



Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>35.00</b>	<b>50.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.15	3.00
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.69	3.00
--	------	------

Urgency of medical decision making	3.85	2.92
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.69	3.00
--------------------------	------	------

Physical effort required	3.69	3.00
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.92	2.92
---	------	------

Outcome depends on the skill and judgment of physician	3.69	2.92
--	------	------

Estimated risk of malpractice suit with poor outcome	3.85	3.00
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.92	3.08
----------------------------------	------	------

Intra-Service intensity/complexity	3.92	3.08
------------------------------------	------	------

Post-Service intensity/complexity	3.85	3.15
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**

CPT Code 72141 [Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material] was identified on the CMS' High Expenditure Procedural Codes Screen. The American College of Radiology (ACR) and American Society of Neuroradiology (ASNR) surveyed 72141, 72142, and 72156 (code family), and convened an expert panel of physicians familiar with the services to review the survey data.

### Work RVU Recommendations

The expert panel recommends maintaining current value for 72141 and 72142. The panel recommends the median survey RVU of 2.29 for 72156, below the existing value of 2.57 RVU.

### Pre, Intra, and Post Service Times

The panel recommends the median survey service period times for all three codes as summarized in the following table:

CPT Code	Short Descriptor	Work RVU	Pre-Service	Intra-Service	Post-Service	Total Time	IWPUT
72141	MR C-spine W/O DYE	1.60	5	20	5	30	0.069
72142	MR C-spine W DYE	1.92	5	23	5	33	0.074
<b>72156</b>	<b>MR C-spine W/O &amp; W DYE</b>	<b>2.29</b>	<b>5</b>	<b>25</b>	<b>5</b>	<b>35</b>	<b>0.083</b>

### Compelling Evidence

While our societies are not submitting arguments for compelling evidence for an increase in value, we would point out that there have been revolutionary changes in MR technology since this procedure was originally valued. Modern pulse sequences have allowed thinner slice profiles, leading to an increase in the number of images typically acquired. The thinner slice profile has led to the detection of subtle abnormalities not visible on old techniques. This includes detection of disk herniations, facet cysts, cord demyelination, tumors, dural arteriovenous fistulas, and arachnoid cysts/adhesions.

Codes 72141, 72142, and 72156 [*Magnetic resonance (eg, Proton) imaging of cervical spine family*] are invaluable tools in investigating a diverse set of pathologies which range from minor to life threatening. They are pivotal tools in investigating back pain, radiculopathy, myelopathy, trauma, tumor, metastatic disease, demyelination, vascular malformations, vascular insults, and infection, among many other central nervous system pathologies. Not only is a positive result significant, a negative result is also pertinent in patient management, in relieving patient anxiety, and in providing assurance to ordering physicians. They are technically challenging examinations to interpret. Subtle findings, combined with pulsation artifact created by CSF flow, require meticulous attention to detail in order to provide proper interpretation. Each MR pulse sequence is interpreted in conjunction with the other sequences, as the differential diagnosis will drastically change depending on how pathology looks on each sequence (no one sequence is diagnostic in isolation). A combination of its utility (as a positive and negative predictor of pathology), intensity, and the amount of technical training necessary to accurately interpret led us to believe that this procedure is appropriately valued as above.

### Comparison to other RUC reviewed MR codes

CPT Code	Short Descriptor	Work RVU	Pre Time	Intra Time	Post Time	Total Time	IWPUT
70547	MR ANGIOGRAPHY NECK W/O DYE	1.20	5	10	10	25	0.086
70336	MAGNETIC IMAGE JAW JOINT	1.48		20		20	0.074

<b>72141</b>	<b>MRI CERVICAL SPINE W/O DYE</b>	<b>1.60</b>	<b>5</b>	<b>20</b>	<b>5</b>	<b>30</b>	<b>0.069</b>
70542	MRI ORBIT/FACE/NECK W/DYE	1.62	8	15	10	33	0.081
73222	MRI JOINT UPR EXTREM W/DYE	1.62	5	20	8	33	0.066
70546	MR ANGIOGRAPH HEAD W/O&W/DYE	1.80	6	15	10	31	0.096
72198	MR ANGIO PELVIS W/O & W/DYE	1.80	5	25	8	38	0.06
<b>72142</b>	<b>MRI CERVICAL SPINE W/DYE</b>	<b>1.92</b>	<b>5</b>	<b>23</b>	<b>5</b>	<b>33</b>	<b>0.074</b>
73220	MRI UPPR EXTREMITY W/O&W/DYE	2.15	10	25	10	45	0.068
71552	MRI CHEST W/O & W/DYE	2.26	7.5	24	10	41.5	0.078
<b>72156</b>	<b>MRI CERVICAL SPINE W/O &amp; W/DYE</b>	<b>2.29</b>	<b>5</b>	<b>25</b>	<b>5</b>	<b>35</b>	<b>0.083</b>
70555	FMRI BRAIN BY PHYS/PSYCH	2.54	10	45	10	65	0.047
75561	CARDIAC MRI FOR MORPH W/DYE	2.60	10	45	10	65	0.048

**Summary of Recommendation for CPT Code 72156 [Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical]**

Our expert panel recommends the median survey value of 2.29 RVU for 72156, below the existing value of 2.57 RVU with median pre, intra and post service period times of 5, 25, and 5 minutes, respectively.

*Key Reference Service (KRS) for 72156:*

Our recommended work RVU of 2.29 is 0.11 RVU lower than the most commonly chosen KRS, 74261 (*Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material*), despite having higher intensity and complexity measures in every category. The lower intensity image processing for CT colonography requires more time, but the higher intensity and complexity for a spine MR supports the higher IWPOT.

<b>CPT Code</b>	<b>Short Descriptor</b>	<b>Work RVU</b>	<b>Pre-Service</b>	<b>Intra-Service</b>	<b>Post-Service</b>	<b>Total Time</b>	<b>IWPOT</b>
<b>72156</b>	<b>MR C-spine W/O &amp; W DYE</b>	<b>2.29</b>	<b>5</b>	<b>25</b>	<b>5</b>	<b>35</b>	<b>0.083</b>
<b>74261</b>	<b>CT Colonography W/O DYE</b>	<b>2.40</b>	<b>5</b>	<b>40</b>	<b>5</b>	<b>50</b>	<b>0.054</b>

*MPC Code for 72156:*

Our recommendation is compared to MPC code 99284 (*Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician physicians, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.*), demonstrating identical intra service times. 72156 is a contrast enhanced exam which, by nature, typically means a complex patient with prior surgery, multiple sclerosis, tumor, etc. This is reflected in the comparable IWPOT. Contrast exams are also very rarely performed as a first line examination; therefore, a prior comparison study will frequently be available. The higher RVU for 99284 is acknowledged based on the longer total time.

<b>CPT Code</b>	<b>Short Descriptor</b>	<b>Work RVU</b>	<b>Pre-Service</b>	<b>Intra-Service</b>	<b>Post-Service</b>	<b>Total Time</b>	<b>IWPOT</b>
<b>72156</b>	<b>MR C-spine W/O &amp; W DYE</b>	<b>2.29</b>	<b>5</b>	<b>25</b>	<b>5</b>	<b>35</b>	<b>0.083</b>
<b>99284</b>	<b>ER E&amp;M Moderate Complexity</b>	<b>2.56</b>	<b>5</b>	<b>25</b>	<b>10</b>	<b>40</b>	<b>0.089</b>

**Summary**

Our expert panel recommends reducing the current value of 72156 to 2.29 RVU with median service period times of 5, 25, and 5 minutes. We believe this compares favorably with the key reference service, 74261, and MPC code, 99284.

Relativity is also appropriate across the 3 codes for MR of the cervical spine as well as across the larger family of MR codes.

### Summary Table

Code	Short Desc	Proposed RVU	Pre-	Intra-	Post-	IWPUT
72148	MRI L-Spine w/o	1.48	5	20	5	0.063
72141	MRI C-Spine w/o	1.60	5	20	5	0.069
72146	MRI T-Spine w/o	1.60	5	20	5	0.069
72149	MRI L-Spine w/	1.78	5	23	5	0.068
72142	MRI C-Spine w/	1.92	5	23	5	0.074
72147	MRI T-Spine w/	1.92	5	23	5	0.074
72156	MRI C-Spine w/o&w/	2.29	5	25	5	0.083
72157	MRI T-Spine w/o&w/	2.29	5	25	5	0.083
72158	MRI L-Spine w/o&w/	2.29	5	25	5	0.083

---

### SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

---

### FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 72156

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology

How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 298998

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The overall number of services described by 72156 provided nationally in a one-year period is estimated to be 298,998

Specialty Diagnostic Radiology	Frequency 264350	Percentage 88.41 %
--------------------------------	------------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

99,666 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2011 Medicare data estimates that CPT code 72156 was billed approximately 99,666 times for Medicare patients nationally in a one-year period.

Specialty Diagnostic Radiology	Frequency 88100	Percentage 88.39 %
--------------------------------	-----------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 72156

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 72157	Tracking Number	Original Specialty Recommended RVU: <b>2.29</b>
		Presented Recommended RVU: <b>2.29</b>
Global Period: XXX		RUC Recommended RVU: <b>2.29</b>

CPT Descriptor: Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: 55-year-old male with history of lung cancer presents with urinary retention, fecal incontinence, and back pain. Evaluate for cord compression.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 21%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 8%

**Description of Pre-Service Work:**

- Review the request for appropriateness, review clinical history.
- Confirm no contraindication for MRI.
- Review lab studies to assess renal function. Review medical record for allergy history, absence of contraindications to contrast injection, factors predisposing to contrast-induced Nephrogenic Systemic Fibrosis, and adjust contrast product and amount to be injected. Request renal consult if necessary.
- Review the nature and risks of contrast reaction with the patient and obtain informed consent where applicable. Supervise IV placement.
- Review any prior applicable studies.
- Communicate protocol to technologist.

**Description of Intra-Service Work:**

- Obtain/interpret scout views of area to be imaged.
- Supervise Gadolinium contrast injection, supervise monitoring for contrast reaction and extravasation.
- Obtain the contrast-phase MR images and review, consider obtaining delayed-phase MR images. Also consider obtaining coronal sequences.
- Obtain/review axial and sagittal planes of T1, T2, and STIR sequences before contrast. Obtain/review sagittal and axial T1 sequences after contrast.
- Interpret the axial and sagittal planes of T1, T2, and STIR pulse sequences of thoracic spine. Evaluate vertebral bodies, pedicles, posterior elements and alignment. Evaluate spinal cord, spinal nerve roots, spinal arteries and veins, thecal sac, epidural space, epidural venous plexus. Evaluate disk spaces, annulus fibrosis, nucleus pulposus, vertebral endplates, anterior longitudinal ligament, posterior longitudinal ligament, interspinous ligaments, ligamenta flava, paraspinal muscles,

prevertebral muscles. Evaluate facet joints. Evaluate the spinal canal, lateral recesses, foramina, and extra-foraminal regions. Evaluate visible paraspinal soft tissues, including aortic contours. Evaluate images for degenerative disease, stenoses, tumor, infection, congenital anomalies, demyelination, cord compression, cord ischemia, trauma, and nerve root thickening or nerve root compression. Count neoplastic, infectious, or demyelinating lesions and measure in two dimensions, if applicable.

- Compare to all pertinent available prior studies.
- Dictate report.

Description of Post-Service Work:

- Confirm lack of complication from contrast agent such as allergic reaction or extravasation of contrast.
- Review and sign the final report.
- Communicate findings with referring physician/emergency department.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Zeke Silva, MD; Kurt Schoppe, MD; Joshua Hirsch, MD; Gregory Nicola, MD				
<b>Specialty(s):</b>	American College of Radiology and American Society of Neuroradiology				
<b>CPT Code:</b>	72157				
<b>Sample Size:</b>	1853	<b>Resp N:</b>	46	<b>Response:</b> 2.4 %	
<b>Description of Sample:</b>	Random Sample				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	30.00	80.00	160.00	600.00
<b>Survey RVW:</b>	1.10	2.03	2.38	2.80	3.10
<b>Pre-Service Evaluation Time:</b>			6.00		
<b>Pre-Service Positioning Time:</b>			0.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.00		
<b>Intra-Service Time:</b>	8.00	15.00	25.00	38.00	40.00
<b>Immediate Post Service-Time:</b>	6.00				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	0.00	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	0.00	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	0.00	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	0.00	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

<b>CPT Code:</b>	72157	<b>Recommended Physician Work RVU: 2.29</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		5.00	0.00	5.00
<b>Pre-Service Positioning Time:</b>		0.00	0.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	0.00	0.00
<b>Intra-Service Time:</b>		25.00		
<b>Immediate Post Service-Time:</b>	5.00			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	0.00	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	0.00	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	0.00	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	0.00	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	0.00	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	0.00	99224x 0.00	99225x 0.00	99226x 0.00



**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
74261	XXX	2.40	RUC Time

CPT Descriptor Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99284	XXX	2.56	RUC Time	5,747,289

CPT Descriptor 1 Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician physicians, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
-----------------------	---------------	-----------------	--------------------	---

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
---------------------------------	---------------	-----------------	--------------------

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 13      % of respondents: 28.2 %

**TIME ESTIMATES (Median)**

	CPT Code: 72157	Key Reference CPT Code: 74261	Source of Time RUC Time
Median Pre-Service Time	5.00	5.00	
Median Intra-Service Time	25.00	40.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>35.00</b>	<b>50.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.15	3.08
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	2.85
--	------	------

Urgency of medical decision making	3.92	3.08
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.00	3.08
--------------------------	------	------

Physical effort required	3.85	3.00
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.00	3.08
---	------	------

Outcome depends on the skill and judgment of physician	3.62	3.00
--	------	------

Estimated risk of malpractice suit with poor outcome	3.62	3.00
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.00	3.08
----------------------------------	------	------

Intra-Service intensity/complexity	3.92	3.00
------------------------------------	------	------

Post-Service intensity/complexity	4.08	3.08
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

## Background

CPT Code 72146 [Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material] is being brought to the RUC for work evaluation as part of a series of spine codes. The American College of Radiology (ACR) and American Society of Neuroradiology (ASNR) surveyed 72146, 72147, and 72157 (code family), and convened an expert panel of physicians familiar with the services to review the survey data.

## Work RVU Recommendations

The expert panel recommends maintaining current value for 72146 and 72147. The panel is recommending a work RVU of 2.29 for code 72157 which is below the existing value of 2.57.

## Pre, Intra, and Post Service Times

The panel recommends the median survey service period times for all three codes as summarized in the following table:

CPT Code	Short Descriptor	Work RVU	Pre-Service	Intra-Service	Post-Service	Total Time	IWPUT
72146	MR T-spine W/O DYE	1.60	5	20	5	30	0.069
72147	MR T-spine W DYE	1.92	5	23	5	33	0.074
72157	MR T-spine W/O & W DYE	2.29	5	25	5	35	0.083

## Compelling Evidence

While our societies are not submitting arguments for compelling evidence for an increase in value, we would point out that there have been revolutionary changes in MR technology since this procedure was originally valued. Modern pulse sequences have allowed thinner slice profiles, leading to an increase in the number of images typically acquired. The thinner slice profile has led to the detection of subtle abnormalities not visible on old techniques. This includes detection of disk herniations, facet cysts, cord demyelination, tumors, dural arteriovenous fistulas, and arachnoid cysts/adhesions.

Codes 72146, 72147, and 72157 [*Magnetic resonance (eg, Proton) imaging of thoracic spine family*] are invaluable tools in investigating a diverse set of pathologies, which range from minor to life threatening. They are pivotal tools in investigating back pain, radiculopathy, myelopathy, trauma, tumor, metastatic disease, demyelination, vascular malformations, vascular insults, and infection, among many other central nervous system pathologies. Not only is a positive result significant, a negative result is also pertinent in patient management, in relieving patient anxiety, and in providing assurance to ordering physicians. They are technically challenging examinations to interpret. Subtle findings, combined with pulsation artifact created by CSF flow, require meticulous attention to detail in order to provide proper interpretation. Each MR pulse sequence is interpreted in conjunction with the other sequences, as the differential diagnosis will drastically change depending on how pathology looks on each sequence (no one sequence is diagnostic in isolation). A combination of its utility (as a positive and negative predictor of pathology), intensity, and the amount of technical training necessary to accurately interpret led us to believe that this procedure is appropriately valued as above.

## Comparison to other RUC reviewed MR codes

CPT Code	Short Descriptor	Work RVU	Pre Time	Intra Time	Post Time	Total Time	IWPUT
70547	MR ANGIOGRAPHY NECK W/O DYE	1.20	5	10	10	25	0.086

CPT Code: 72157							
70336	MAGNETIC IMAGE JAW JOINT	1.48		20		20	0.074
<b>72141</b>	<b>MRI CERVICAL SPINE W/O DYE</b>	<b>1.60</b>	<b>5</b>	<b>20</b>	<b>5</b>	<b>30</b>	<b>0.069</b>
70542	MRI ORBIT/FACE/NECK W/DYE	1.62	8	15	10	33	0.081
73222	MRI JOINT UPR EXTREM W/DYE	1.62	5	20	8	33	0.066
70546	MR ANGIOGRAPH HEAD W/O&W/DYE	1.80	6	15	10	31	0.096
72198	MR ANGIO PELVIS W/O & W/DYE	1.80	5	25	8	38	0.06
<b>72142</b>	<b>MRI CERVICAL SPINE W/DYE</b>	<b>1.92</b>	<b>5</b>	<b>23</b>	<b>5</b>	<b>33</b>	<b>0.074</b>
73220	MRI UPPR EXTREMITY W/O&W/DYE	2.15	10	25	10	45	0.068
71552	MRI CHEST W/O & W/DYE	2.26	7.5	24	10	41.5	0.078
<b>72156</b>	<b>MRI CERVICAL SPINE W/O &amp; W/DYE</b>	<b>2.29</b>	<b>5</b>	<b>25</b>	<b>5</b>	<b>35</b>	<b>0.083</b>
70555	FMRI BRAIN BY PHYS/PSYCH	2.54	10	45	10	65	0.047
75561	CARDIAC MRI FOR MORPH W/DYE	2.60	10	45	10	65	0.048

**Summary of Recommendation for CPT Code 72157 [Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic]**

Our expert panel recommends 2.29 RVUs which is between the 25<sup>th</sup> and median survey RVUs and below the existing value of 2.57 RVU. We are recommending median pre, intra, and post service period times of 5, 25, and 5 minutes, respectively. The recommended value was chosen to parallel the MRI cervical spine family for which all previous RVU values and times were in parity.

*Key Reference Service (KRS) for 72157:*

Our recommended work RVU of 2.29 is 0.11 RVU lower than the most commonly chosen KRS, 74261 (*Computed tomographic (CT) colonography, diagnostic, including image post processing; without contrast material*), despite having higher intensity and complexity measures in every category. The lower intensity image processing for CT colonography requires more time, but the higher intensity and complexity for a spine MR supports the higher IWPUP.

CPT Code	Short Descriptor	Work RVU	Pre-Service	Intra-Service	Post-Service	Total Time	IWPUP
<b>72157</b>	<b>MR T-spine W/O &amp; W DYE</b>	<b>2.29</b>	<b>5</b>	<b>25</b>	<b>5</b>	<b>35</b>	<b>0.083</b>
<b>74261</b>	<b>CT Colonography W/O DYE</b>	<b>2.40</b>	<b>5</b>	<b>40</b>	<b>5</b>	<b>50</b>	<b>0.054</b>

*MPC Code for 72157:*

Our recommendation is compared to MPC code 99284 (*Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician physicians, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.*), demonstrating nearly identical intra service times. 72157 is a contrast enhanced exam which, by

nature, typically means a complex patient with prior surgery, multiple sclerosis, tumor, etc. This is reflected in the comparable IWPUP. Contrast exams are also very rarely performed as a first line examination; therefore, a comparison study will frequently be available. The higher RVU for 99284 is acknowledged based on the longer total time.

CPT Code	Short Descriptor	Work RVU	Pre-Service	Intra-Service	Post-Service	Total Time	IWPUP
<b>72157</b>	<b>MR T-spine W/O &amp; W DYE</b>	<b>2.29</b>	<b>5</b>	<b>25</b>	<b>5</b>	<b>35</b>	<b>0.083</b>

99284	ER E&M Moderate Complexity	2.56	5	25	10	40	0.089
-------	----------------------------	------	---	----	----	----	-------

### Summary

Our expert panel recommends reducing the current value of 72157 to 2.29 RVU with median service period times of 5, 25, and 5 minutes. We believe this compares favorably with the key reference service, 74261, and MPC code, 99284. Relativity is also appropriate across the 3 codes for MR of the thoracic spine as well as across the larger family of MR codes.

### Summary Table

Code	Short Desc	Proposed RVU	Pre-	Intra-	Post-	IWPUT
72148	MRI L-Spine w/o	1.48	5	20	5	0.063
72141	MRI C-Spine w/o	1.60	5	20	5	0.069
72146	MRI T-Spine w/o	1.60	5	20	5	0.069
72149	MRI L-Spine w/	1.78	5	23	5	0.068
72142	MRI C-Spine w/	1.92	5	23	5	0.074
72147	MRI T-Spine w/	1.92	5	23	5	0.074
72156	MRI C-Spine w/o&w/	2.29	5	25	5	0.083
72157	MRI T-Spine w/o&w/	2.29	5	25	5	0.083
72158	MRI L-Spine w/o&w/	2.29	5	25	5	0.083

### SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

### FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 72157

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology                      How often? Commonly

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 229389

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The overall number of services described by 72157 provided nationally in a one-year period is estimated to be 229,389

Specialty Diagnostic Radiology                      Frequency 210850                      Percentage 91.91 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 76,463 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2011 Medicare data estimates that CPT code 72157 was billed approximately 76463 times for Medicare patients nationally in a one-year period.

Specialty Diagnostic Radiology                      Frequency 70275                      Percentage 91.90 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 72157

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs

**Global Period:** XXX

**Meeting Date:** April 2013

**CPT Long Descriptors:**

*77372 Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based*

**1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:**

The Society prepared a practice expense survey and presented it to the research subcommittee. The surveys were sent electronically to 400 radiation oncologists. The specialties convened a consensus panel that included a number of experts familiar with these services to evaluate the survey results and existing direct practice expense inputs for these procedures. The specialties discarded the surveys from the hospital-based respondents, as requested by the research subcommittee. The panel reviewed the office survey results from 18 surveys.

**2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison. You must provide an explanation for the selection of reference codes. Reference Code Rationale:**

CPT code 77372 is currently priced in the office. As such, we have included columns with the existing inputs for reference.

**3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:**

**Pre Service Activities**

*Complete pre-service diagnostic & referral forms & Coordinate pre-surgery services*

A number of insurance companies require preauthorization for SRS. This time is allotted to complete the pre service forms and work with the insurance company on clinical matters.

**Provide pre-service education/obtain consent**

The clinical staff calls the patient prior to arriving for treatment. They will answer any questions regarding the procedure and go over what to expect during treatment. They may ask the patient not to eat or drink anything after midnight. They will discuss medications. They will discuss the need to have a family member or friend must accompany them the day of treatment and should drive them home following the procedure.

**Prepare Delivery System Unit for Treatment**

This line item is included in the service period in the existing inputs. However, it we believe it is more appropriate to include it in the pre service period.

**4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:**

We are not recommending additional clinical times, supplies or equipment from existing inputs. However, when we compute the time for the SRS machine we get 75 minutes, not 51. We included rows 23, 30, 32, 36, 42 and 49. When we compute the time for the pulse oximeter we get 55 minutes not 51. We included rows 30, 32, 36, 42 and 49.

**5. Please describe in detail the clinical activities of your staff:**

Pre-Service Clinical Labor Activities:

The physicist has prepared the machine for treatment prior to patient arriving in the treatment area. To ensure the accuracy of the treatment setup, the physicist then verifies the stereotactic isocenter using the Winston-Lutz phantom test.

Intra-Service Clinical Labor Activities:

The patient is taken into the treatment room, and the physician and the physicist together review the original and new films, the prescription, and the data that was entered into the treatment machine. The nurse is assisting the patient in getting comfortable and then takes the patient's vital signs. Once these vitals have been documented, the patient is then placed on the treatment couch. The nurse then lets the radiation therapist and the physicist position the patient with the appropriate immobilization system, and the head ring is calibrated to the stereotactic isocenter and the tests that were performed to validate the patient setup. Once the patient is then positioned, the nurse then inserts the IV for the patient, and the SRS treatment delivery begins.

During the treatment delivery, the physicist and the radiation therapist are in the control room at all times to monitor the delivery procedure. The nurse monitors the oxygen (O<sub>2</sub>) saturation of the patient. The amount of radiation given is continuously tracked.

The patient is taken out of the immobilization apparatus. (After treatment is complete the neurosurgeon removes the head frame, as described in CPT Code 61793.) The patient is then taken into a separate room for recovery.

Post-Service Clinical Labor Activities:

Phone calls are made by the nurse to follow up on side effects and phone in prescriptions.



SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
12	ISSUE: MRI-Neck and Lumbar Spine																			
13	TAB: 25																			
14						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
15	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
16	REF	70496	Computed tomographic a	17	0.067			1.75			38	8				20				10
17	CURRENT CMS/Other	72141	Magnetic resonance (eg, protor	#DIV/0!				1.60			30									
18	SVY	72141	Magnetic resonance (eg,	52	0.076	1.00	1.60	1.75	1.80	2.30	30	5			5	10	20	25	27	5
19	REC	72141	Magnetic resonance (eg, protor		0.063	1.48					30	5				20				5
20																				
21						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
22	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
23	REF	74177	Computed tomography, a	13	0.064			1.82			35	5				25				5
24	REF	74178	Computed tomography, a	13	0.060			2.01			40	5				30				5
25	CURRENT CMS/Other	72142	Magnetic resonance (eg, protor	#DIV/0!				1.92			36									
26	SVY	72142	Magnetic resonance (eg,	52	0.077	1.10	1.75	2.00	2.10	2.50	33	5			8	11	23	28	35	5
27	REC	72142	Magnetic resonance (eg, protor		0.068	1.78					33	5				23				5
28																				
29						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
30	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
31	REF	74261	Computed tomographic (	13	0.054			2.40			50	5				40				5
32	CURRENT CMS/Other	72156	Magnetic resonance (eg, protor	#DIV/0!				2.57			47									
33	SVY	72156	Magnetic resonance (eg,	52	0.083	1.10	2.01	2.29	2.75	3.00	35	5			5	15	25	38	40	5
34	REC	72156	Magnetic resonance (eg, protor		0.083	2.29					35	5				25				5
35																				
36						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
37	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
38	REF	70496	Computed tomographic a	18	0.067			1.75			38	8				20				10
39	CURRENT CMS/Other	72146	Magnetic resonance (eg, protor	#DIV/0!				1.60			30									
40	SVY	72146	Magnetic resonance (eg,	46	0.076	1.00	1.61	1.75	1.80	2.30	30	5			8	12	20	25	26	5
41	REC	72146	Magnetic resonance (eg, protor		0.063	1.48					30	5				20				5
42																				
43						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
44	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
45	REF	74178	Computed tomography, a	11	0.060			2.01			40	5				30				5
46	CURRENT CMS/Other	72147	Magnetic resonance (eg, protor	#DIV/0!				1.92			36									
47	SVY	72147	Magnetic resonance (eg,	46	0.075	1.00	1.75	2.00	2.10	3.00	35	6			10	14	23	28	35	6
48	REC	72147	Magnetic resonance (eg, protor		0.068	1.78					33	5				23				5
49																				
50						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
51	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
52	REF	74261	Computed tomographic (	13	0.054			2.40			50	5				40				5
53	CURRENT CMS/Other	72157	Magnetic resonance (eg, protor	#DIV/0!				2.57			47									
54	SVY	72157	Magnetic resonance (eg,	46	0.084	1.10	2.03	2.38	2.80	3.10	37	6			8	15	25	38	40	6
55	REC	72157	Magnetic resonance (eg, protor		0.083	2.29					35	5				25				5
56																				
57						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
58	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
59	REF	70496	Computed tomographic a	18	0.067			1.75			38	8				20				10
60	CURRENT CMS/Other	72148	Magnetic resonance (eg, protor	#DIV/0!				1.48			28									
61	SVY	72148	Magnetic resonance (eg,	49	0.076	1.00	1.60	1.75	1.82	2.30	30	5			6	12	20	25	28	5
62	REC	72148	Magnetic resonance (eg, protor		0.063	1.48					30	5				20				5
63																				
64						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
65	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
66	REF	74177	Computed tomography, a	11	0.064			1.82			35	5				25				5
67	CURRENT CMS/Other	72149	Magnetic resonance (eg, protor	#DIV/0!				1.78			33									
68	SVY	72149	Magnetic resonance (eg,	49	0.075	1.10	1.75	2.00	2.10	3.00	35	6			10	14	23	28	35	6
69	REC	72149	Magnetic resonance (eg, protor		0.068	1.78					33	5				23				5
70																				
71						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
72	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
73	REF	74261	Computed tomographic (	14	0.054			2.40			50	5				40				5
74	CURRENT CMS/Other	72158	Magnetic resonance (eg, protor	#DIV/0!				2.36			43									
75	SVY	72158	Magnetic resonance (eg,	49	0.082	1.20	2.08	2.30	2.75	3.10	36	6			5	15	25	38	40	5
76	REC	72158	Magnetic resonance (eg, protor		0.083	2.29					35	5				25				5

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor:

<b>72141</b>	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material
<b>72142</b>	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; with contrast material(s)
<b>72156</b>	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical
<b>72146</b>	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material
<b>72147</b>	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; with contrast material(s)
<b>72157</b>	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic
<b>72148</b>	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material
<b>72149</b>	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; with contrast material(s)
<b>72158</b>	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar

Global Period: XXX Meeting Date: April 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The American College of Radiology and the American Society of Neuroradiology convened a consensus panel to finalize the practice expense data for CPT codes 72141-72158.

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

Since 72141-72158 are existing codes, we used the PEAC approved data as the basis for the practice expense inputs.

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:

- We have increased the intra-service “assist physician/acquire images” time for CPT codes 72147 (*MRI T-spine w/contrast*) and 72157 (*MRI T-spine w/o & w/contrast*) to parallel the times for the *w/contrast* and *w/o and w/contrast* for the other MRI spine codes, 72142 and 72149, and 72156 and 72158, respectively.
- The room times have been revised to equal the service period time; only the times relating to T-spine actually increased.
- A DVD, patient gown and exam paper were added to the *w/o contrast* codes, 72141, 72146, and 72148, similar to the recently RUC reviewed MRI brain codes.
- For the *w/o contrast* codes, 72141, 72146, and 72148, the film inputs have been moved from SK034 (film, x-ray 14in x 17in) to SK098 (film, x-ray, laser print) to maintain consistency across the family.

5. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Retrieve prior appropriate imaging exams and hang for MD review. Verify orders, review the chart, verify physician order including clinical information, confirm contrast protocol with interpreting physician

Intra-Service Clinical Labor Activities:

- Greet patient, provide gowning, ensure appropriate medical records are available
- Provide pre-service education/obtain consent/ Interview patient for contraindications
- Prepare room, equipment, supplies/ Enter patient data and choose coil
- Prepare and position patient/ monitor patient/ set up IV
- Assist physician in performing procedure/ Acquire images
- Clean room/equipment by physician staff
- Process films, hang films, and review study with interpreting MD prior to patient discharge
- Escort patient from exam room due to magnetic sensitivity

Post-Service Clinical Labor Activities:

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U
1	<b>Revised at RUC 4/25/13</b>			<b>REF CODE</b>		<b>REF CODE</b>		<b>REF CODE</b>		<b>REF CODE</b>		<b>REF CODE</b>		<b>REF CODE</b>		<b>REF CODE</b>		<b>REF CODE</b>		<b>REF CODE</b>	
2	*Please note: If a supply has a purchase price of \$100 or more			72141	72141	72142	72142	72156	72156	72146	72146	72147	72147	72157	72157	72148	72148	72149	72149	72158	72158
3	Meeting Date: April 2013 Tab: 25 Specialty: ACR & ASNR	CMS Code	Staff Type	Magnetic resonance (eg, proton) imaging.	Magnetic resonance (eg, proton) imaging.	Magnetic resonance (eg, proton) imaging.	Magnetic resonance (eg, proton) imaging.	Magnetic resonance (eg, proton) imaging.	Magnetic resonance (eg, proton) imaging.	Magnetic resonance (eg, proton) imaging.	Magnetic resonance (eg, proton) imaging.	Magnetic resonance (eg, proton) imaging.	Magnetic resonance (eg, proton) imaging.	Magnetic resonance (eg, proton) imaging.	Magnetic resonance (eg, proton) imaging.	Magnetic resonance (eg, proton) imaging.	Magnetic resonance (eg, proton) imaging.	Magnetic resonance (eg, proton) imaging.	Magnetic resonance (eg, proton) imaging.	Magnetic resonance (eg, proton) imaging.	Magnetic resonance (eg, proton) imaging.
4	LOCATION			Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac
5	GLOBAL PERIOD			XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
6	TOTAL CLINICAL LABOR TIME	L047A	MRI Tech	66.0	55.0	78.0	74.0	88.0	84.0	55.0	64.0	55.0	74.0	80.0	84.0	66.0	55.0	78.0	74.0	88.0	84.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L047A	MRI Tech	8.0	3.0	8.0	5.0	8.0	5.0	8.0	3.0	8.0	5.0	8.0	5.0	8.0	3.0	8.0	5.0	8.0	5.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L047A	MRI Tech	58.0	52.0	70.0	69.0	80.0	79.0	56.0	52.0	60.0	69.0	72.0	79.0	58.0	52.0	70.0	69.0	80.0	79.0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L047A	MRI Tech	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
10	PRE-SERVICE																				
11	Start: Following visit when decision for surgery or procedure made																				
12	Complete pre-service diagnostic & referral forms																				
13	Coordinate pre-surgery services																				
14	Schedule space and equipment in facility																				
15	Provide pre-service education/obtain consent																				
16	Follow-up phone calls & prescriptions *Other Clinical Activity - specify: - Retrieve prior appropriate imaging exams and hang for MD review. Verify orders, review the chart, verify physician orders including clinical	L047A	MRI Tech	8	3	8	5	8	5	8	3	8	5	8	5	8	3	8	5	8	5
17	End: When patient enters office/facility for surgery/procedure																				
18	SERVICE PERIOD																				
19	Start: When patient enters office/facility for surgery/procedure:																				
20	Greet patient, provide gowning, ensure appropriate medical records are available	L047A	MRI Tech	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
21	Obtain vital signs						3		3				3		3			3		3	
22	Provide pre-service education/obtain consent/ Interview patient for contraindications	L047A	MRI Tech	7	7	9	7	9	7	7	7	9	7	9	7	7	7	9	7	9	7
23	Prepare room, equipment, supplies/ Enter patient data and choose coil	L047A	MRI Tech	5	5	7	7	7	7	5	5	7	7	7	7	5	5	7	7	7	7
24	Setup scope (non facility setting only)																				
25	Prepare and position patient/ monitor patient/ set up IV	L047A	MRI Tech	3	3	5	5	5	5	3	3	5	5	5	5	3	3	5	5	5	5
26	Sedate/apply anesthesia																				
27	*Other Clinical Activity - specify:																				
28	Intra-service																				
29	Acquire images	L047A	MRI Tech	20	20	30	30	38	38	20	20	20	30	30	38	20	20	30	30	38	38
30	Post-Service																				
31	Monitor pt. following service/check tubes, monitors, drains																				
32	Clean room/equipment by physician staff	L047A	MRI Tech	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
33	Clean Scope																				
34	Clean Surgical Instrument Package																				
35	Complete diagnostic forms, lab & X-ray requisitions																				
36	Review/read X-ray, lab, and pathology reports																				
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions																				
38	*Other Clinical Activity - specify:																				
39	Process films, hang films, and review study with interpreting MD prior to patient discharge	L047A	MRI Tech	15	11	11	11	13	13	15	11	11	11	13	13	15	11	11	11	13	13
40	Escort patient from exam room due to magnetic sensitivity	L047A	MRI Tech	2	0	2	0	2	0	0	0	2	0	2	0	2	0	2	0	2	0
41	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
42	Dischrg mgmt (1.0 x 99238) (enter 12 min)			n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
43	Dischrg mgmt (1.0 x 99239) (enter 15 min)			n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
44	End: Patient leaves office																				
45	POST-SERVICE Period																				
46	Start: Patient leaves office/facility																				
47	Conduct phone calls/call in prescriptions																				
48	Office visits: List Number and Level of Office Visits			# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits
49	99211 16 minutes		16																		
50	99212 27 minutes		27																		
51	99213 36 minutes		36																		
52	99214 53 minutes		53																		
53	99215 63 minutes		63																		
54	Total Office Visit Time			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
55	*Other Clinical Activity - specify:																				
56	End: with last office visit before end of global period																				
57																					

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U
1	Revised at RUC 4/25/13			REF CODE		REF CODE		REF CODE		REF CODE		REF CODE		REF CODE		REF CODE		REF CODE		REF CODE	
2	*Please note: If a supply has a purchase price of \$100 or more			72141	72141	72142	72142	72156	72156	72146	72146	72147	72147	72157	72157	72148	72148	72149	72149	72158	72158
3	Meeting Date: April 2013 Tab: 25 Specialty: ACR & ASNR	CMS Code	Staff Type	Magnetic resonance (eg, proton) imaging.	Magnetic resonance (eg, proton) imaging.	Magnetic resonance (eg, proton) imaging.	Magnetic resonance (eg, proton) imaging.	Magnetic resonance (eg, proton) imaging.	Magnetic resonance (eg, proton) imaging.	Magnetic resonance (eg, proton) imaging.	Magnetic resonance (eg, proton) imaging.	Magnetic resonance (eg, proton) imaging.	Magnetic resonance (eg, proton) imaging.	Magnetic resonance (eg, proton) imaging.	Magnetic resonance (eg, proton) imaging.	Magnetic resonance (eg, proton) imaging.	Magnetic resonance (eg, proton) imaging.	Magnetic resonance (eg, proton) imaging.	Magnetic resonance (eg, proton) imaging.	Magnetic resonance (eg, proton) imaging.	Magnetic resonance (eg, proton) imaging.
4	LOCATION			Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac
5	GLOBAL PERIOD			XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
58	MEDICAL SUPPLIES**	CODE	UNIT																		
59	earplugs	SJ018	pair	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
60	film, x-ray 14in x 17in	SK034	item	10						10						10					
61	x-ray envelope	SK091	item	1		1		1		1		1		1		1		1		1	
62	kit, iv starter	SA019	kit			1	1	1	1			1	1	1	1			1	1	1	1
63	drape, non-sterile, sheet 40in x 60in	SB006	item			1	1	1	1			1	1	1	1			1	1	1	1
64	gloves, non-sterile	SB022	pair			1	1	1	1			1	1	1	1			1	1	1	1
65	gown, patient	SB026	item		1	1	1	1	1		1	1	1	1	1		1	1	1	1	1
66	paper, exam table	SB036	foot		7	7	7	7	7		7	7	7	7	7		7	7	7	7	7
67	angiocatheter 14g-24g	SC001	item			1	1	1	1			1	1	1	1			1	1	1	1
68	heparin lock	SC012	item			1	1	1	1			1	1	1	1			1	1	1	1
69	iv tubing (extension)	SC019	foot			1	1	1	1			1	1	1	1			1	1	1	1
70	needle, 18-27g	SC029	item			1	1	2	2			1	1	2	2			1	1	2	2
71	syringe 20ml	SC053	item			1	1	1	1			1	1	1	1			1	1	1	1
72	bandage, strip 0.75in x 3in (Bandaid)	SG021	item			1	1	1	1			1	1	1	1			1	1	1	1
73	sodium chloride 0.9% inj bacteriostatic (30ml uou)	SH068	item			1	1	1	1			1	1	1	1			1	1	1	1
74	computer media, dvd	SK013	item		1	1	1	1	1		1	1	1	1	1		1	1	1	1	1
75	film, x-ray, laser print	SK098	item		10	10	10	12	12		10	10	10	12	12		10	10	10	12	12
76	swab-pad, alcohol	SJ053	item			1		1				1		1	1			1	1	1	1
77	gauze, sterile 2in x 2in	SG053	item			1		1				1		1				1		1	
78	tape, surgical paper 1in (Micropore)	SG079	inch			6		6				6		6				6		6	
79	povidone swabsticks (3 pack uou)	SJ043	item			1		1				1		1				1		1	
80	contrast		cc																		
81	EQUIPMENT	CODE																			
82	room, MR	EL008		58	31	70	45	80	53	58	31	60	45	72	53	58	31	70	45	80	53
83	film alternator (motorized film viewbox)	ER029			11	11	11	13	13		11	11	11	13	13		11	11	11	13	13
84	film processor, dry, laser	ED024			11	11	11	13	13		11	11	11	13	13		11	11	11	13	13
85	Power injector																				
86																					

AMA/Specialty Society RVS Update Committee Summary of Recommendations  
*CMS Fastest Growing / Codes Reported Together 75% or More /*  
*CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request: Final Rule for 2013 Screen*

April 2013

**CT-Angiography-Abdomen and Pelvis**

In the Final Rule for 2013, CMS re-stated they believe that when codes are bundled, the new codes should be reviewed along with their component codes to ensure consistency in RVUs and inputs. The survey of CPT code 74174 *Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing* pre-dates this CMS recommendation. CMS believes there is an anomalous relationship between the physician times assigned to codes in this family. CPT code 74174 describes computed tomographic angiography (CTA) of both the abdomen and pelvis together. This CPT code includes 5 minutes of pre-service time, 30 minutes of intraservice time, and 5 minutes of post-service time, which is consistent with several other similar bundled CPT codes. CPT code 74175 describes CTA of the abdomen only, and includes 10 minutes of pre-service time, 30 minutes of intra-service time, and 10 minutes of post-service time. Similarly, CPT code 72191 describes CTA of the pelvis only, and includes 9 minutes of pre-service time, 30 minutes of intra-service time, and 10 minutes of post-service time. CMS does not believe that CTA of just the abdomen or just the pelvis should include more pre- and post-service time than the combined code. Also, while CMS believes furnishing the bundled code does not involve much more time than furnishing the stand-alone codes, they find it unlikely that the bundled service requires exactly the same intra-service time as the component services. CMS requested recommendations from the RUC and other public commenters on the appropriate work and time values for these services. In January of 2012, the Relativity Assessment Workgroup reviewed the specialty societies' proposal to equalize the pre and post times across the family at 5 minutes and retain the existing work RVUs. This recommendation was placed on the April 2013 RUC agenda to re-review the rationale and recommend changes to the times based on the existence of new pre-service packages.



The RUC noted that the specialty societies proposed two distinct actions on these three codes. First, the pre-service and post-service times for the component codes, 72191 *CTA pelvis with and without contrast* and 74175 *CTA abdomen with and without contrast*, should not be higher than the bundled code 74174 *CTA abdomen and pelvis with and without contrast*. The RUC agreed and recommends 5 minutes of pre-service time and 5 minutes of post-service time for both 72191 and 74175, so that they are identical to the pre- and post-service components of 74174. Secondly, the specialties noted that while the intra-service times are all identical, 30 minutes, the relativity among the work RVUs for these three codes is appropriate. Thus, a new survey of the family is not necessary. The RUC disagreed stating that while the relativity of the work values for these three codes may be appropriate, the intra-service time appears anomalous. CPT code 74174 requires review of two anatomical sites and should thus take some additional intra-service time for the physician to interpret and report the findings compared to the single-site components codes. **The RUC recommends the current values as interim, with modified pre- and post-service times for the following codes: 72191 (work RVU= 1.81, pre time= 5 minutes, intra time= 30 minutes, post time= 5 minutes); 74175 (work RVU= 1.90, pre time= 5 minutes, intra time= 30 minutes, post time= 5 minutes); and 74174 (work RVU= 2.20, pre time= 5 minutes, intra time= 30 minutes, post time= 5 minutes). In addition, the RUC recommends all three codes be re-surveyed for physician work and time at the October 2013 RUC meeting.**

CPT Code (●New)	CPT Descriptor	Global Period	Work RVU Recommendation
72191	Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing (Do not report 72191 in conjunction with 73706 or 75635. For CTA aorto-iliofemoral runoff, use 75635)  (Do not report 72191 in conjunction with 74175. For a combined computed tomographic angiography abdomen and pelvis study, use 74174)	XXX	1.81  (No Change)  (Interim Value-Resurvey for October 2013)
74174	Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing (Do not report 74174 in conjunction with 72191, 73706, 74175, 75635, 76376, 76377)  (For CTA aorto-iliofemoral runoff, use 75635)	XXX	2.20  (No Change)  (Interim Value-Resurvey for October 2013)

74175	<p>Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing</p> <p>(Do not report 74175 in conjunction with 73706 or 75635. For CTA aorto-iliofemoral runoff, use 75635)</p> <p>(Do not report 74175 in conjunction with 72191. For a combined computed tomographic angiography abdomen and pelvis study, use 74174)</p> <p>For combinations of CT of the abdomen with CT of the pelvis performed at the same session, use the following table. Do not report more than one CT of the abdomen or CT of the pelvis for any session.</p> <table border="1"> <tr> <th>Stand Alone Code</th><th>74150 CT Abdomen WO contrast</th><th>74160 CT Abdomen W Contrast</th><th>74170 CT Abdomen WO/W Contrast</th></tr> <tr> <td>72192 CT Pelvis WO Contrast</td><td>74176</td><td>74178</td><td>74178</td></tr> <tr> <td>72193 CT Pelvis W Contrats</td><td>74178</td><td>74177</td><td>74178</td></tr> <tr> <td>72194 CT Pelvis WO/W contrast</td><td>74178</td><td>74178</td><td>74178</td></tr> </table>	Stand Alone Code	74150 CT Abdomen WO contrast	74160 CT Abdomen W Contrast	74170 CT Abdomen WO/W Contrast	72192 CT Pelvis WO Contrast	74176	74178	74178	72193 CT Pelvis W Contrats	74178	74177	74178	72194 CT Pelvis WO/W contrast	74178	74178	74178	XXX	<p>1.90</p> <p>(No Change)</p> <p>(Interim Value-Resurvey for October 2013)</p>
Stand Alone Code	74150 CT Abdomen WO contrast	74160 CT Abdomen W Contrast	74170 CT Abdomen WO/W Contrast																
72192 CT Pelvis WO Contrast	74176	74178	74178																
72193 CT Pelvis W Contrats	74178	74177	74178																
72194 CT Pelvis WO/W contrast	74178	74178	74178																



**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor:

Computed tomographic angiography, abdomen and pelvis; with contrast material(s), including noncontrast images, if performed, and image postprocessing

(Do not report 74174 in conjunction with 72191, 73706, 74175, 75635, 76376, 76377)

(For CTA aorto-iliofemoral runoff, use 75635)

Global Period: XXX

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The ACR utilized a consensus panel process to develop recommended inputs. The ACR Practice Expense Committee was assembled using representatives from each of the ACR sub-specialty Economics Committees, thus assuring a broad representation of all the multiple radiology sub-specialties, general radiology and radiation oncology. Attention was paid to the geographic distribution, practice type (academic, private practice) and practice size of the representatives. This Committee was the final common pathway of all the recommendations that are submitted.

If you have provide any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:

The ACR used 74178 (Computed tomography abdomen and pelvis; without contrast material in one or both body regions, followed by with contrast materials and further sections in one or both body regions) and 76377 (3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; requiring image postprocessing on an independent workstation) as comparison codes. Code 74178 is a recently RUC surveyed code, was the second most commonly chosen reference service and the practice expense inputs also compares favorably with our surveyed code. Both codes involve the study of the abdomen and pelvis with and without the administration of IV contrast.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information
- Greet patient and provide gowning
- Education/instruction/counseling/obtain consent
- Prepare room, equipment, supplies
- Prepare and position patient/ monitor patient/ set up IV
- Perform CT examination to obtain source images

Intra-Service Clinical Labor Activities:

- Assist physician in performing procedure/Computer post processing
- Acquire images

Post-Service Clinical Labor Activities:

- Clean room/equipment
- Starting IV for high volume and rate power injection
- Process films, hang films and review study with interpreting MD prior to patient discharge

	A	B	C	D
1	Feb-11			<b>74174</b>
2	<b>AMA/Specialty Society RVS Update Commmittee Recommendation</b>	<b>CMS Code</b>	<b>STAFF</b>	<b>Computed tomographic angiography, abdomen and pelvis; with contrast material(s), including noncontrast images, if performed, and image postprocessing</b>
3	<b>LOCATION</b>			<b>NonFac</b>
4	<b>GLOBAL PERIOD</b>			<b>XXX</b>
5	<b>TOTAL CLINICAL LABOR TIME</b>		<b>RT</b>	122
6	<b>TOTAL PRE-SERV CLINICAL LABOR TIME</b>	L041B	<b>RT</b>	7
7	<b>TOTAL SERVICE PERIOD CLINICAL LABOR TIME</b>		<b>RT</b>	115
8	<b>PRE-SERVICE PERIOD</b>			
9	<b>Start: Following visit when decision for surgery or procedure made</b>			
11	- Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information	L041B	<b>RT</b>	7
12	<b>End: When patient enters office/facility for surgery/procedure</b>			
13	<b>SERVICE PERIOD</b>			
14	<b>Start: When patient enters office/facility for surgery/procedure</b>			
15	<b>Pre-service</b>			
16	Greet patient and provide gowning	L041B	<b>RT</b>	3
17	Education/instruction/counseling/obtain consent	L041B	<b>RT</b>	2
18	Prepare room, equipment, supplies	L041B	<b>RT</b>	4
19	Prepare and position patient/ monitor patient/ set up IV	L041B	<b>RT</b>	5
21	<b>Intra-service</b>			
22	Assist physician in performing procedure/Computer post processing	L046A	<b>RT</b>	33
23	Acquire images	L041B	<b>RT</b>	45
24	<b>Post-Service</b>			
25	Clean room/equipment	L041B	<b>RT</b>	3
27	Other Clinical Activity: Process films, hang films and review study with interpreting MD prior to patient discharge	L046A	<b>RT</b>	20
28	<b>End: Patient leaves office</b>			
29	<b>MEDICAL SUPPLIES</b>			
30	Alcohol Swab	SJ053		1
31	Angiocatheter	SC002		1
32	Band aid	SG021		1
33	Betadine Swab	SJ043		1
34	CD	SK016		1
35	Drape, Sheet	SB014		1
36	Extension Tubing	SC019		3
37	Film, 14x17 (sheets)	SK034		8
38	Film, 14x17, laser (surrogate for digital archival)	SK098		23
39	Film jacket	73405		0
40	Film developer/cost per exposure	SK089		8
41	Film fixer	SK092		8
42	Gauze 2x2	SG053		1
43	Gauze 2x2, nonsterile	SG050		1
44	Gloves, sterile (pair)	SB022		1
45	Heplock	SC012		1
46	IV start kit	SA019		1
47	Needle, 20G	SC025		0
48	Needle, 18-27G	SC029		1
49	Patient gown, disposable	SB026		1
50	Saline (cc)	SH065		15
51	Syringe, 20cc	SC053		0
52	Table paper (ft)	SB036		7
53	Tape (inch)	SG075		6
54	Tube, connecting	SD260		0
55	Tube, extension (cm)			76
56	stop-cock, 4-way	SC050		1
57	Syringe, pressure	SC060		1
58	tubing, sterile, connecting	SD212		1
59	<b>Equipment</b>			
60	3D reconstruction workstation	ED014		20
61	CT Room	EL007		57
62	Film alternator	ER029		20
63	Film processor	ED024		20
64	Printer, laser	ED032		10

	A	B	C	D	E	F	G	H	J
1									
2				76377	76377	74178	74178	7417XX	74174
3	Meeting Date: April 2012 Tab: 49 Specialty: ACR	CMS Code	Staff Type	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality; requiring image post processing on an independent workstation.  RUC Approved April 2005	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality; requiring image post processing on an independent workstation.  CMS Refined	Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by with contrast material(s) and further sections in one or both body regions.  RUC Approved February 2010	Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by with contrast material(s) and further sections in one or both body regions.  CMS Refined	Computed tomographic angiography, abdomen and pelvis; with contrast material(s), including noncontrast images, if performed, and image postprocessing  Revised at Feb 2011 RUC	Computed tomographic angiography, abdomen and pelvis; with contrast material(s), including noncontrast images, if performed, and image postprocessing  CMS Refined
4	LOCATION			Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac
5	GLOBAL PERIOD			XXX	XXX	XXX	XXX	XXX	XXX
6	TOTAL CLINICAL LABOR TIME	L046A	CT Tech	38.0	38.0	90.0	90.0	128.0	122.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L046A	CT Tech	0.0	0.0	7.0	7.0	7.0	7.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L046A	CT Tech	38.0	38.0	83.0	83.0	121.0	115.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0	0.0	0.0
10	PRE-SERVICE								
11	Start: Following visit when decision for surgery or procedure made								
12	Complete pre-service diagnostic & referral forms								
13	Coordinate pre-surgery services								
14	Schedule space and equipment in facility								
15	Provide pre-service education/obtain consent								
16	Follow-up phone calls & prescriptions								
17	Other Clinical Activity - specify:								
18	- Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information	L041B	RT			7		7	
19	End: When patient enters office/facility for surgery/procedure								
20	SERVICE PERIOD								
21	Start: When patient enters office/facility for surgery/procedure:								
22	Greet patient, provide gowning, ensure appropriate medical records are available	L041B	RT			3		3	
23	Education/instruction/counseling/obtain consent	L041B	RT			3		3	
24	Obtain vital signs								
25	Provide pre-service education/obtain consent								
26	Prepare room, equipment, supplies	L041B	RT			4		4	
27	Setup scope (non facility setting only)								
28	Prepare and position patient/ monitor patient/ set up IV	L041B	RT			5		5	
29	Sedate/apply anesthesia								
30	Intra-service								
31	Acquire images	L041B	RT			45		45	
32	Starting IV for high volume and rate power injection								
33	Assist physician in performing procedure/ Computer post processing	L046A	CT Tech	33				33	
34	Post-Service								
35	Monitor pt. following service/check tubes, monitors, drains								
36	Clean room/equipment by physician staff	L041B	RT			3		3	
37	Clean Scope								
38	Clean Surgical Instrument Package								
39	Complete diagnostic forms, lab & X-ray requisitions								
40	Review/read X-ray, lab, and pathology reports								
41	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions								
42	Other Clinical Activity - specify:								
43	Process films, hang films and review study with interpreting MD prior to patient discharge	L046A	CT Tech	5		20		25	
47	End: Patient leaves office								
48	POST-SERVICE Period								
49	Start: Patient leaves office/facility								
58	Other Clinical Activity - specify: Review films for adequacy	L046A	CT Tech						
59	End: with last office visit before end of global period								
60	MEDICAL SUPPLIES	CODE	UNIT						
61	swab-pad, alcohol	SJ053	item			1	1	1	1
62	angiocatheter set	SC002	item			1	1	1	1
63	bandage, strip 0.75in x 3in (Bandaid)	SG021	item			1	1	1	1
64	povidone swabsticks (3 pack uou)	SJ043	item			1	1	1	1
65	computer media, optical disk 2.6gb	SK016	item			1		1	1
66	drape, sterile, three-quarter sheet	SB014	item			1	1	1	1
67	iv tubing (extension)	SC019	foot			1	1	1	3
68	film, x-ray 14in x 17in	SK034	item	8	8			8	8
69	film, x-ray, laser print	SK098	item			23	23	23	23
70	x-ray envelope	SK091	item			1		1	
71	x-ray developer solution	SK089	oz	8	8			8	8
72	x-ray fixer solution	SK092	oz	8	8			8	8
73	gauze, sterile 2in x 2in	SG053	item			1	1	1	1
74	gauze, non-sterile 2in x 2in	SG050	item			1	1	1	1
75	gloves, non-sterile	SB022	pair			1	1	1	1
76	heparin lock	SC012	item			1	1	1	1
77	kit, iv starter	SA019	kit			1	1	1	1
78	needle, 14-20g, biopsy	SC025	item			1	1	1	

	A	B	C	D	E	F	G	H	J
1									
2				76377	76377	74178	74178	7417XX	74174
3	Meeting Date: April 2012 Tab: 49 Specialty: ACR	CMS Code	Staff Type	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality; requiring image post processing on an independent workstation.  RUC Approved April 2005	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality; requiring image post processing on an independent workstation.  CMS Refined	Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by with contrast material(s) and further sections in one or both body regions.  RUC Approved February 2010	Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by with contrast material(s) and further sections in one or both body regions.  CMS Refined	Computed tomographic angiography, abdomen and pelvis; with contrast material(s), including noncontrast images, if performed, and image postprocessing  Revised at Feb 2011 RUC	Computed tomographic angiography, abdomen and pelvis; with contrast material(s), including noncontrast images, if performed, and image postprocessing  CMS Refined
4	LOCATION			Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac
5	GLOBAL PERIOD			XXX	XXX	XXX	XXX	XXX	XXX
79	gown, patient	SB026	item			1	1	1	1
80	sodium chloride 0.9% flush syringe	SH065	item			15	15	15	15
81	syringe 20ml	SC053	item			1	1	1	
82	paper, exam table	SB036	foot			7	7	7	7
83	tape, elastic, 1in (Elastoplast, Elasticon) (5yd uou)	SG075	item			6	6	6	6
84	Y-set connection tubing	SD260	item					1	
85	tube, extension (cm)	SC019	foot					76	
86	syringe, pressure (radiology)	SC060	item						1
87	tubing, sterile, connecting (fluid administration)	SD212	item						1
88	stop cock, 4-way	SC050	item						1
89	needle, 18-27g	SC029	item						1
90	syringe, 25ml (MRI power injector)	SC059	item				1		
91	contrast		ml						
92	contrast syringe 200 cc		item						
93	cotton ball		item						
94	D5W		item						
95	gloves, sterile		pair						
96	saline		cc						
97	EQUIPMENT	CODE							
98	computer workstation, 3D reconstruction CT-MR	ED014		1	38			38	20
99	room, CT	EL007				X	57	82	57
100	film alternator (motorized film viewbox)	ER029		1	9	X	57	82	20
101	film processor, dry, laser	ED024		1				82	20
102	printer, laser, paper	ED032				X	20	10	10
103	Power Injector	ER079							
104	Film Processor, wet	ED025			9				
105	CT Scanner								



	A	B	C	K	L	M	N	O	P
1						April 2012			April 2012
2				741XX	74175	74175	721XX	72191	72191
3	Meeting Date: April 2012 Tab: 49 Specialty: ACR	CMS Code	Staff Type	Computed tomographic angiography, abdomen, without contrast material(s), followed by contrast material(s), including image postprocessing  RUC Approved February 2001	Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing  CMS Refined	Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing  RUC April 2012	Computed tomographic angiography, pelvis, without contrast material(s), followed by contrast material(s), including image post-processing  RUC Approved February 2001	Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing  CMS Refined	Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing  RUC April 2012
4	LOCATION			Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac
5	GLOBAL PERIOD			XXX	XXX	XXX	XXX	XXX	XXX
6	TOTAL CLINICAL LABOR TIME	L046A	CT Tech	122.0	98.0	103.0	122.0	60.0	106.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L046A	CT Tech	5.0	5.0	5.0	5.0	0.0	5.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L046A	CT Tech	112.0	93.0	98.0	112.0	60.0	101.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			5.0	0.0	0.0	5.0	0.0	0.0
10	PRE-SERVICE								
11	Start: Following visit when decision for surgery or procedure made								
12	Complete pre-service diagnostic & referral forms								
13	Coordinate pre-surgery services								
14	Schedule space and equipment in facility								
15	Provide pre-service education/obtain consent								
16	Follow-up phone calls & prescriptions								
17	Other Clinical Activity - specify:								
18	- Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information	L041B	RT	5		5	5		5
19	End: When patient enters office/facility for surgery/procedure								
20	SERVICE PERIOD								
21	Start: When patient enters office/facility for surgery/procedure:								
22	Greet patient, provide gowning, ensure appropriate medical records are available	L041B	RT	3		3	3		3
23	Education/instruction/counseling/obtain consent	L041B	RT	2		2	2		2
24	Obtain vital signs								
25	Provide pre-service education/obtain consent								
26	Prepare room, equipment, supplies	L041B	RT	5		2	5		5
27	Setup scope (non facility setting only)								
28	Prepare and position patient/ monitor patient/ set up IV	L041B	RT	7		7	7		7
29	Sedate/apply anesthesia								
30	Intra-service								
31	Acquire images	L041B	RT	28		28	28		28
32	Starting IV for high volume and rate power injection			5			5		
33	Assist physician in performing procedure/ Computer post processing	L046A	CT Tech	57		33	57		33
34	Post-Service								
35	Monitor pt. following service/check tubes, monitors, drains								
36	Clean room/equipment by physician staff	L041B	RT	5		3	5		3
37	Clean Scope								
38	Clean Surgical Instrument Package								
39	Complete diagnostic forms, lab & X-ray requisitions								
40	Review/read X-ray, lab, and pathology reports								
41	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions								
42	Other Clinical Activity - specify:								
43	Process films, hang films and review study with interpreting MD prior to patient discharge	L046A	CT Tech			20			20
47	End: Patient leaves office								
48	POST-SERVICE Period								
49	Start: Patient leaves office/facility								
58	Other Clinical Activity - specify: Review films for adequacy	L046A	CT Tech	5			5		
59	End: with last office visit before end of global period								
60	MEDICAL SUPPLIES		CODE UNIT						
61	swab-pad, alcohol	SJ053	item	1	1	1	1	1	1
62	angiocatheter set	SC002	item	1	1	1	1	1	1
63	bandage, strip 0.75in x 3in (Bandaid)	SG021	item	1	1	1	1	1	1
64	povidone swabsticks (3 pack uou)	SJ043	item		1	1		1	1
65	computer media, optical disk 2.6gb	SK016	item	1	1	0.1	1	1	0.1
66	drape, sterile, three-quarter sheet	SB014	item		1	1		1	1
67	iv tubing (extension)	SC019	foot		3	3		3	3
68	film, x-ray 14in x 17in	SK034	item	12	8	8	12	8	8
69	film, x-ray, laser print	SK098	item		11	11		11	11
70	x-ray envelope	SK091	item	1			1		
71	x-ray developer solution	SK089	oz		8	8		8	8
72	x-ray fixer solution	SK092	oz		8	8		8	8
73	gauze, sterile 2in x 2in	SG053	item		1	1		1	1
74	gauze, non-sterile 2in x 2in	SG050	item		1	1		1	1
75	gloves, non-sterile	SB022	pair		1	1		1	1
76	heparin lock	SC012	item		1	1		1	1
77	kit, iv starter	SA019	kit		1	1		1	1
78	needle, 14-20g, biopsy	SC025	item						

	A	B	C	K	L	M	N	O	P
1						April 2012			April 2012
2				741XX	74175	74175	721XX	72191	72191
3	Meeting Date: April 2012 Tab: 49 Specialty: ACR	CMS Code	Staff Type	Computed tomographic angiography, abdomen, without contrast material(s), followed by contrast material(s), including image postprocessing  RUC Approved February 2001	Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing  CMS Refined	Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing  RUC April 2012	Computed tomographic angiography, pelvis, without contrast material(s), followed by contrast material(s), including image post-processing  RUC Approved February 2001	Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing  CMS Refined	Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing  RUC April 2012
4	LOCATION			Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac
5	GLOBAL PERIOD			XXX	XXX	XXX	XXX	XXX	XXX
79	gown, patient	SB026	item	1	1	1	1	1	1
80	sodium chloride 0.9% flush syringe	SH065	item		15	15		15	15
81	syringe 20ml	SC053	item						
82	paper, exam table	SB036	foot		7	7		7	7
83	tape, elastic, 1in (Elastoplast, Elasticon) (5yd uou)	SG075	item	6	6	6	6	6	6
84	Y-set connection tubing	SD260	item						
85	tube, extension (cm)	SC019	foot	76		3	76		3
86	syringe, pressure (radiology)	SC060	item		1	1		1	1
87	tubing, sterile, connecting (fluid administration)	SD212	item	1	1	1	1	1	1
88	stop cock, 4-way	SC050	item	1	1	1	1	1	1
89	needle, 18-27g	SC029	item	1	1	1	1	1	1
90	syringe, 25ml (MRI power injector)	SC059	item			1			1
91	contrast		ml	150			150		
92	contrast syringe 200 cc		item	1			1		
93	cotton ball		item	1			1		
94	D5W		item	250cc			250cc		
95	gloves, sterile		pair	1			1		
96	saline		cc	10			10		
97	EQUIPMENT	CODE							
98	computer workstation, 3D reconstruction CT-MR	ED014		45	15	33	45	15	33
99	room, CT	EL007			40	40		40	40
100	film alternator (motorized film viewbox)	ER029			15	15		15	15
101	film processor, dry, laser	ED024			15	15		15	15
102	printer, laser, paper	ED032			10	10		10	10
103	Power Injector	ER079		45			45		
104	Film Processor, wet	ED025							
105	CT Scanner			45			45		

AMA/Specialty Society RVS Update Committee Summary of Recommendations  
*MPC List / CMS High Expenditure Procedural Codes/CMS Request: Final Rule for 2013*  
April 2013

**Fluoroscopic Guidance**

CPT code 77003 was identified through the CMS High Expenditure Procedural Codes screen and the MPC List screen. The RUC submitted work and practice recommendations for the 2013 Medicare Physician Payment Schedule. In the Final Rule for 2013, CMS indicated that the Agency will maintain the current work RVU of 0.60 for CPT code 77003 as interim. CMS indicated that it was necessary to review code 77003 alongside codes 77001 and 77002 in 2013 for the 2014 Medicare Physician Payment Schedule. CMS requested public comments on the appropriate work values and practice expense inputs for these services. The RUC recommended surveying for work and developing PE inputs for 77001 and 77002 for review at the April 2013 RUC meeting. CPT code 77003 was recently reviewed in January 2012 and was not resurveyed with the family.

***77001 Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 74 radiologists and anesthesiologists and agreed with the specialty societies that the respondents overestimated the physician time involved in this service and that the following current physician time components should be maintained: pre-service time of 0 minutes, intra-service time of 9 minutes and post-service time of 4 minutes. The RUC reviewed the survey and determined that the current value of 0.38 is appropriate for this service. To validate this work value, the RUC compared the surveyed code to key reference service 36148 *Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); additional access for therapeutic intervention (List separately in addition to code for primary procedure)* (work RVU=1.00, 15 minutes intra-service). While both 77001 and 36148 involve catheter directed procedures, 36148 includes both the vascular access and imaging guidance whereas, 77001 represents the guidance only, which requires less intensity to perform. Less work and the lower intensity account for the lower value for 77001. Additionally, MPC code 95874 *Needle electromyography for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)* (work RVU=0.37, 20 minutes intra-service) was reviewed and the RUC agreed that with slightly less total time and higher intensity 77001 should be valued slightly higher. **The RUC recommends a work RVU of 0.38 for CPT code 77001.**

***77002 Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)***

The RUC reviewed the survey results from 73 radiologists, anesthesiologists and physical medicine and rehabilitation physicians and recommended the following physician time components: pre-service time of 7 minutes, intra-service time of 15 minutes and post-service time of 5 minutes. The RUC determined that the current value of 0.54 is appropriate for this service. To validate this work value, the RUC compared the surveyed code to key reference service 76937 *Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites,*



documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure) (work RVU=0.30, 0 minutes pre-service, 10 minutes intra-service and 4 minutes post-service) and agreed that with higher intra-service time and intensity, 77002 should be valued higher than the reference code. Additionally, recently valued MPC codes 93224 *External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation by a physician or other qualified health care professional* (work RVU=0.52, 2 minutes pre-service, 15 minutes intra-service and 7 minutes post-service) and 76536 *Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation* (work RVU=0.56, 4 minutes pre-service, 10 minutes intra-service and 4 minutes post-service) were reviewed and the RUC agreed that 77002 has slightly more total time than 93224 and should be valued slightly higher and 77002 has more time, but is less intense to perform than 76536 and should be valued slightly higher. **The RUC recommends a work RVU of 0.54 for CPT code 77002.**

### 77003

#### ***Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)***

The RUC reviewed the RUC recommendations from January 2012 for CPT code 77003 and agreed to reaffirm the established values, as they are appropriate relative to the family of services reviewed at the April 2013 RUC meeting. In January 2012, the RUC reviewed the survey responses from 122 anesthesiologists, interventional radiologists, radiologists, spine surgeons and pain medicine physicians and determined that the physician work for CPT code 77003 should be maintained at 0.60 work RVUs, lower than the survey's 25<sup>th</sup> percentile. The RUC reaffirms the following recommended physician time components: pre-service time of 7 minutes, intra-service time of 15 minutes and post-service time of 5 minutes. **The RUC recommends reaffirming a work RVU of 0.60 for CPT code 77003.**

### Practice Expense

The RUC recommends practice expense for CPT codes 77001 and 77002 with minor modifications as approved by the PE Subcommittee. The RUC reaffirms recently reviewed practice expense for CPT code 77003 as previously approved by the PE Subcommittee.

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
77001	Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access	ZZZ	0.38 (No Change)

	<p>site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)</p> <p>(Do not use 77001 in conjunction with 77002)</p> <p>(If formal extremity venography is performed from separate venous access and separately interpreted, use 36005 and 75820, 75822, 75825, or 75827)</p>		
77002	<p>Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)</p> <p>(See appropriate surgical code for procedure and anatomic location)</p> <p>(77002 includes all radiographic arthrography with the exception of supervision and interpretation for CT and MR arthrography)</p> <p>(Do not report 77002 in conjunction with 32554, 32555, 32556, 32557, 70332, 73040, 73085, 73115, 73525, 73580, 73615, 0232T)</p> <p>(For injection(s) of platelet rich plasma, use 0232T)</p> <p>(77002 is included in the organ/anatomic specific radiological supervision and interpretation procedures 49440, 74320, 74355, 74445, 74470, 74475, 75809, 75810, 75885, 75887, 75890, 75892, 75989)</p>	XXX	<p>0.54</p> <p>(No Change)</p>

77003	<p>Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)</p> <p>(Injection of contrast during fluoroscopic guidance and localization [77003] is included in 22526, 22527, 27096, 62263, 62264, 62267, 62270-62282, 62310-62319)</p> <p>(Fluroscopic guidance for subarachnoid puncture for diagnostic radiographic myelography is in included in supervision and interpretation codes 72240-72270)</p> <p>(For epidural or subarachnoid needle or catheter placement and injection, see 62270-62282 ,62310- 62319 )</p> <p>(For sacroiliac joint arthrography, see 27096)</p> <p>(For paravertebral facet joint injection, see 64490- 64495). For paravertebral facet joint nerve destruction by neurolysis, see 64633- 64636. For transforaminal epidural needle placement and injection, see 64479- 64484 )</p> <p>Do not report 77002, 77003 in conjunction with 22586, 27096, 64479–64484, 64490-64495, 64633- 64636 , 0195T, 0196T, 0309T)</p> <p>(For percutaneous or endoscopic lysis of epidural adhesions, 62263, 62264 include fluoroscopic guidance and localization)</p>	XXX	<p>0.60</p> <p>(January 2012 RUC Recommendation)</p>
-------	--	-----	--

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 77001	Tracking Number	Original Specialty Recommended RVU: <b>0.38</b>
		Presented Recommended RVU: <b>0.38</b>
Global Period: ZZZ		RUC Recommended RVU: <b>0.38</b>

CPT Descriptor: Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: 60-year-old male patient in need of hemodialysis. Tunneled central venous access placement is performed (the catheter placement is separately reported) during which fluoroscopic guidance is used to facilitate the catheter and wire manipulations and ensure proper positioning of the catheter.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 88%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 65%

**Description of Pre-Service Work:**

Description of Intra-Service Work: Following achievement of venous access (separately reported), fluoroscopy is used to manipulate the guidewire and subsequently the catheter into an appropriate central venous position. Any contrast injection through access site (via needle, catheter or sheath) for venographic evaluation and mapping of appropriate path is included. Additional fluoroscopy after venography may be necessary for optimal positioning. Spot film or other radiographic confirmation of final catheter position is performed. Description of all aspects of fluoroscopic guidance are reported with procedure.

Description of Post-Service Work: A report describing the guidance procedure, including the final position of the needle/catheter, is dictated, proofread, and submitted for the patient's medical record. The results of the procedure are communicated to the referring physician when appropriate.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Zeke Silva, MD; Kurt Schoppe, MD; Sean Tutton, MD; Robert Vogelzang, MD; Michael Hall, MD; Jerry Niedzwiecki, MD; Marc Lieb, MD; Richard Rosenquist, MD				
<b>Specialty(s):</b>	American College of Radiology, Society of Interventional Radiology, and American Society of Anesthesiologists				
<b>CPT Code:</b>	77001				
<b>Sample Size:</b>	2297	<b>Resp N:</b>	74	<b>Response:</b> 3.2 %	
<b>Description of Sample:</b>	Random Sample				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	56.00	113.00	300.00	5000.00
<b>Survey RVW:</b>	0.10	0.60	1.00	1.10	3.00
<b>Pre-Service Evaluation Time:</b>			10.00		
<b>Pre-Service Positioning Time:</b>			0.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.00		
<b>Intra-Service Time:</b>	0.00	15.00	20.00	30.00	60.00
<b>Immediate Post Service-Time:</b>	<b>10.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: ZZZ Global Code

<b>CPT Code:</b>	77001	<b>Recommended Physician Work RVU: 0.38</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		0.00	0.00	0.00
<b>Pre-Service Positioning Time:</b>		0.00	0.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	0.00	0.00
<b>Intra-Service Time:</b>		9.00		
<b>Immediate Post Service-Time:</b>	<b>4.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00
---------------	-------------	-------------	-------------	-------------

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
36148	ZZZ	1.00	RUC Time

CPT Descriptor Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); additional access for therapeutic intervention (List separately in addition to code for primary procedure)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
92025	XXX	0.35	RUC Time	113,686

CPT Descriptor 1 Computerized corneal topography, unilateral or bilateral, with interpretation and report

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
95874	ZZZ	0.37	RUC Time	56,504

CPT Descriptor 2 Needle electromyography for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
93923	XXX	0.45	RUC Time

CPT Descriptor Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure measurements with bidirectional Doppler waveform recording and analysis, at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental volume plethysmography at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental transcutaneous oxygen tension measurements at 3 or more levels), or single level study with provocative functional maneuvers (eg, measurements with postural provocative tests, or measurements with reactive hyperemia)

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 27      % of respondents: 36.4 %

**TIME ESTIMATES (Median)**

	<u>CPT Code:</u> 77001	<u>Key Reference CPT Code:</u> 36148	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	9.00	15.00	

Median Immediate Post-service Time	4.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>13.00</b>	<b>15.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.78	2.48
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.70	2.67
--	------	------

Urgency of medical decision making	2.56	2.44
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.15	3.04
--------------------------	------	------

Physical effort required	2.67	2.59
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.11	2.81
---	------	------

Outcome depends on the skill and judgment of physician	3.41	3.19
--	------	------

Estimated risk of malpractice suit with poor outcome	2.70	2.52
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.59	2.67
----------------------------------	------	------

Intra-Service intensity/complexity	3.19	3.19
------------------------------------	------	------

Post-Service intensity/complexity	2.33	2.30
-----------------------------------	------	------

## Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

### Introduction

CPT code 77001 is being reviewed along with 77002 to ensure relativity across this family of codes after 77003 was recently surveyed and its value accepted by CMS on an interim basis. This family of codes describes the use of fluoroscopic guidance for localization of needles or catheters during a variety of procedures.

### Background

CMS previously identified CPT code 77003 (*Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural or subarachnoid)*) as potentially misvalued through its screen of MPC codes. Code 77003 was re-surveyed twice by the specialties, with recommendations accepted by the RUC in January of 2012. In the 2013 Final Rule, CMS accepted the RUC recommended value of 77003 as “interim” for 2013, indicating they “believe it is necessary to review this service alongside very similar CPT codes 77001 and 77002 to determine the appropriate relative value for this high volume, high expenditure procedure code.”

CPT code 77001 (*Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (list separately in addition to code for primary procedure)*) describes the use of fluoroscopy to ensure appropriate positioning of the guidewires and catheters during central line placement, replacement, repositioning, or removal. The American College of Radiology, Society of Interventional Radiology, and American Society of Anesthesiologists surveyed this family, including CPT codes 77001 and 77002, in March 2013, and convened an expert panel of physicians familiar with these services to review the survey data.

### Global Period

CPT code 77001 was surveyed as a ZZZ add-on code and, across all three societies, pre and post-service work times were indicated, similar to the other XXX codes in this family (77002 and 77003). This proposed change in global period from ZZZ to XXX would serve to correctly capture the non-duplicative work performed during 77001 and maintain consistency with 77002 and 77003.

### Work RVU Recommendation

The expert panel recommends maintaining the existing work RVU of 0.38.

### Service Times

The panel recommends the following service period times for 77001: pre, intra, and post times of 7, 20, and 5 minutes, respectively. This is predicated on the RUCs agreement that a change in the global period is appropriate.

The pre and post times had median survey values of 10 minutes each for 77001. However, the panel recommends using the recent RUC approved pre and post survey times for 77003 (7 and 5 minutes, respectively), which appropriately reflect the work involved with the imaging guidance used in both 77001 and 77002.

The panel recommends the median intra-service time of 20 minutes, which reflects the time required for fluoroscopic guidance during manipulation of guide wires and catheters in the mediastinal vessels.

### Key Reference Service

The most commonly selected key reference service was CPT code 36148 (*Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); additional access for therapeutic intervention (List separately in addition to code for primary procedure)*). This ZZZ code was selected by approximately one third of those surveyed, and it has 1.00 work RVU with an intra service time of 15 minutes.



While both 77001 and 36148 involve the catheter directed procedures, 36148 includes both the vascular access and imaging guidance whereas 77001 represents the guidance only, which is lower intensity work.

Code	Descriptor	RVU	Pre	Intra	Post	Total	IWPUT
77001	Fluoro guidance during central catheter	0.38	0	9	4	13	0.006
36148	Additional AV shunt access	1.00	0	15	0	15	0.067

### MPC Comparison

The panel recommendation of 0.38 RVUs for 77001 is bracketed by three MPC codes with XXX and ZZZ global periods: 92025 (*Computerized corneal topography, unilateral or bilateral, with interpretation and report*), 95874 (*Needle electromyography for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)*), and 93923 (*Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure measurements with bidirectional Doppler waveform recording and analysis, at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental volume plethysmography at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental transcutaneous oxygen tension measurements at 3 or more levels), or single level study with provocative functional maneuvers (eg, measurements with postural provocative tests, or measurements with reactive hyperemia)*).

Code	Descriptor	RVU	Pre	Intra	Post	Total	IWPUT	Global
92025	Computerized corneal topography	0.35	5	12	0	17	0.020	XXX
95874	EMG during chemodenervation	0.37	0	20	0	20	0.019	ZZZ
77001	Fluoro guidance during central catheter	0.38	0	9	4	13	0.006	ZZZ
93923	Doppler/duplex extremity	0.45	3	10	3	16	0.032	XXX

### Comparison within the Family

Allowing for our suggested change in global period for 77001 from ZZZ to XXX, and using the service times outlined above, this creates a structure that accurately reflects the work of performing 77001, while creating a proper family of codes.

Codes in Family	Descriptor	Recommended RVUs	Pre Time	Intra Time	Post Time	Total Time	IWPUT
77001	Fluoro guidance during central catheter	0.38	0	9	4	13	0.006
77002	Fluoro guidance during biopsy	0.54	7	15	5	27	0.018
77003	Fluoro guidance for spine intervention	0.60	7	15	5	27	0.022

The data summarized in the table above demonstrate the relative work involved in the procedures surveyed within the fluoroscopic guidance code family. While the intra-procedure survey times decrease through the code family, the IWPUT across the different codes appropriately reflects the differences in intensity related to the anatomy and technical difficulty of these procedures.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☒ Other reason (please explain) This is not a stand-alone service. It would only be reported along with another procedure when that procedure was done with fluoroscopic guidance and that guidance was not already bundled into the procedure

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. This code would only be reported in conjunction with a procedure when imaging guidance is not already bundled into the code that describes the underlying procedure. The incidence of this will decrease markedly, as CPT code changes to bundle fluoroscopic guidance into a large number of codes will be accounted for.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 77001

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology                      How often? Commonly

Specialty Interventional Radiology                      How often? Commonly

Specialty Anesthesiology                      How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 1390206

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The overall number of services described by 77001 provided nationally in a one-year period is estimated to be 1,390,206

Specialty Diagnostic Radiology                      Frequency 823750                      Percentage 59.25 %

Specialty Interventional Radiology                      Frequency 145000                      Percentage 10.43 %

Specialty Anesthesiology                      Frequency 600                      Percentage 0.04 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 463,402 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2011 Medicare data estimates that CPT code 77001 was billed approximately 463,402 times for Medicare patients nationally in a one-year period.

Specialty Diagnostic Radiology	Frequency 274600	Percentage 59.25 %
Specialty Interventional Radiology	Frequency 48400	Percentage 10.44 %
Specialty Anesthesiology	Frequency 250	Percentage 0.05 %

Do many physicians perform this service across the United States? Yes

---

### **Professional Liability Insurance Information (PLI)**

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 77001

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 77002	Tracking Number	Original Specialty Recommended RVU: <b>0.54</b>
		Presented Recommended RVU: <b>0.54</b>
Global Period: XXX		RUC Recommended RVU: <b>0.54</b>

CPT Descriptor: Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 65-year-old male with hip pain and suspected joint effusion is referred for joint aspiration. Fluoroscopic guidance is used to advance a needle into the joint space, after which joint fluid is aspirated (needle aspiration is reported separately).

Percentage of Survey Respondents who found Vignette to be Typical: 85%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 47%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 28%

Description of Pre-Service Work: The physician reviews the patient's prior imaging studies (eg, radiographs, computed tomography [CT] scans, magnetic resonance imaging [MRI] scans) to be familiar with the patient's anatomy to plan an appropriate trajectory for the needle placement (including access site, pertinent landmarks, and variant anatomy). The physician dresses in radiation attire and instructs the radiologic technologists in the imaging equipment required and the proper settings for the imaging equipment.

Description of Intra-Service Work: The patient is placed on an X-ray table and positioned appropriately depending on the type of procedure to be performed. Preliminary fluoroscopy is performed to identify the appropriate level and approach for the initial needle placement, and the skin entry site is prepped and marked. Sterile drapes are applied. During the needle placement, intermittent fluoroscopy is used to confirm the correct approach and the need for needle repositioning or realignment. When the needle position appears correct, radiographic contrast may be injected to confirm the proper position or tissue samples may be acquired and reviewed. If the position is not correct, additional fluoroscopy is utilized to guide repositioning until the proper position is achieved.

Description of Post-Service Work: A report describing the guidance procedure, including the final position of the needle/catheter, is dictated, proofread, and submitted for the patient's medical record. The results of the procedure are communicated to the referring physician when appropriate.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Zeke Silva, MD; Kurt Schoppe, MD; Sean Tutton, MD; Robert Vogelzang, MD; Michael Hall, MD; Jerry Niedzwiecki, MD; Marc Lieb, MD; Richard Rosenquist, MD; Joseph P. Zuhosky, MD				
<b>Specialty(s):</b>	American College of Radiology, Society of Interventional Radiology, American Society of Anesthesiologists, American Academy of Physical Medicine and Rehabilitation				
<b>CPT Code:</b>	77002				
<b>Sample Size:</b>	2447	<b>Resp N:</b>	73	<b>Response:</b> 2.9 %	
<b>Description of Sample:</b>	Random Sample				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	2.00	30.00	50.00	150.00	1100.00
<b>Survey RVW:</b>	0.30	0.50	0.90	1.12	5.00
<b>Pre-Service Evaluation Time:</b>			10.00		
<b>Pre-Service Positioning Time:</b>			0.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.00		
<b>Intra-Service Time:</b>	3.00	10.00	15.00	20.00	60.00
<b>Immediate Post Service-Time:</b>	10.00				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	0.00	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

<b>CPT Code:</b>	77002	<b>Recommended Physician Work RVU: 0.54</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		7.00	0.00	7.00
<b>Pre-Service Positioning Time:</b>		0.00	0.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	0.00	0.00
<b>Intra-Service Time:</b>		15.00		
<b>Immediate Post Service-Time:</b>	5.00			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	0.00	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	0.00	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	0.00	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		

<b>Prolonged Services:</b>	<u>0.00</u>	99354x <b>0.00</b>	55x <b>0.00</b>	56x <b>0.00</b>	57x <b>0.00</b>
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x <b>0.00</b>	99225x <b>0.00</b>	99226x <b>0.00</b>	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
76937	ZZZ	0.30	RUC Time

CPT Descriptor Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
93224	XXX	0.52	RUC Time	522,889

CPT Descriptor 1 External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation by a physician or other qualified health care professional

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
76536	XXX	0.56	RUC Time	647,021

CPT Descriptor 2 Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code:** 25      **% of respondents:** 34.2 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 77002</b>	<b>Key Reference CPT Code: 76937</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	7.00	0.00	
Median Intra-Service Time	15.00	10.00	
Median Immediate Post-service Time	5.00	4.00	
Median Critical Care Time	0.0	0.00	

Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>27.00</b>	<b>14.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.36	2.20
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.44	2.24
Urgency of medical decision making	2.24	2.20

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.12	2.96
Physical effort required	2.32	2.20
<b><u>Psychological Stress (Mean)</u></b>		
The risk of significant complications, morbidity and/or mortality	2.68	2.56
Outcome depends on the skill and judgment of physician	3.28	3.16
Estimated risk of malpractice suit with poor outcome	2.56	2.32

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.32	2.08
Intra-Service intensity/complexity	3.04	2.76
Post-Service intensity/complexity	1.88	1.80

---

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

### Introduction

CPT code 77002 is being reviewed along with 77001 to ensure relativity across this family of codes after 77003 was recently surveyed and its value accepted by CMS on an interim basis. This family of codes describes the use of fluoroscopic guidance for localization of needles or catheters during a variety of procedures.

### Background

CMS previously identified CPT code 77003 (*Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural or subarachnoid)*) as potentially misvalued through its screen of MPC codes. Code 77003 was re-surveyed twice by the specialties, with recommendations accepted by the RUC in January of 2012. In the 2013 Final Rule, CMS accepted the RUC recommended value of 77003 as “interim” for 2013, indicating they “believe it is necessary to review this service alongside very similar CPT codes 77001 and 77002 to determine the appropriate relative value for this high volume, high expenditure procedure code.”

CPT code 77002 (*Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)*) describes the use of fluoroscopy to ensure appropriate positioning of the needle during a variety of procedures, such as joint aspirations and injections, bone biopsies, and percutaneous access of implantable surgical devices. The American College of Radiology, Society of Interventional Radiology, American Society of Anesthesiologists, and American Academy of Physical Medicine and Rehabilitation surveyed this family, including CPT codes 77001 and 77002, in March 2013, and convened an expert panel of physicians familiar with these services to review the survey data.

### Work RVU Recommendation

The expert panel recommends the existing work RVU of 0.54.

### Service Times

The panel recommends pre, intra, and post times of 7, 15, and 5 minutes, respectively.

The pre and post times had median survey values of 10 minutes each for 77002. However, the panel recommends using the recent RUC approved survey values for 77003 (7 and 5 minutes, respectively), which appropriately reflects the specific work involved with imaging guidance.

The panel recommends the median intra-service time of 15 minutes.

### Key Reference Service

The most commonly selected key reference service was CPT code 76937 (*Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)*). This code was selected by approximately one third of those surveyed, and it has 0.30 work RVU with pre, intra, and post service times of 0, 10, and 4 minutes, respectively.

CPT code 77002 has much longer survey times and greater surveyed complexity (on all 11 measures) than the key reference service. Given the relative differences in time required for each procedure, this comparison properly reflects the value assigned to 77002.

Code	Descriptor	RVU	Pre	Intra	Post	Total	IWPUT
77002	Fluoro guidance during biopsy	0.54	7	15	5	27	0.018
76937	Ultrasound guidance for vascular access	0.30	0	10	4	14	0.021

### MPC Comparison

The panel recommendation of 0.54 RVUs for 77002 is bracketed by two recently valued MPC codes: 93224 (*External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording,*



scanning analysis with report, review and interpretation by a physician or other qualified health care professional) and 76536 (Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation).

Code	Descriptor	RVU	Pre	Intra	Post	Total	IWPUT
93224	EKG monitoring	0.52	2	15	7	24	0.021
77002	Fluoro guidance during biopsy	0.54	7	15	5	27	0.018
76536	Head and neck u/s	0.56	4	10	4	18	0.038

### Comparison within the Family

The data summarized in this table demonstrate the relative work involved in the procedures surveyed within the fluoroscopic guidance code family. While the intra-procedure survey times decrease through the code family, the IWPUT across the different codes appropriately reflects the differences in intensity related to the anatomy and technical difficulty of these procedures.

Codes in Family	Descriptor	Recommended RVUs	Pre Time	Intra Time	Post Time	Total Time	IWPUT
77001	Fluoro guidance during central catheter	0.38	7	20	5	32	0.006
77002	Fluoro guidance during biopsy	0.54	7	15	5	27	0.018
77003	Fluoro guidance for spine intervention	0.60	7	15	5	27	0.022

### SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☒ Other reason (please explain) This is not a stand-alone service. It would only be reported along with another procedure when that procedure was done with fluoroscopic guidance and that guidance was not already bundled into the procedure

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. This code would only be reported in conjunction with a procedure when imaging guidance is not already bundled into the code that describes the underlying procedure. The incidence of this will decrease markedly, as CPT code changes to bundle fluoroscopic guidance into a large number of codes will be accounted for.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 77002

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology                      How often? Commonly

Specialty Physical Medicine and Rehabilitation                      How often? Commonly

Specialty Anesthesiology                      How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 742191

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The overall number of services described by 77002 provided nationally in a one-year period is estimated to be 742,191

Specialty Diagnostic Radiology	Frequency 253900	Percentage 34.20 %
--------------------------------	------------------	--------------------

Specialty Physical Medicine and Rehabilitation	Frequency 73250	Percentage 9.86 %
--	-----------------	-------------------

Specialty Anesthesiology	Frequency 57800	Percentage 7.78 %
--------------------------	-----------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 247,397 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2011 Medicare data estimates that CPT code 77002 was billed approximately 247,397 times for Medicare patients nationally in a one-year period.

Specialty Diagnostic Radiology	Frequency 84600	Percentage 34.19 %
--------------------------------	-----------------	--------------------

Specialty Physical Medicine and Rehabilitation	Frequency 24400	Percentage 9.86 %
--	-----------------	-------------------

Specialty Anesthesiology	Frequency 19250	Percentage 7.78 %
--------------------------	-----------------	-------------------

Do many physicians perform this service across the United States? Yes

**Professional Liability Insurance Information (PLI)**

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 77002

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 77003	Tracking Number	Original Specialty Recommended RVU: <b>0.60</b>
		Presented Recommended RVU: <b>0.60</b>
Global Period: XXX		RUC Recommended RVU: <b>0.60</b>

CPT Descriptor: Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: The patient is a 52 year-old male with neck pain and radicular pain from cervical disc disease that has not responded to conservative therapy. He is scheduled for a cervical epidural steroid injection (the injection is reported separately), and fluoroscopic guidance is used during needle placement to assure proper position of the needle and maximize safety.

NOTE: Placement of the needle/catheter is not included in code 77003, but rather is included in the injection code(s). When completing this survey, consider only the fluoroscopic guidance as described by code 77003. Do not include the injection procedure.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 44%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 30%

Description of Pre-Service Work: The physician reviews the patients prior imaging studies (radiographs, CT scans, MRI exams) to be familiar with the patients spine anatomy (numbering of levels, anatomic variants, prior surgery, pathology, etc.). The physician dresses in radiation attire and instructs radiologic technologists in imaging equipment required and the proper settings for the imaging equipment.

Description of Intra-Service Work: The patient is placed on an x-ray table in the prone, decubitus or prone oblique position, depending on the type of injection to be performed. Preliminary fluoroscopy is performed to identify the appropriate level and approach for initial needle placement, and the skin entry site marked. During the needle/catheter placement, intermittent fluoroscopy is used to confirm the correct approach and need for needle repositioning or realignment. When the needle position appears correct, radiographic contrast may be injected to confirm proper position. If position is not correct, additional fluoroscopy is provided during repositioning until proper position is achieved. If a catheter is to be placed, additional fluoroscopic guidance is provided during and after the catheter positioning to confirm proper positioning, and additional contrast injection may be performed.

Description of Post-Service Work: A report describing the guidance procedure, including the final position of the needle/catheter is dictated, proofread and submitted for the patient record

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	01/2012				
<b>Presenter(s):</b>	Marc Lieb, MD; Christopher Merifield, MD; Joe Zuhosky, MD; William Sullivan, MD; Eddy Fraifeld, MD; Sean Tutton, MD; Zeke Silva, MD; David Caraway, MD				
<b>Specialty(s):</b>	ASA, ISIS, NASS, ACR, SIR, AAPMR, AAPM, ASIPP				
<b>CPT Code:</b>	77003				
<b>Sample Size:</b>	1203	<b>Resp N:</b>	122	<b>Response:</b> 10.1 %	
<b>Sample Type:</b>	Panel	<b>Additional Sample Information:</b>			
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	20.00	100.00	500.00	4500.00
<b>Survey RVW:</b>	0.18	0.64	1.00	1.31	2.00
<b>Pre-Service Evaluation Time:</b>			10.00		
<b>Pre-Service Positioning Time:</b>			0.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.00		
<b>Intra-Service Time:</b>	2.00	10.00	15.00	20.00	60.00
<b>Immediate Post Service-Time:</b>	5.00				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	0.00	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	0.00	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	0.00	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	0.00	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

<b>CPT Code:</b>	77003	<b>Recommended Physician Work RVU: 0.60</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		7.00	0.00	7.00
<b>Pre-Service Positioning Time:</b>		0.00	0.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	0.00	0.00
<b>Intra-Service Time:</b>		15.00		
<b>Immediate Post Service-Time:</b>	5.00			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	0.00	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	0.00	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	0.00	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	0.00	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	0.00	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	0.00	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
72291	XXX	1.31	RUC Time

CPT Descriptor Radiological supervision and interpretation, percutaneous vertebroplasty, vertebral augmentation, or sacral augmentation (sacroplasty), including cavity creation, per vertebral body or sacrum; under fluoroscopic guidance

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
92083	XXX	0.50	RUC Time	2,651,934

CPT Descriptor 1 Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
76700	XXX	0.81	RUC Time	1,053,471

CPT Descriptor 2 Ultrasound, abdominal, real time with image documentation; complete

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
77001	ZZZ	0.38	RUC Time

CPT Descriptor Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 38      % of respondents: 31.1 %**

**TIME ESTIMATES (Median)**

	<b>CPT Code: 77003</b>	<b>Key Reference CPT Code: 72291</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	7.00	45.00	
Median Intra-Service Time	15.00	60.00	
Median Immediate Post-service Time	5.00	15.00	
Median Critical Care Time	0.0	0.00	

Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>27.00</b>	<b>120.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.42	3.37
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.63
Urgency of medical decision making	3.29	3.24

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.18	4.16
Physical effort required	2.89	3.05
<b><u>Psychological Stress (Mean)</u></b>		
The risk of significant complications, morbidity and/or mortality	4.18	4.11
Outcome depends on the skill and judgment of physician	4.39	4.39
Estimated risk of malpractice suit with poor outcome	4.55	4.45

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.76	2.76
Intra-Service intensity/complexity	4.11	4.16
Post-Service intensity/complexity	2.31	2.39

---

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

This code was flagged for review as part of the CMS request for review of services included on the MPC list. In their Action Plan, the specialties suggested that this code be revisited after we had two years of data that reflect all the recent coding changes that will impact use of this code. {Fluoroscopic guidance was bundled into 1. facet joint injections (codes 64490-64495) in 2010; 2. transforaminal epidural injections (codes 64479-64484) in 2011; 3. SI joint injections (code 27096) and 4. paravertebral facet joint destruction (new codes 64633– 64636, which replaced 64622-64627) in 2012} The specialties believed that it would be necessary to have 2012 data in order to establish dominant specialty, site of service, associated diagnoses and identification of procedures for which fluoroscopic guidance would remain separately reportable. The RAW and the RUC requested that the code be surveyed for this September 2011 meeting.

**For the September 2011 meeting eight specialty societies participated in the survey and collected 100 responses. The key reference service selected by the survey respondents was 77002 – Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device). With median survey value of 1.00 RVUs and 25<sup>th</sup> percentile of 0.61 RVUs. The specialty societies recommended maintaining the current value of 0.60.**

**Due to RUC Members' concerns that the surveyees were not clear that code 77003 includes only guidance and might have included the work of the injection in their responses, the specialty societies were asked to re-survey with clear instructions in the vignette as well as an updated CPT descriptor. The vignette and RSL were reviewed by the Research Committee, which made a suggestion that 77002 should not be used on the RSL.**

**Eight specialty societies surveyed the code 77003 with revised vignette, descriptor and RSL, and collected 122 responses. The results came back with identical median value, nearly identical 25<sup>th</sup> percentile value and identical intra-service time as the survey for September 2011 meeting.**

**The specialty societies recommend maintaining of the current value of 0.60 RVUs for 77003.**

Comparison Codes:

Code	Descriptor	Pre-Service	Intra-Service	Post - Service	Global	RVUw
76886	Ultrasound, infant hips, real time with imaging documentation; limited, static (not requiring physician manipulation)	0	15	0	XXX	0.62
77300	Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician	0	15	0	XXX	0.62
51797	Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure)	0	15	0	ZZZ	0.80

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. This code would only be reported in conjunction with a procedure when imaging guidance is not already bundled into the code that describes the underlying procedure. The incidence of this will decrease markedly, as CPT code changes to bundle fluoroscopic guidance into a large number of codes will be accounted for.

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 77003

If the recommendation is from multiple specialties, please provide information for each specialty.

How often? Commonly

How often? Commonly

How often? Commonly

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate that this would be 1.5 times the Medicare frequency

Percentage 32.27 %

Percentage 24.88 %

Percentage 17.99 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?  
574,054 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.  
Please explain the rationale for this estimate. 2010 Medicare frequency for 77003 minus the 2010 Medicare frequency of  
the services which were since revised to bundle 77003: ( transforaminal injections (64479, 64483), neurolytic agent nerve  
destruction 64622, 64626) and SI joint injection (27096))

2010 Frequency for 77003:	1,890,663
less 2010 Frequency for 64479:	43,666
less 2010 Frequency for 64483:	803,663
less 2010 Frequency for 64622:	137,505
less 2010 Frequency for 64626:	30,537
less 2010 Frequency for 27096:	301,238



Estimated Medicare Frequency for revised code 77003: 574,054

Specialty Interventional Pain Management	Frequency 192868	Percentage 33.59 %
--	------------------	--------------------

Specialty Anesthesiology	Frequency 148714	Percentage 25.90 %
--------------------------	------------------	--------------------

Specialty Physical Medicine and Rehabilitation	Frequency 107547	Percentage 18.73 %
--	------------------	--------------------

Do many physicians perform this service across the United States? Yes

---

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 77003

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

# SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
12	<b>ISSUE: Fluoroscopic Guidance</b>																			
13	<b>TAB: 27</b>																			
14	Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE-TIME			INTRA-TIME					IMMD
15						MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
16	REF	36148	Introduction of needle and/or catheter	27	0.067			1.00			15						15			
17	CURRENT	77001	Fluoroscopic guidance for central venous catheter placement		0.032			0.38			13						9			4
18	SVY	77001	Fluoroscopic guidance for central venous catheter placement	74	0.028	0.10	0.60	1.00	1.10	3.00	40	10			0	15	20	30	60	10
19	REC	77001	Fluoroscopic guidance for central venous catheter placement		0.032			0.38			13						9			4
20																				
21																				
22	Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE-TIME			INTRA-TIME					IMMD
23						MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
24	REF	76937	Ultrasound guidance for vascular catheter placement	25	0.021			0.30			14						10			4
25	CURRENT CMS/Other	77002	Fluoroscopic guidance for needle placement		#DIV/0!			0.54			12									
26	SVY	77002	Fluoroscopic guidance for needle placement	73	0.030	0.30	0.50	0.90	1.12	5.00	35	10			3	10	15	20	60	10
27	REC	77002	Fluoroscopic guidance for needle placement		0.018			0.54			27	7					15			5

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor:

77001: Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)

Global Period: ZZZ Meeting Date: April 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The American College of Radiology, Society of Interventional Radiology, and American Society of Anesthesiologists convened a consensus panel to finalize the practice expense data for CPT 77001.

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

Since 77001 is an existing code for fluoroscopic guidance but has not been PEAC reviewed, we used 76937 (ultrasound guidance) and 36556 (insertion of non-tunneled central venous catheter) as references, and also included the PE inputs for 77001 from the RUC Database.

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:

- We are recommending a global period change from ZZZ to XXX for this code. Accordingly, pre and post service activity specific to the imaging equipment has been added.
- 3 minutes of pre-service time assigned to "Retrieve prior imaging exams".
- The "assist physician" time is equal to our physician work intra-service time.
- The film input has been changed from SK034 (film, x-ray 14in x 17in) to SK028 (film, fluoroscopic 14 x 17) to maintain consistency across the family.
- Supply inputs, SM013 (disinfectant, surface (Envirocide, Sanizide)), SB008 (drape, sterile, c-arm, fluoro), and SK089 (x-ray developer solution), have been added.
- An alternator was added, and the film alternator was changed from ED025 (film processor, wet) to ED024 (film processor, dry, laser) to maintain consistency with 77002.
- The room time reflects typical use exclusive to a patient.

5. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Retrieve prior imaging exams, hang for MD review, verify orders, review chart to incorporate relevant clinical information, confirm contrast protocol with interpreting MD.

Intra-Service Clinical Labor Activities:

- Prepare room, equipment, supplies.
- Prepare and position patient/ monitor patient/ set up IV.
- Assist physician with fluoro and image acquisition.
- Clean room/equipment by physician staff.
- Process films, hang films and review study with interpreting MD prior to patient discharge

Post-Service Clinical Labor Activities:

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor:

77002: Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)

Global Period: XXX Meeting Date: April 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The American College of Radiology, Society of Interventional Radiology, American Society of Anesthesiologists, and American Academy of Physical Medicine and Rehabilitation convened a consensus panel to finalize the practice expense data for CPT 77002.

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

Since 77002 is an existing code for fluoroscopic guidance, we used the PEAC approved data as the basis for the practice expense inputs; 76003 was replaced by 77002. We've also included 20610 (Arthrocentesis) as a reference.

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:

- "Retrieve prior imaging exams" was added to pre-time.
- "Prepare room", "prepare patient", and "clean room" were added at the standard times.
- The "assist physician" time is equal to our physician work intra-service time.
- "Process films" time was added.
- Supply items SB008 (drape, sterile, c-arm, fluoro) and SK089 (x-ray developer solution) have been added.
- The room time reflects typical use exclusive to a patient.

5. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information and confirm contrast protocol with interpreting MD.

Intra-Service Clinical Labor Activities:

- Prepare room, equipment, supplies/ Enter patient demographic information into the MRI scanner.
- Prepare and position patient/ monitor patient/ set up IV.
- Assist physician with fluoro and image acquisition.
- Clean room/equipment by physician staff.
- Process films, hang films and review study with interpreting MD prior to patient discharge.

Post-Service Clinical Labor Activities:

Specialty Society(s) ASA, ISIS, AAPM, ACR, SIR, NASS, ASIPP, AAPMR

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor: Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, subarachnoid)

Global Period: XXX Meeting Date: January 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

**A consensus panel comprised of representatives from the specialty societies convened to review the PE inputs for code 77003. The panel included physicians from a variety of practice locales and settings.**

If you have provided any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:

**We have included several additional CPT codes on our spreadsheet. CPT code 75901 is included as a supervision and interpretation (S&I) reference code and although the code is not in this spine family it is recently RUC'ed and follows the same process of care. CPT code 77002 has been included as another S&I. This code is in the spine family. However, the direct line items for clinical time are not available, so just the summed times, supplies and equipment items are included in the spreadsheet. The current inputs for CPT code 77003 are included as a reference. CPT code 62310 has been included on the spreadsheet as well. That is a typical surgical companion code that is billed with 77003 (source is the 5% file). We have included that code to demonstrate there is no double counting of clinical times. Finally, CPT code 64493 has been included as an example of what the inputs of a bundled code look like.**

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

**A Radiology Tech will prepare prior imaging studies for review by the physician.**

Intra-Service Clinical Labor Activities:

**The Radiology Tech will prepare the imaging equipment and input patient and procedure information. S/he positions the imaging equipment and assists with patient positioning. S/he will perform the required imaging and at the end of the procedure will clean the equipment and process and store the films.**

Post-Service Clinical Labor Activities:

**N/A**

	A	B	C	D	E	F	G	H	I	J	K	N	O	P	Q	R
1	<b>Meeting Date:</b> February 2012 <b>Specialty:</b> ASA, ISIS, AAPM, AAOS, ACRO, NASS, ASIPP, AAPMR, ACR and SIR			<b>75901</b> <i>Mechanical removal of pericatheter obstructive material (eg. Fibrin sheath) from central venous device via separate venous access, radiologic supervision and interpretation</i>  Reference Code		<b>77002</b> <i>Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injectio, localizaiton device)</i>  Reference Code		<b>77003</b> <i>Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)</i>  <b>RECOMMENDATIONS</b>		<b>77003</b> <i>Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)</i>  CURRENT (CMS made changes to PEAC approved)		<b>62310</b> <i>Injection, single (not via indwelling catheter), not including neurolytic substance, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid, crvical or thoracic</i>  Example of Code Billed w/77003		<b>64493</b> <i>Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level</i>  Example of a bundled code		
2		<b>CMS</b>	<b>Staff</b>													
3	<b>LOCATION</b>	<b>Code</b>	<b>Type</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Non Facility</b>	<b>Facility</b>
4	<b>GLOBAL PERIOD</b>			XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	000	000	000	000	000
5	<b>TOTAL CLINICAL LABOR TIME</b>	L041B	RadTech	68.0	0.0	35.0	0.0	23.0	0.0	10.0	0.0			20.0		
6	<b>TOTAL CLINICAL LABOR TIME</b>	L037D	RN/LPN/MTA									77.0	21.0		67.0	24.0
7	<b>TOTAL PRE-SERV CLINICAL LABOR TIME</b>			0.0	0.0	3.0	0.0	3.0	0.0	3.0	0.0	11.0	21.0	3.0	11.0	21.0
8	<b>TOTAL SERVICE PERIOD CLINICAL LABOR TIME</b>			68.0	0.0	32.0	0.0	20.0	0.0	7.0	0.0	63.0	0.0	17.0	53.0	0.0
9	<b>TOTAL POST-SERV CLINICAL LABOR TIME</b>			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.0	0.0	0.0	3.0	3.0
10	<b>PRE-SERVICE</b>															
11	<b>Start: Following visit when decision for surgery or procedure made</b>													RT	RN/LPN/MTA	
12	Complete pre-service diagnostic & referral forms											3	3		3	3
13	Coordinate pre-surgery services												5		0	5
14	Schedule space and equipment in facility												5		0	5
15	Provide pre-service education/obtain consent											5	5		5	5
16	Follow-up phone calls & prescriptions											3	3		3	3
17	Other Clinical Activity (please specify)	L041B	RadTech			3		3		3				3		
18																
19	<b>End: When patient enters office/facility for surgery/procedure</b>															
20	<b>SERVICE PERIOD</b>															
21	<b>Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure</b>													RT	RN/LPN/MTA	
22	Greet patient, provide gowning, ensure appropriate medical records are available											3			3	
23	Obtain vital signs											3			5	
24	Provide pre-service education/obtain consent														3	
25	Prepare room, equipment, supplies	L041B	RadTech	3				1		1		3			3	
26	Setup scope (non facility setting only)															
27	Prepare and position patient/ monitor patient/ set up IV	L041B	RadTech	12				1		1		3			3	
28	Sedate/apply anesthesia															
29	<b>Intra-service</b>															
30	Assist physician in performing procedure	L037D	RN/LPN/MTA									30			15	
31	Assist physician with flouro and image acquisition	L041B	RadTech	45				15						15		
32	<b>Post-Service</b>															
33	Monitor pt. following service/check tubes, monitors, drains											15			15	
34	Clean room/equipment by physician staff	L041B	RadTech	3				1		2		3			3	
35	Clean Scope															
36	Clean Surgical Instrument Package															
37	Complete diagnostic forms, lab & X-ray requisitions															
38	Review/read X-ray, lab, and pathology reports															
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions											3			3	
40	Discharge day management															
41	Other Clinical Activity (please specify)													2		
42	<i>Process films, hang films and review study with interpreting MD prior to patient discharge</i>	L041B	RadTech	5				2		3						
43	<b>End: Patient leaves office</b>															



	A	B	C	D	E	F	G	H	I	J	K	N	O	P	Q	R
1	<b>Meeting Date:</b> February 2012 <b>Specialty:</b> ASA, ISIS, AAPM, AAOS, ACRO, NASS, ASIPP, AAPMR, ACR and SIR			<b>75901</b> <i>Mechanical removal of pericatheter obstructive material (eg. Fibrin sheath) from central venous device via separate venous access, radiologic supervision and interpretation</i>  Reference Code		<b>77002</b> <i>Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injectio, localizaiton device)</i>  Reference Code		<b>77003</b> <i>Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)</i>  <b>RECOMMENDATIONS</b>		<b>77003</b> <i>Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)</i>  CURRENT (CMS made changes to PEAC approved)		<b>62310</b> <i>Injection, single (not via indwelling catheter), not including neurolytic substance, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid, crvical or thoracic</i>  Example of Code Billed w/77003		<b>64493</b> <i>Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level</i>  Example of a bundled code		
2		<b>CMS</b>	<b>Staff</b>													
3	<b>LOCATION</b>	<b>Code</b>	<b>Type</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Non Facility</b>	<b>Facility</b>
44	<b>POST-SERVICE Period</b>															
45	<b>Start: Patient leaves office/facility</b>													<b>RT</b>	<b>RN/LPN/MTA</b>	
46	Conduct phone calls/call in prescriptions											3			3	3
47	Office visits:															
48	List Number and Level of Office Visits			<b>pre</b>		<b>pre</b>		<b>post</b>		<b>post</b>		<b>post</b>		<b>post</b>	<b>post</b>	
49	99211 16 minutes		16													
50	99212 27 minutes		27													
51	99213 36 minutes		36													
52	99214 53 minutes		53													
53	99215 63 minutes		63													
54	99238 12 minutes		12													
55	Total Office Visit Time			<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
56	Other Activity (please specify)															
57	<b>End: with last office visit before end of global period</b>				<b>0</b>		<b>0</b>		0		0		0			0
58	<b>MEDICAL SUPPLIES</b>		<b>Unit</b>													
59	drape, sterile, c-arm, flouro	SB008						1		1				1		
60	film, flourosopic 14x17	SK028		3		1		1		1						
61	x-ray developer solution	SK089						1		1						
62	x-ray fixer solution	SK092						1		1						
63	x-ray ID card	SK093				1										
64	cap, surgical	SB001										1				
65	gloves, sterile	SB024										2				
66	gloves, non-sterile	SB022				1		1								
67	disinfectant	SM013				1		1								
68	gown, staff	SB027										1				
69	mask, surgical	SB033										1				
70	underpad 2ft x 3ft (chux)	SB044										1				
71	computer media, dvd	SK013				1										
72	pack, minimum multi-specialty visit	SA048										1		1		
73	tray, epidural	SA064										1				
74	drape, sterile barrier 16in x 29in	SB007		3												
75	x-ray envelope	SK091		1		1		1								
76	needle, 18-25	SC028												1		
77	Marcaine	SH021												5		
78	syringe	SC051												1		
79	film, dry, radiographic, 8x10	SK025												2		
80	pack, basic injection	SA041												1		
81	<b>Equipment</b>															
82	film alternator	ER029				3		2		3						
83	film processor	ED025				3		2		3						
84	room, radiographic-flouro	EL014		68		9		18		7		37				
85	stretcher	EF018										26		40		
86	room, mobile C-ARM	EL018												19		
87	printer, laser, paper	ED032												19		
88	x-ray view box, 4 panel	ER067												19		

AMA/Specialty Society RVS Update Committee Summary of Recommendations  
*CMS Fastest Growing / CMS Request - Practice Expense Review /*  
*CMS High Expenditure Procedural Codes / Services with Stand-Alone PE Procedure Time*

April 2013

**IMRT –PE Only**

CPT codes 77301 and 77338 were identified through the Services with Stand-Alone PE Procedure Time screen. In October 2012, the RUC recommended that the PE Subcommittee review the direct PE inputs for these services at the April 2013 meeting. CMS requested a practice expense survey for clinical staff time only, which was conducted for the family. The specialty societies convened a consensus panel that included a number of experts familiar with these services to evaluate the survey results and existing direct practice expense inputs for these procedures.

***77301 Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications***

The PE Subcommittee reviewed the survey results from 22 radiation oncologists and noted that the survey times are higher than the current clinical staff times. The specialty society did not present compelling evidence to increase any of the existing PE times. The PE subcommittee agreed that the existing times were appropriate. The specialty clarified that the patient is only in the office from the beginning of the service period through *acquire and process CT scan* (line 38) and that two, not three, staff present during the *contouring* phase of the procedure (lines 39-41). The specialty also clarified that CMS clinical labor type, *Medical Dosimetrist/Medical Physicist (L107A)* was not included as an option on the survey, because it is not a known staff type in a typical clinic that performs this service and respondents would not recognize it. The service can be performed by a senior dosimetrist or a junior physicist and is typically performed by a senior dosimetrist. As a result, the survey respondents chose dosimetrist as the staff type. The specialty recommends and the PE Subcommittee agrees that the *Medical Dosimetrist/Medical Physicist (L107A)* is representative of the senior dosimetrist staff level and should be maintained as one of the two staff, along with the *Medical Physicist (L152A)*, performing contouring for this service. **The RUC reviewed and approved the direct practice expense inputs as submitted by the specialty and recommended by the Practice Expense Subcommittee.**

***77338 Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan***

The PE Subcommittee reviewed the survey results from 22 radiation oncologists and noted that the survey times are higher than the current clinical staff times. The specialty society did not present compelling evidence to increase any of the existing PE times. The PE subcommittee agreed that the existing times were appropriate. **The RUC reviewed and approved the direct practice expense inputs as submitted by the specialty and recommended by the Practice Expense Subcommittee.**

<b>CPT Code (•New)</b>	<b>CPT Descriptor</b>	<b>Global Period</b>	<b>Work RVU Recommendation</b>
77301	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications  (Dose plan is optimized using inverse or forward planning technique for modulated beam delivery [eg, binary, dynamic MLC] to create highly conformal dose distribution. Computer plan distribution must be verified for positional accuracy based on dosimetric verification of the intensity map with verification of treatment set-up and interpretation of verification methodology)	XXX	7.99  (No Change)  (PE Input Recommendations Only)
77338	Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan  (Do not report 77338 more than once per IMRT plan)  (For immobilization in IMRT treatment, see 77332- 77334 )  (Do not report 77338 in conjunction with 0073T, compensator based IMRT)	XXX	4.29  (No change)  (PE Input Recommendations Only)

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

**Global Period:** XXX

**Meeting Date:** April 2013

**CPT Long Descriptors:**

*77301 Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications*

**1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:**

The Society prepared a practice expense survey and presented it to the research subcommittee. The surveys were sent electronically to 300 radiation oncologists. The specialties convened a consensus panel that included a number of experts familiar with these services to evaluate the survey results and existing direct practice expense inputs for these procedures. The specialties discarded the surveys from the hospital-based respondents, as requested by the research subcommittee. The panel reviewed the office survey results from 22 surveys.

**2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison. You must provide an explanation for the selection of reference codes. Reference Code Rationale:**

CPT code 77301 is currently priced in the office. As such, we have included columns with the existing inputs for reference.

**3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:**

We are recommending maintaining the two minutes of clinical time for “complete pre-service diagnostic & referral forms”. The clinical staff spend time with the insurance companies/radiation oncology benefit managers to get approval to move forward with planning for an IMRT case.

We are also recommending maintaining 10 minutes of pre planning physics time in the pre service period. We believe the survey results support including this time. We did not include a specific question on the survey requesting time for this specific activity (oversight on our part) but over half of the survey respondents wrote in extra physics time either in pre service or the service period. This is a critical function of the physicist.

**4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:**

We are making some modifications to the clinical time in the intra service period.

*Acquire and Process CT Scan*

The time remains the same for this step.

*Contouring (including image correlation & manipulation) –*

The physics time remains the same for this category.

We are making the recommendation to maintain the MP/Dos blend time of 45 minutes. We did not have that as a staff option on the survey (MP/Phy is a CMS staff type that blends the rate of a physicist and a dosimetrist). The survey respondents included 50 minutes of dosimetrist time in the data.

*Planning*

We are recommending a change for this category. The survey results indicate that some of the planning work is done by a dosimetrist. As such, we are recommending maintaining 85 minutes of physics time and adding 20 minutes of MP/Dos blend time. The 20 minutes reflects half of the time indicated on the surveys for dosimetrists, to account for the pay difference in the blend figure.

*Plan Verification*

The time remains the same for this step.

We are not recommending any changes in supplies.

We are not recommending any changes in equipment. However, we did note that when you sum the appropriate rows for the simulator, accelerator, phantom, chamber and the electrometer (rows 32, 34, 38 and 48) the result is 48 minutes not the 47 that CMS currently has in the database.

**5. Please describe in detail the clinical activities of your staff:**

Pre-Service Clinical Labor Activities:

The nursing staff will Complete pre-service diagnostic & referral forms, discuss the forms and necessary referrals with the patient and make calls to the practices to which the patient has been referred as necessary.

Service Clinical Labor Activities:

The nursing staff will greet patient, provide gowning and ensure appropriate medical records are available for the procedure. They will then obtain vital signs and Provide pre-service education/obtain consent.

The Radiation Therapist will prepare room, equipment, supplies for the CT based procedure. Once the nursing staff has completed their work with the patient, the Radiation Therapist will Prepare and position patient on the CT table.

The Radiation Therapist Aligns the patient with respect to the scan center of the CT scan and the plane of the CT table using three or four externally mounted lasers that are positioned in the same way as the alignment lasers in the linac treatment room. They then mark the patient with

radiopaque markers, and then take multiple AP and Lat scout scans and adjust patient position after each scout such that at the end of the process the patient is aligned without rotation in the x,y and z axis and the external markers are appropriately centered for the area to be imaged and that the patient is comfortable in this position, or else this is adjusted.

The Radiation Therapist then selects the appropriate CT technique based on the anticipated needs of the IMRT process, acquires and processes the CT data set scan. They then discuss the acquired images with the physician, evaluating appropriate bladder, rectal filling. After approval, the patient is marked with tattoos at the external markers or at a preselected isocenter. The data is then transferred to the treatment planning computer.

The medical physicist evaluates the planning CT for artifacts and Hounsfield Unit anomalies. He or she will then evaluate fusion image data sets for appropriate voxel characteristics and if acceptable fuse image data sets.

*The contouring phase:*

A combination of the medical physicist and medical dosimetrist contour the external contour(s) of the patient, table and devices, review all M.D. created contours with physician, interpolate contours & create expansions for CTV and PTV based on M.D. contouring and Rx, create density overrides, review the entire final 3-D contour set with physician.

After the initial contouring is completed, the medical physicist will review all contours for high spatial frequency characteristics that may interfere with the sampling voxels of the optimization algorithm kernel. Perform contour vertex expansion/reduction as necessary.

The Medical Physicist will perform Boolean operations on contours to resolve optimization constraint and objective conflicts and create synthetic structure contours for use in optimization and evaluation.

*Next is the planning phase:*

The dosimetrist will enumerate critical normal tissues adjacent to tumor volume, enter partial dose/volume objectives and constraints for normal tissues and PTV's, Dosimetrist, physicist and physician create initial gantry and table angles for field families, Evaluate initial plan for goodness of fit for tumor and normal tissue dose constraints, Modify tumor and normal tissue dose constraints if necessary to re-run plan, iterate plan until dose constraints are acceptable, typically creating a series of possible optimization endpoints for later comparison and selection.

After initial optimizations are completed, the medical physicist will evaluate dose plan distribution and objective function values for excessive influence of non-unit density HU values, modify and override densities as necessary. The physicist will then re-run plans with optimized parameters. He or she will then evaluate and rank plans for physics and radiobiological-based optimization using a dose response index for the probability of uncomplicated tumor control.

After the physician has completed the review of the above described plan and options and selected the final isodose plan to be delivered, the dosimetrist will review plan, transfer to R&V

system, create synthetic orthogonal isocenter digitally reconstructed radiographs, calculate and transfer phantom planar dose sets and create staff worklists.

*Delivery verification process:*

In the final stage, the medical physicist verifies the plan by delivering the dose distribution to a phantom with appropriate dose measuring devices. The physicist will acquire, process and review phantom/film/EPID or diode Dosimetry referenced to ion chamber single point dosimetry to confirm correct dose delivery compared with graphical plan. He or she will prepare a gamma analysis (distance to agreement and relative dose correspondence) for Physician review. Investigate any anomalous results and modify isodose plan, dose rate, etc. as necessary.

Post-Service Clinical Labor Activities:

At the conclusion of the image acquisition portion of the procedure the Radiation Therapist will clean and replace equipment used for the patient. The nursing staff will coordinate necessary prescriptions with the physician and call the pharmacy, instruct the patient and perform follow up phone calls to the patient.

AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs

**Global Period:** XXX

**Meeting Date:** April 2013

**CPT Long Descriptors:**

*77338 Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan*

**1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:**

The Society prepared a practice expense survey and presented it to the research subcommittee. The surveys were sent electronically to 300 radiation oncologists. The specialties convened a consensus panel that included a number of experts familiar with these services to evaluate the survey results and existing direct practice expense inputs for these procedures. The specialties discarded the surveys from the hospital-based respondents, as requested by the research subcommittee. The panel reviewed the office survey results from 22 surveys.

**2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison. You must provide an explanation for the selection of reference codes. Reference Code Rationale:**

CPT code 77338 is currently priced in the office. As such, we have included columns with the existing inputs for reference.

**3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:**

We are not recommending minutes above the PE Subcommittee standards.

**4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:**

We are not recommending an increase over the current inputs in clinical staff time, supplies or equipment. Although we believe when you add the activities for the treatment planning system the result is 118 minutes, not 100. Also, we believe the time on the desktop computer should be 18 minutes, not 118.

**5. Please describe in detail the clinical activities of your staff:**

Pre-Service Clinical Labor Activities:

N/A



Intra-Service Clinical Labor Activities:

The dosimetrist/medical physicist loads the IMRT plan with associated fluence patterns. The dosimetrist/medical physicist reviews the fluence patterns from the IMRT plans and then constructs the MLC motion pattern to produce the desired fluence or reviews and adjusts the MLC position and segment number constraints. The MLC position set is then created using the radiation treatment planning (RTP) system and/or MLC shaper system. The dosimetrist/medical physicist then modifies individual leaf positions to reduce or increase dose as necessary. Repeat for each of the 9 fields. Dose is recalculated based on modified patterns as necessary.

The medical physicist will then review each resultant MLC segment, digitally overlaid on the region of interest, for conformality and appropriateness of position. The medical physicist will modify individual leaf positions to remove inappropriate MLC leaf positions and review all segments to confirm an appropriate minimum number of monitor units per segment based on leaf speed and maximum leaf travel. This process is repeated for all 9 fields. After all changes have been made, the medical physicist operates the software that recalculates the resultant MLC driven fluence and reviews the effect on the final dose distribution. The process is then repeated for both the initial and any separate boost IMRT segments.

The dosimetrist formats and prints the final MLC pattern map for entry into the patient's chart. The dosimetrist then uploads into the record and verify software that controls the linear accelerator's treatment delivery performance the information that defines each beam's MLC pattern of segments, confirming that each set of independent jaw positions and leaf positions are accurately transferred and repeating for each field

Post-Service Clinical Labor Activities:

N/A

	A	B	C	D	E	F	G	H	I	J	
2				REFERENCE CODE		Survey Results (N=22)		Recommendations			
3	<p>*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.</p> <p>**Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.</p>			77301		77301		77301			
4	<b>Meeting Date: April 2013</b> <b>Tab: 28 IMRT</b> <b>Specialty: Radiation Oncology</b>	<b>CMS Code</b>	<b>Staff Type</b>	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications							
5	<b>LOCATION</b>			<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>		
6	<b>GLOBAL PERIOD</b>			<b>XXX</b>	<b>XXX</b>	<b>XXX</b>	<b>XXX</b>	<b>XXX</b>	<b>XXX</b>		
7	<b>TOTAL CLINICAL LABOR TIME</b>			<b>391</b>	<b>0</b>	<b>417</b>	<b>0</b>	<b>388</b>	<b>0</b>		
8	<b>TOTAL PRE-SERV CLINICAL LABOR TIME</b>			<b>12</b>	<b>0</b>	<b>4</b>	<b>0</b>	<b>12</b>	<b>0</b>		
9		L037D	RN/LPN/MTA	2		4		2			
10		L152A	Physics	10		0		10			
11	<b>TOTAL SERVICE PERIOD CLINICAL LABOR TIME</b>			<b>369</b>	<b>0</b>	<b>413</b>	<b>0</b>	<b>374</b>	<b>0</b>		
12		L037D	RN/LPN/MTA	6		9		6			
13		L050C	RadTherapist	48		59		48			
14		L152A	Physics	270		255		255			
15		L063A	Dosimetrist			90					
16		L107A	MP/Dos	45				65			
17	<b>TOTAL POST-SERV CLINICAL LABOR TIME</b>	L037D	RN/LPN/MTA	<b>10</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2</b>	<b>0</b>		
18	<b>PRE-SERVICE</b>										
19	<b>Start: Following visit when decision for surgery or procedure made</b>										
20	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	2		4(8)		2			
21	Coordinate pre-surgery services										
22	Schedule space and equipment in facility										
23	Provide pre-service education/obtain consent										
24	Follow-up phone calls & prescriptions										
25	*Other Clinical Activity - specify: Pre Planning	L152A	Physics	10				10			
26	<b>End: When patient enters office/facility for surgery/procedure</b>										
27	<b>SERVICE PERIOD</b>										
28	<b>Start: When patient enters office/facility for surgery/procedure:</b>										
29	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	3		3(10)		3			
30	Obtain vital signs	L037D	RN/LPN/MTA			3(6)					
31	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	3		3(9)		3			
32	Prepare room, equipment, supplies	L050C	RadTherapist	2		4(9)		2			
33	Setup scope (non facility setting only)										
34	Prepare and position patient/ monitor patient/ set up IV	L050C	RadTherapist	2		5(7)		2			
35	Sedate/apply anesthesia										
36	*Other Clinical Activity - specify:										
37	<b>Intra-service</b>			<b>356</b>		<b>390</b>		<b>361</b>			
38	Aquire and Process CT Scan	L050C	RadTherapist	41		45 (48)		41			
39		L107A	Dosimetrist			50 (53)					
40	Countouring (include image correlation and manipulation)	L107A	MP/Dos	45				45			
41		L152A	Physics	80		80 (73)		80			
42			Dosimetrist			40(54)					
43	Planning	L107A	MP/Dos					20			
44		L152A	Physics	100		85(99)		85			
45	Plan Verification	L152A	Physics	90		90 (92)		90			
46	<b>Post-Service</b>										
47	Monitor pt. following service/check tubes, monitors, drains										
48	Clean room/equipment by physician staff	L050C	RadTherapist	3		5(8)		3			
49	Clean Scope										
50	Clean Surgical Instrument Package										
51	Complete diagnostic forms, lab & X-ray requisitions										
52	Review/read X-ray, lab, and pathology reports										
53	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions										
54	*Other Clinical Activity - specify:										
58	<b>End: Patient leaves office</b>										
59	<b>POST-SERVICE Period</b>										
60	<b>Start: Patient leaves office/facility</b>										
61	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	10		2(3)		2			
69	*Other Clinical Activity - specify:										
70	<b>End: with last office visit before end of global period</b>										

	A	B	C	D	E	F	G	H	I	J	
2				REFERENCE CODE		Survey Results (N=22)		Recommendations			
3	<p><b>*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.</b></p> <p><b>**Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.</b></p>			77301		77301		77301			
4	<b>Meeting Date: April 2013</b> <b>Tab: 28 IMRT</b> <b>Specialty: Radiation Oncology</b>	CMS Code	Staff Type	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications							
5	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility		
6	GLOBAL PERIOD			XXX	XXX	XXX	XXX	XXX	XXX		
71	<b>MEDICAL SUPPLIES**</b>	<b>CODE</b>	<b>UNIT</b>								
72	pack, minimum multi-specialty visit	SA048	pack	1				1			
73	markers, radiographic, multi-modality	SD096		4				4			
74	tray, catheter insertion (w-o catheter)	SA063		1				1			
75	catheter, Foley	SD024		1				1			
76	gloves, non-sterile	SB022		2				2			
77	film, x-ray 8in x 10in	SK038		20				20			
78	film, x-ray 14in x 17in	SK034		6				6			
79	film, dry, radiographic, 8in x 10in	SK025		6				6			
80	x-ray developer solution	SK089		20				20			
81	acetone	SL001		6				6			
82	computer media, optical disk	SK015		0.33				0.33			
83	computer media, floppy disk	SK014		1				1			
84	paper, photo printing (8.5 x 11)	SK058		20				20			
85											
86	<b>EQUIPMENT</b>	<b>CODE</b>									
87	IMRT CT-based simulator	ER005		47				47			
88	IMRT Accelerator	ER089		47				47			
89	phantom, solid water calibration	ER050		47				47			
90	chamber, Farmer-type	ER014		47				47			
91	electrometer, PC-based, dual channel	ER028		47				47			
92	Treatment planning system, IMRT	ED033		330				330			
93	IMRT physics tools	ER006		15				15			
94	printer, dye sublimation	ED031		15				15			
95	film processor, dry, laser	ED024		15				15			
96	film dosimetry equipment-software	ER030		60				60			
97	film processor, wet	ED025		15				15			

When you add rows (32, 34, 38 and 48) the result is 48

Included rows 25, 38, 40, 41, 43, 44 and 45

	A	B	C	D	E	F	G	H	I	J
2				REFERENCE CODE		Survey Results (N=22)		Recommendations		
3	<p>*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.</p>			77338		77338		77338		
4	Meeting Date: April 2013 Tab: Tab 28 IMRT Specialty: Radiation Oncology	CMS Code	Staff Type	Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan						
5	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	
6	GLOBAL PERIOD			XXX	XXX	XXX	XXX	XXX	XXX	
7	TOTAL CLINICAL LABOR TIME			118	0	135	0	118	0	
8	TOTAL PRE-SERV CLINICAL LABOR TIME			0	0	0	0	0	0	
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			118	0	135	0	118	0	
10		L063A	Dos	18		70		18		
11		L107A	Dos/MP	90				90		
12		L152A	MP	10		65		10		
13	TOTAL POST-SERV CLINICAL LABOR TIME			0	0	0	0	0	0	
14	PRE-SERVICE									
23	SERVICE PERIOD									
24	Start: When patient enters office/facility for surgery/procedure:									
25	Greet patient, provide gowning, ensure appropriate medical records are available									
26	Obtain vital signs									
27	Provide pre-service education/obtain consent									
28	Prepare room, equipment, supplies									
29	Setup scope (non facility setting only)									
30	Prepare and position patient/ monitor patient/ set up IV									
31	Sedate/apply anesthesia									
32	*Other Clinical Activity - specify:									
33	Intra-service									
34	Assist Physician			118		135		118		
35	Evaluate fluence patterns, create MLC pattern, review and modify the MLC position and segment number constraints. Repeat for each field	L063A	Dos			45(47)				
36		L107A	Dos/MP	45				45		
37		L152A	MP							
38	Review each resultant MLC segment, overlayed on the region of interest for conformity and appropriateness of position. Modify individual leaf positions to remove inappropriate MLC leaf positions. Repeat for each field. Review all segments for minimum number of	L063A	Dos							
39		L107A	Dos/MP	45				45		
40		L152A	MP			50(45)				
41	Review resultant MLC driven fluence and review the effect on the dose distribution	L063A	Dos							
42		L107A	Dos/MP							
43		L152A	MP	10		15(27)		10		
44	Create final device on MLC shaper, format and print the final mlc segment fluence map. Upload into record and verify software that controls the linear accelerator's treatment delivery performance, confirming each set of independent jaw postions and leaf positions are	L063A	Dos	18		25(35)		18		
45		L107A	Dos/MP							
46		L152A	MP							
47	Post-Service									
48	Monitor pt. following service/check tubes, monitors, drains									
49	Clean room/equipment by physician staff									
55	*Other Clinical Activity - specify:									
59	End: Patient leaves office									
60	POST-SERVICE Period									
61	Start: Patient leaves office/facility									
62	Conduct phone calls/call in prescriptions									
70	*Other Clinical Activity - specify:									
71	End: with last office visit before end of global period									

	A	B	C	D	E	F	G	H	I	J
2				REFERENCE CODE						Survey Results (N=22)
				Recommendations						
3	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.			77338		77338		77338		
4	Meeting Date: April 2013 Tab: Tab 28 IMRT Specialty: Radiation Oncology	CMS Code	Staff Type	Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan						
5	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	
6	GLOBAL PERIOD			XXX	XXX	XXX	XXX	XXX	XXX	
72	MEDICAL SUPPLIES**	CODE	UNIT							
73	pack, minimum multi-specialty visit	SA048	pack							
74	paper, laser printing (each sheet)	SK057		9				9		
75										
76	EQUIPMENT	CODE								
77	treatment planning system, IMRT (Corvus w-Peregrine 3D Monte Carlo)	ED033		100				100	We believe the time on the treatment planning system should really be 118 minutes when you sum rows 36, 39, 43 and 44.	
78	computer system, record and verify	ED011		18				18		
79	computer, desktop, w-monitor	ED021		118				18		
80	printer, laser, paper	ED032		9				9		
81	MLC Shaper	ED041		18				18		

AMA/Specialty Society RVS Update Committee Summary of Recommendations  
*CMS Request: Final Rule for 2013*

April 2013

**Continuing Medical Physics Consultation – PE Only**

CPT Codes 77336 *Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy* was identified in the Final Rule for 2013 as a potentially misvalued service. CMS requested that the RUC review the direct practice expense (PE) inputs only, for this family of services.

The PE for 77336 has changed since this service was last reviewed in September 2002. The specialty society provided compelling evidence regarding a change in technology, staff type, staff time and equipment. Since this service was last reviewed, treatments have become increasingly complex with the use of modulated fields, gated delivery, and intricate non-coplanar patient setup geometries. Multileaf collimators (MLC's) have replaced simple alloy blocks and dynamic jaw movement has replaced simple physical wedges. Stereotactic treatment delivery and on-board imaging has allowed the use of smaller fields, making accurate patient positioning and accurate and precise delivery even more critical. The treatment units that deliver the radiation beams have become more complex as well, incorporating imaging hardware, computerized control and even robotic positioning. Equipment and treatment complexity now requires a higher level of oversight to assure that treatments are delivered safely. Further, it is now necessary that the medical physicist and not the dosimetrist provide this service and ongoing patient support. One can no longer verify a correct setup by simple inspection of gantry angle and choice of beam modifier. It is the physicist who has the required training and expertise in all aspects of the radiation therapy treatment process from patient imaging to planning to treatment delivery. The PE Subcommittee reviewed and approved this compelling evidence and the RUC agreed.

The PE Subcommittee recommends the addition of a new piece of equipment *beam characterization measurement equipment kit* to replace previous equipment items. This equipment is used by the physicist to verify the delivery of the radiation beams of the treatment unit and imaging system, which has not been performed as part of a code that the patient would receive prior to this service. Invoices for this equipment are included.

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

CPT Code (●New)	CPT Descriptor	Global Period	Work RVU Recommendation
77336	Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy	XXX	0.00 (No Change) (PE Input Recommendations Only)

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

**Global Period:** XXX

**Meeting Date:** April 2013

**CPT Long Descriptors:**

*77336 Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy*

**1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:**

The American Society for Radiation Oncology (ASTRO) and the American Association of Physicists in Medicine (AAPM) convened a consensus panel that included a number of experts familiar with these services to evaluate the existing direct practice expense inputs for these procedures.

**2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison. You must provide an explanation for the selection of reference codes. Reference Code Rationale:**

CPT code 77336 is currently priced in the office. As such, we have included columns with the existing inputs for reference.

**3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:**

We are not recommending more minutes than PE Subcommittee standards.

**4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:**

*Compelling Evidence: Change in Technology*

The technology of radiation therapy has changed dramatically since CPT code 77336 was last reviewed. Since that time, treatments have become increasingly complex with the use of modulated fields, gated delivery, and intricate non-coplanar patient setup geometries. Multileaf collimators (MLC's) have replaced simple alloy blocks; dynamic jaw movement has replaced simple physical wedges. Stereotactic treatment delivery and on-board imaging has allowed the use of smaller fields, making accurate patient positioning and accurate and precise delivery even more critical. The treatment units that deliver the radiation beams have become more complex as well, incorporating imaging hardware, computerized control and even robotic positioning.

While this increased equipment and treatment complexity has improved patient outcomes, a higher level of oversight is required to assure that treatments are delivered safely, in accordance with the Radiation Oncologist's prescription.



*Change in Staff Type*

Further, it is now necessary that the medical physicist and not the dosimetrist provide this oversight and ongoing patient support. The complexity and computerization of today's treatments make patient setup much less intuitive. One can no longer verify a correct setup by simple inspection of gantry angle and choice of beam modifier. The conditions and discrepancies that can lead to treatment error are much less obvious than in the past. It is the physicist who has the required training and expertise in all aspects of the radiation therapy treatment process: from patient imaging to planning to treatment delivery. Physicists understand linacs and their associated equipment. They understand the flow of patient data and images through the entire imaging-treatment-recording chain. They understand and are well versed in failure and recovery modes. They are uniquely suited to recognize the conditions that can lead to patient treatment error. We are therefore requesting that the staffing inputs for 77336 be changed from a dosimetrist/physicist mix to physicist only. The provision of these oversight activities by a medical physicist are recommended by both the 2010 ACR Technical Standard for the Performance of Radiation Oncology Physics for External Beam Therapy and the ASTRO/ACR Guide to Radiation Oncology Coding.

*Increase in Clinical Staff Time*

Further, the time and effort required for the duties of 77336 have increased due to a number of factors including the volume of data and images associated with each treatment record that must be reviewed, the increased frequency of consultations with the radiation oncologist regarding treatment issues and the time required to observe the setups of patients where there are issues of patient or beam positioning. As such, we are requesting an increase in the time inputs for 77336, from 32 to 36 minutes.

*Pre Service Activities*

We are making the recommendation to move radiation beam verification of the treatment unit/on board imaging systems from the service period to the pre service period. We believe based on current PE Subcommittee conventions, it is better suited in Pre Service.

*Change in Equipment*

We are recommending the addition of two additional pieces of equipment. The first is CMS equipment #ED011 Record and Verify system. This piece of equipment is essential to this procedure because the record and verify system is where all of the patient treatment data is stored and accessed for review. All of the analysis and calculations, which the physicist performs during 77336 utilizes this computer system.

We are also recommending the addition of a new piece of equipment *Beam Characterization measurement equipment kit*. This equipment is used by the physicist to verify the radiation beams of the treatment unit and imaging system. The specific instruments used for beam verification have changed due to advances in measuring technology. This kit reflects current best measurement practice and hardware. This equipment item replaces all of the equipment items included in the current direct practice expense equipment list.

**5. Please describe in detail the clinical activities of your staff:**

The work performed by the Qualified Medical Physicist under 77336 includes a number of activities whose purpose is to ensure the continuing accurate execution of the Radiation Oncologist's treatment prescription.

Pre-Service Clinical Labor Activities:

The physicist performs characterization and verification of the radiation beams of the treatment unit and the on-board imaging systems to ensure accurate dose delivery and imaging.

Intra-Service Clinical Labor Activities:

The weekly patient chart review begins with a check of the prescription to determine if there have been any changes or additions. The radiation therapy treatment plan is reviewed to ensure that it is still in accordance with that treatment prescription. Special attention is paid to any changes in total dose or fractionation that may have been ordered. The medical physicist will consult with the Radiation Oncologist immediately with any questions or discrepancies. The medical physicist will also review the patient's daily treatment records to verify that all treatment parameters remain consistent with the treatment plan. These parameters include beam mode, energy, geometry, weighting and monitor unit settings. Any recorded overrides or deviations from the treatment plan are investigated. Daily patient setup notes from the radiation therapist(s) are reviewed. Special attention is paid to weekly geometric measurements, which may indicate a change in the patient's tumor or difficulties with patient positioning or beam delivery.

The medical physicist will review the daily and cumulative doses that are recorded in the patient chart and will compare these with expected values to verify that the tumor has received the correct dose at that point in the patient's treatment course. The physicist will also check the elapsed days from the start of treatment to verify that there have not been any significant treatment interruptions. An additional area of review includes the images taken during treatment to verify proper beam positioning, beam blocking, and patient alignment. These images are compared to reference images by the Radiation Oncologist who will order patient position shifts if the reference and treatment images do not match. The medical physicist will review the images and verify that all shifts were executed correctly and that follow-up images were taken and approved in accordance with the Radiation Oncologist directives.

For many patients, the medical physicist will participate in the patient's setup and/or imaging on the treatment machine. This may be done to verify proper compliance with the physician's prescription, to further investigate discrepancies or anomalies noted during the chart review process, or to provide specific assistance for a treatment related problem identified by the radiation oncologist or radiation therapist. The physicist will frequently consult with the radiation oncologist and/or radiation therapist in the resolution of these problems.

Other ongoing patient-specific medical physicist duties within 77336 include such tasks as participation in weekly chart rounds and daily patient planning conferences where patients and treatment plans are discussed and questions from the radiation therapists, dosimetrists and Radiation Oncologists which may arise during a patient's treatment course are answered.

Physicist work under 77336 includes support of the treatment delivery system operation. This includes investigating any system anomalies or error messages related to patient treatment or

imaging, assuring their resolution and verifying that they did not affect the accuracy of the patient's treatment. Physics work also includes characterization and verification of the radiation beams of the treatment unit and on-board imaging systems. These measurements and calculations are conducted by the medical physicist using calibrated measuring equipment and include such parameters as radiation output accuracy, energy level and beam alignment. All factors must be within tight tolerances in order to deliver the prescribed dose to the patient. This process is required by professional guidelines as well as by accrediting and regulatory agencies.

Post-Service Clinical Labor Activities:

N/A

	A	B	C	D	E	F	G
2				<b>REFERENCE CODE</b>	<b>Recommendations</b>		
3	<p><b>*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.</b></p> <p><b>**Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.</b></p>			<b>77336</b>	<b>77336</b>		
4	<b>Meeting Date: April 2013</b> <b>Tab: Tab 31 CPT Code 77336</b> <b>Specialty: Radiation Oncology</b>	<b>CMS Code</b>	<b>Staff Type</b>	Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support			
5	<b>LOCATION</b>			<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>
6	<b>GLOBAL PERIOD</b>			<b>XXX</b>	<b>XXX</b>	<b>XXX</b>	<b>XXX</b>
7	<b>TOTAL CLINICAL LABOR TIME</b>			<b>32</b>	<b>0</b>	<b>36</b>	<b>0</b>
8	<b>TOTAL PRE-SERV CLINICAL LABOR TIME</b>	L152A	MP	<b>6</b>	<b>0</b>	<b>6</b>	<b>0</b>
9	<b>TOTAL SERVICE PERIOD CLINICAL LABOR TIME</b>			<b>26</b>	<b>0</b>	<b>30</b>	<b>0</b>
10		L063A	Dos				
11		L107A	Dos/MP	26			
12		L152A	MP	0		30	
13	<b>TOTAL POST-SERV CLINICAL LABOR TIME</b>			<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
14	<b>PRE-SERVICE</b>						
15	<b>Start: Following visit when decision for surgery or procedure made</b>						
16	Complete pre-service diagnostic & referral forms						
17	Coordinate pre-surgery services						
18	Schedule space and equipment in facility						
19	Provide pre-service education/obtain consent						
20	Follow-up phone calls & prescriptions						
21	*Other Clinical Activity - specify:specify: radiation beam verification of the treatment unit/on board imaging systems	L152A	MP	6		6	
22	<b>End: When patient enters office/facility for surgery/procedure</b>						
23	<b>SERVICE PERIOD</b>						
24	<b>Start: When patient enters office/facility for surgery/procedure:</b>						
25	Greet patient, provide gowning, ensure appropriate medical records are available						
26	Obtain vital signs						
27	Provide pre-service education/obtain consent						
28	Prepare room, equipment, supplies						
29	Setup scope (non facility setting only)						
30	Prepare and position patient/ monitor patient/ set up IV						
31	Sedate/apply anesthesia						
32	*Other Clinical Activity -						
33	<b>Intra-service</b>						
34	<b>Assist Physician PERFORM PROCEDURE</b>			<b>26</b>		<b>30</b>	
35	Analyze dose patterns and positions	L107A	Dos/MP	7			
36		L152A	MP			7	
37	Analyze system overrides. Calculate cumulative doses.	L107A	Dos/MP	7			
38	Confirm target dose.	L152A	MP			7	
39	Apply field shifts	L107A	Dos/MP	4			
40		L152A	MP			8	
41	Participate in patient setup to verify compliance with treatment prescription	L107A	Dos/MP	8			
42		L152A	MP			8	
43	<b>Post-Service</b>						
44	Monitor pt. following service/check tubes, monitors, drains						
45	Clean room/equipment by physician staff						
51	*Other Clinical Activity - specify:						
55	<b>End: Patient leaves office</b>						
56	<b>POST-SERVICE Period</b>						
57	<b>Start: Patient leaves office/facility</b>						
58	Conduct phone calls/call in prescriptions						
66	*Other Clinical Activity - specify:						
67	<b>End: with last office visit before end of global period</b>						

	A	B	C	D	E	F	G
2				<b>REFERENCE CODE</b>	<b>Recommendations</b>		
3	<p><b>*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.</b></p> <p><b>**Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.</b></p>			<b>77336</b>		<b>77336</b>	
4	<p><b>Meeting Date: April 2013</b></p> <p><b>Tab: Tab 31 CPT Code 77336</b></p> <p><b>Specialty: Radiation Oncology</b></p>	<b>CMS Code</b>	<b>Staff Type</b>	Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support			
5	<b>LOCATION</b>			<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>
6	<b>GLOBAL PERIOD</b>			<b>XXX</b>	<b>XXX</b>	<b>XXX</b>	<b>XXX</b>
68	<b>MEDICAL SUPPLIES**</b>	<b>CODE</b>	<b>UNIT</b>				
69	pack, minimum multi-specialty visit	SA048	pack				
70	paper, laser printing (each sheet)	SK057	each	2			
71							
72	<b>EQUIPMENT</b>	<b>CODE</b>					
73	Computer system, record and verify	ED011				22	
74	Beam characterization measurement equipment kit	NEW				6	
75	barometer, aneroid	ER012		9			
76	calibration (AAPM ADCL), ion chamber	ER013		9			
77	chamber, Farmer-type	ER014		9			
78	densitometer, film	ER018		9			
79	electrometer, PC-based, dual channel	ER028		9			
80	phantom, 3-D	ER046		9			
81	phantom, solid water calibration check	ER050		9			
82	phantom, water, includes remote motor drive	ER051		9			
83	printer, laser, paper	ED032		5			

The American College of Radiology, with more than 30,000 members, is the principal organization of radiologists, radiation oncologists, and clinical medical physicists in the United States. The College is a nonprofit professional society whose primary purposes are to advance the science of radiology, improve radiologic services to the patient, study the socioeconomic aspects of the practice of radiology, and encourage continuing education for radiologists, radiation oncologists, medical physicists, and persons practicing in allied professional fields.

The American College of Radiology will periodically define new practice guidelines and technical standards for radiologic practice to help advance the science of radiology and to improve the quality of service to patients throughout the United States. Existing practice guidelines and technical standards will be reviewed for revision or renewal, as appropriate, on their fifth anniversary or sooner, if indicated.

Each practice guideline and technical standard, representing a policy statement by the College, has undergone a thorough consensus process in which it has been subjected to extensive review, requiring the approval of the Commission on Quality and Safety as well as the ACR Board of Chancellors, the ACR Council Steering Committee, and the ACR Council. The practice guidelines and technical standards recognize that the safe and effective use of diagnostic and therapeutic radiology requires specific training, skills, and techniques, as described in each document. Reproduction or modification of the published practice guideline and technical standard by those entities not providing these services is not authorized.

Revised 2010 (Resolution 7)\*

## **ACR TECHNICAL STANDARD FOR THE PERFORMANCE OF RADIATION ONCOLOGY PHYSICS FOR EXTERNAL BEAM THERAPY**

---

### **PREAMBLE**

These guidelines are an educational tool designed to assist practitioners in providing appropriate radiation oncology care for patients. They are not inflexible rules or requirements of practice and are not intended, nor should they be used, to establish a legal standard of care. For these reasons and those set forth below, the American College of Radiology cautions against the use of these guidelines in litigation in which the clinical decisions of a practitioner are called into question.

The ultimate judgment regarding the propriety of any specific procedure or course of action must be made by the physician or medical physicist in light of all the circumstances presented. Thus, an approach that differs from the guidelines, standing alone, does not necessarily imply that the approach was below the standard of care. To the contrary, a conscientious practitioner may responsibly adopt a course of action different from that set forth in the guidelines when, in the reasonable judgment of the practitioner, such course of action is indicated by the condition of the patient, limitations of available resources, or advances in knowledge or technology subsequent to publication of the guidelines. However, a practitioner who employs an approach substantially different from these guidelines is advised to document in the patient record information sufficient to explain the approach taken.

The practice of medicine involves not only the science, but also the art of dealing with the prevention, diagnosis, alleviation, and treatment of disease. The variety and complexity of human conditions make it impossible to always reach the most appropriate diagnosis or to predict with certainty a particular response to treatment.

Therefore, it should be recognized that adherence to these guidelines will not assure an accurate diagnosis or a successful outcome. All that should be expected is that the practitioner will follow a reasonable course of action based on current knowledge, available resources, and the needs of the patient to deliver effective and safe medical care. The sole purpose of these guidelines is to assist practitioners in achieving this objective.

### **I. INTRODUCTION**

The success of radiation oncology depends on the accuracy of delivery of specified absorbed doses to selected targets, in both tumors and normal tissues. This standard was revised by the American College of Radiology (ACR) with assistance from the American Association of Physicists in medicine (AAPM) to assist the medical physicist in ensuring the accurate and safe delivery of external beam radiation therapy. Since the practice of radiation oncology physics occurs in a variety of settings, the judgment of the medical physicist should be used to apply these standards to individual practices.

### **II. QUALIFICATIONS AND RESPONSIBILITIES OF PERSONNEL**

#### **A. Qualifications**

A Qualified Medical Physicist is an individual who is competent to practice independently one or more of the subfields in medical physics. The American College of Radiology (ACR) considers certification, continuing education, and experience in the appropriate subfield(s) to demonstrate that an individual is competent to practice one or more of the subfields in medical physics and to be

a Qualified Medical Physicist. The ACR strongly recommends that the individual be certified in the appropriate subfields by the American Board of Radiology (ABR), the Canadian College of Physics in Medicine, or by the American Board of Medical Physics (ABMP).

The appropriate subfield of medical physics for this standard is Therapeutic Medical Physics. (Previous medical physics certification categories including Radiological Physics and Therapeutic Radiological Physics are also acceptable.)

A Qualified Medical Physicist should meet the [ACR Practice Guideline for Continuing Medical Education \(CME\)](#). (ACR Resolution 17, 1996 – revised in 2012, Resolution 42)

In addition, the Qualified Medical Physicist must meet any qualifications imposed by the state and/or local radiation control agency to practice radiation oncology physics and/or to provide oversight of the establishment and conduct of the physics quality management program.

#### B. Credentialing

The qualifications of a medical physicist and subsequent delineation of clinical privileges must be set forth either in a job description or through the medical staff membership process in the appropriate category.

#### C. Professional Relationships

##### 1. Accountability

The Qualified Medical Physicist must be accountable directly to the medical director of radiation oncology. Where medical physicists are employed in a setting that precludes direct reporting to the medical director on administrative matters, the medical physicist should also be accountable to the appropriate senior institutional administrator with oversight responsibility for radiation oncology.

##### 2. Authority

A Qualified Medical Physicist must direct the radiation oncology physics program. In most settings, this will include direction of medical dosimetrists, junior/resident physicists, therapy equipment service engineers; other physics support staff personnel, and radiation therapists in their physics-related responsibilities. Responsibilities and reporting status of support staff must be clearly defined by the medical physicist. In departments with more than one medical physicist, delegation of responsibility

and lines of communication must be clearly established.

#### D. Professional Development

The Qualified Medical Physicist is expected to remain current with technical developments, standards of practice, professional issues, and changes in regulatory requirements by attending national and regional meetings, conferences, and symposia and through access to current journals and books.

#### E. Professional Arrangements

This standard applies to any arrangement by which medical physics services are provided: by contract with the individual, by contract with a medical physics private practice group, by contract with a physician group employing physicists, or by direct employment.

### III. SPECIFICS

#### A. Responsibilities

Medical physicists are primarily and professionally engaged in the design, optimization, technical evaluation, and precise and accurate delivery of treatment plans. They are also responsible for radiation protection of patients and staff. Their role may include clinical, research, educational, and administrative duties. The responsibilities of the medical physicist must be clearly defined by the medical director.

#### B. Equipment Needs

The Qualified Medical Physicist must determine the need for, specify, and have access to dosimetric and treatment planning equipment, including but not limited to the following:

1. Measurement instruments to calibrate all treatment equipment and patient monitoring devices. Such instruments must include ionization chambers/electrometers used as local standards, ionization chambers/electrometers used as field instruments, readout devices, constancy check instruments, and plastic and water filled dosimetric phantoms.
2. A three-dimensional computerized treatment planning system.
3. Computerized water phantom systems with appropriate ionization chambers or diodes.
4. Film densitometry systems or solid-state detector array systems.
5. In vivo patient dose measuring systems, e.g., diodes, metal oxide silicon field effect transistors (MOSFETs), thermoluminescence dosimeters

(TLDs), or optically stimulated luminescence (OSL) dosimeters.

6. Radiation protection measurement devices.
7. Appropriate quality assurance test tools for radiation therapy equipment.
8. Equipment to support special external beam techniques (such as those listed in section III.C).

The Qualified Medical Physicist must participate in the specification, selection, acceptance, and commissioning of radiation-producing machines, accessories, and computerized treatment planning systems. The physics staff should also supervise arrangements for proper maintenance of this equipment. The medical physicist will periodically evaluate all equipment for continued utility, appropriateness, reliable performance, age, and condition and make recommendations on a practical life span, obsolescence, and replacement.

### C. Personnel Requirements

The numbers of medical physicists and support personnel must be appropriate for the types, the levels of complexity, and the volume of the external beam services offered. External beam physics services generally include calibration of the radiation beams, safe and appropriate operation of the treatment units, continuing quality assurance, and support of the radiation oncologist's dose prescription. This clinical support includes patient-specific dose measurements (if requested), monitoring of the custom block fabrication process or appropriate use of multileaf collimation (MLC), and responsibility for the technical accuracy of the computerized treatment plans, including patient data acquisition and calculation and dose delivery verification as necessary. A medical physicist must be available for each institution that uses therapeutic equipment. Special external beam treatment techniques — e.g., stereotactic techniques, intensity modulated radiation therapy (IMRT) including volumetric modulated arc therapy (VMAT), total-body irradiation (TBI), image-guided radiation therapy (IGRT), total skin electron treatment (TSET) — require additional physics support at a level higher than that required for routine external beam therapy.

Staffing requirements are in addition to those required to provide services outside the scope of this standard, including brachytherapy, radiation safety, research, administration, and education and training programs. Trainees with medical physics responsibilities must be supervised and their work reviewed by a medical physicist or his/her designee.

Commissioning of modern therapy systems is a critically important, time-consuming process. The technological complexity of modern systems requires a well-designed and carefully implemented series of steps for data

collection, analysis, computer modeling, and validation on the specific system as installed. Such a large and important task requires appropriate focus by a physicist directly accountable for the accuracy of the system's clinical use. In many cases, the services of a consultant physicist with expertise in such commissioning processes may be an acceptable approach. Regardless of the approach chosen by the practice, the qualified medical physicist responsible for the site should determine the scope of work to be performed consistent with the clinical scope of service in the practice, and the appropriate timeline for the work to ensure that all quality and safety aspects are afforded sufficient focus. The qualified medical physicist should review the final results of the commissioning process and independently repeat a subset of the measurements. The qualified medical physicist determines when the therapy system can commence clinical use and communicates any possible limitations on the scope of use.

Physics support staff should be appropriately trained. Medical dosimetrists should be certified by the Medical Dosimetry Certification Board. In-house therapy equipment service engineers should participate in the manufacturer's training program.

Prior to the introduction of a new modality, such as IMRT including VMAT, TBI, intraoperative radiation therapy, stereotactic techniques, TSET, and dedicated special purpose treatment units, the administrator and the medical director should consult the medical physicist so that adjustments to staffing can be made for specialized procedures. Issues related to several complex treatment techniques are dealt with in other standards and guidelines [1-4].

## IV. QUALITY MANAGEMENT PROGRAM

### A. Introduction

Quality management (QM) in radiation oncology may be defined as those procedures that ensure a consistent and safe fulfillment of the dose prescription. The medical physicist is responsible for designing and implementing those aspects of the QM program that involve the use of the external beam radiotherapy equipment. The medical physicist is also responsible for reviewing and approving the procedures followed by the radiation therapy and dosimetry staff in planning and delivering the prescribed dose.

Quality management of radiation therapy equipment is primarily an ongoing evaluation of functional performance characteristics. Accordingly, the medical physicist must develop, implement, supervise, and review the policies and procedures that encompass radiation therapy equipment.



## B. General Protocol Outline

The goal of the QM program for external beam radiation therapy equipment is to ensure that the performance characteristics defined by physical parameters and established during commissioning of the equipment remain within acceptable limits. Procedures must be established to verify that all equipment meets the manufacturer's specifications and to establish baseline performance values for new or refurbished equipment or for equipment following major repair. Once a baseline standard has been established, a protocol for periodic QM tests must be developed for monitoring the baseline performance values. The protocol for QM tests should recommend the equipment to be used, the frequency of measurement, techniques to be followed, suggested performance criteria, action levels, and routes of notification. QM test procedures should be able to measure parameter changes smaller than tolerance or action levels.

The effectiveness of the QM program should be evaluated annually. Such evaluations help to maintain a uniform standard dose among different treatment facilities, ensuring more accurate dissemination of treatment regimens and results in the literature. A written summary of physics activities along with the results of the evaluation should be reviewed with and approved by the medical director and senior institutional administrator annually. This written summary should be incorporated into the institution's overall QM program.

## C. Specific Protocols

### 1. Measurement equipment

A program must be in place to ensure the accuracy and precision of measurement equipment used for calibration and constancy checks of treatment machines and instruments used for patient dosimetry. The program must have documented procedures for instrument calibration to ensure traceability to accredited calibration facilities and to affirm instrument precision and accuracy.

Redundancy in dose calibration equipment is recommended to ensure that instruments are holding their calibration. A check system can be established by comparing the response of the measurement equipment with an appropriate long-lived radioactive source. If access to an appropriate check source is unavailable, it is recommended that both a local standard and a field dosimetry system be maintained and routinely compared.

### 2. Calibration of treatment machines and independent verification of output

Protocols for calibrating treatment machines must follow those protocols currently published by the American Association of Physicists in Medicine and adhere to state and federal guidelines.

An independent check of the output of each beam must be performed annually to verify that the treatment unit calibration is consistent with national standards. The independent check should be performed by either:

- a. A medical physicist who did not perform the annual output calibration, using a dosimetry system other than the one that was used during the annual calibration (this dosimetry system must also have calibration factors traceable to an accredited dosimetry calibration laboratory); or
- b. Using an independent TLD service that is designed to measure doses within an uncertainty of 5%.

### 3. Radiotherapy simulators, imaging equipment, and treatment devices

Procedures for establishing and maintaining the imaging equipment used in planning radiation therapy treatment planning (e.g., computed tomography (CT) and magnetic resonance (MR) scanners, radiography equipment), should be an integral part of a QM program. The medical physicist must be aware of the factors that affect image quality as well as the effect of image distortions on treatment planning. The medical physicist should ensure that those elements of imaging equipment quality control directly relevant to radiation oncology planning are carried out at an appropriate frequency.

### 4. Treatment planning computer systems

The treatment planning computer model must be verified using actual beam data measured by the qualified medical physicist on the same treatment unit for which the model will be applied for patient planning. Treatment planning computer systems must undergo rigorous acceptance tests and commissioning to ensure that the calculated output satisfactorily agrees with measured beam data for a series of test cases and to ensure that the hardware and software were installed properly. (See the ACR–ASTRO Practice Guideline for 3D External Beam Radiation Planning and Conformal

Therapy.) All users must receive proper training. Documented training should be given to new users and following major software releases.

Graphical planning systems must be tested to ensure that they meet the published specifications of the system. All features of the system that are used by the practice must be tested. Both central-axis and off-axis beam characteristics at specific points should be tested for various field sizes to confirm the spatial accuracy of the dose display. A study must be performed for open fields, blocked fields, and wedged fields. The calculated data must be compared with measured data. Suggested standards of agreement have been published. The limitations of the dose-calculational algorithm(s) must be established and presented to the radiation oncologists.

If the graphical planning system is used to define beam apertures, then this function should be tested along with margin tools used to define the planning target volume.

In many graphical planning systems, the dose can be displayed in terms of absolute dose or relative dose. The exact method of dose display must be consistent with the treatment planning approach that is used clinically. The user must confirm that the relative dose distribution is as described in the system manual. The absolute dose calculation must be confirmed by measurements under normal conditions in radiation fields of various sizes.

If dose-volume histograms are used in the analysis of the plan, their validity must be checked. Various dose distributions can be calculated whose characteristics are known. The dose and volume results from the dose-volume histogram can be checked against the known values.

Periodic tests (e.g., standard plans) must be performed routinely and after any major service or software change to ensure the accuracy of monitor unit and/or dose-calculation algorithms, to ensure that any software changes (including editing of beam data files) were implemented correctly and have not corrupted the beam data, to ensure that any hardware changes were installed properly, and to verify that the system performance is consistent with its initial commissioning.

## 5. Electrical, mechanical, and radiation safety

A documented program must be implemented to assess potential safety hazards and to check the integrity of mechanical and electrical patient care devices. This program should include periodic inspections of patient dose-monitoring devices, treatment machines, and simulators (including the patient support assembly), and the accessories to these machines, including MLC systems, treatment couches, imaging systems, immobilization devices, and beam attenuators.

The radiation protection program must be designed to cover all treatment and imaging equipment and be consistent with state and federal regulations and the as-low-as-reasonably-achievable (ALARA) concept.

## V. CLINICAL PRACTICE

### A. Availability

The medical physicist must be available for continuing medical physics consultation for patients, consultation with the radiation oncologist and to provide advice or direction to staff when patient treatment is being planned or conducted. Procedures must be established to meet clinic needs for periods when a medical physicist is not immediately available on site, including standard procedures and covering physicists.

The medical physicist must review, as soon as possible, all dosimetric and physics activities that occurred during his/her absence. Authority to perform specific clinical physics duties must be delegated by the medical physicist to each member of the physics staff in accordance with their training and competence. The radiation oncologist must be informed of the clinical activities authorized for each member and/or the locum tenens physicist. Daily on-site availability is preferable. Practices without a full-time medical physicist must have regular on-site physics support during hours of clinical activity at least 2 days a week and provide 0.4 full time equivalents (FTE) coverage. In addition, state or local regulatory requirements must be met.

### B. Calculation Procedures and Protocols

#### 1. Patient data

Patient data may be acquired through digital or manual techniques. All data used in the dose-distribution calculation and implementation process should be reviewed by a member of the physics staff for reasonableness prior to its use in computation. The spatial linearity (in 3 dimensions) of CT or other digital images used for planning should be verified by test imaging

of appropriate phantoms having fixed fiducials and/or known external dimensions.

## 2. Monitor units or treatment time

Each practice must have a written procedure that defines how to calculate the monitor units or treatment time for all routine treatments. Such calculations should be based on measured dosimetric parameters. Tables of these dosimetric parameters must be compiled.

All calculations of monitor units or treatment time must be verified by a system for independent checking by another person or method before the first treatment if the total number of fractions is five or fewer or otherwise before the third fraction. Verification must begin with a review of the written dose prescription. IMRT has different requirements (See the ACR–ASTRO Practice Guideline for Intensity-Modulated Radiation Therapy [IMRT].) Documentation of this review and verification must be inserted in the patient’s treatment record.

## 3. External beam dose distributions

External beam dose distributions must be generated as requested by the radiation oncologist. Cumulative dose distributions should be generated as appropriate. The medical physicist must review all dose distributions. The physics review must include a review of the dose prescription and the patient’s treatment record to ensure that the graphical dose distribution is consistent with the dose prescription and the treatment record.

## 4. Treatment plan beam parameters

The medical physicist must review and verify the parameters that are used to describe the radiation beam or beams used in the treatment plan. They include the target-to-patient distance, the collimator rotation and opening, a description of the beam aperture or MLC pattern(s) when shaped fields are used, the identification of wedges or compensator if such are used, the relative beam weight or normalization, and all gantry and treatment couch parameters.

## 5. External beam dose distributions and associated coordinate systems

Independent systems involved in the treatment simulation, planning and delivery process may have different image characteristics and

coordinate systems. Faithful data transfer and coordinate translation must be achieved, and this process must be routinely tested. One method to test the data chain is via an “end-to-end” test, which may contain some or all of the following components:

- a. Simulation, including CT scanning of a dosimetry phantom.
- b. Phantom image data transfer to the treatment planning system.
- c. Creation of a treatment plan with variables such as independent jaws, wedging, blocking, noncoplanar beams, or other techniques at the discretion of the medical physicist.
- d. Calculation, monitor unit verification and transfer of the plan to the record and verify system or treatment unit, in the custom of the clinic.
- e. Treatment of the dosimetry phantom with dosimeter(s) in place.
- f. Analysis of dose measured compared to that predicted by the planning system.
- g. In each of the imaging systems (simulation and planning), a check of spatial fidelity, Hounsfield unit (HU) value, and beam geometry (size, source skin distance [SSD], etc.) against nominal values.

Alternative methods of completely testing the image/data chain may be devised by the medical physicist.

## C. Clinical Quality Management

### 1. Plan implementation

Appropriate implementation of the dose prescription is critical for safe and effective radiotherapy treatment. Routine review of all patient treatment plans must be performed by the medical physicist and must include review of patient and dosimetric data as well as beam and machine parameters and their faithful transfer from simulation to planning to treatment unit.

### 2. System overview

The medical physicist must review all of the technical aspects of the treatment delivery system on an established schedule. This review must be presented to the medical director and administration on a documented, periodic basis.

### 3. Chart rounds

The medical physicist should participate in weekly department-wide chart rounds to ensure

the fulfillment of the prescription and review any changes in dose, patient setup(s), and simulation and port films.

The medical physicist should be present to review and/or supervise complicated simulations as well as treatment setups and communicate specific requirements directly.

#### 4. Medical physics chart review protocol

The medical physicist must develop a chart review protocol for reviewing treatment records. This protocol should review new or modified treatment fields, treatment prescription, simulation instructions, isodose distributions, special dose calculations and measurements, monitor units (time) calculations, in vivo measurements, daily treatment records, and cumulative doses. The review must assess accuracy of information as well as completeness and clarity of the record. If verify and record systems are used, the physics chart check protocol must include reviewing all treatment related data recorded therein.

##### a. Physicist's continuing chart review

The medical physicist must review each patient's chart to ensure accuracy of calculation, appropriateness of charting data, and fulfillment of the physicians' written prescription. Any deviation from the radiotherapy prescription should be reported in a timely manner to the responsible radiation oncologists so that corrective action can be taken. The physics chart review must be conducted at least weekly.

##### b. Completion of treatment chart review

At the completion (end) of treatment (EOT), the medical physicist must review the entire chart to affirm the fulfillment of the initial and/or revised prescribed dose. This review must be performed within 1 week of EOT and documented in the treatment record. Any deviations from the physician treatment plan or radiotherapy prescription must be documented and promptly brought to the attention of the attending radiation oncologist.

## VI. NEW PROCEDURES

The practice of radiation oncology often involves the implementation of new procedures and technologies. When these are being considered, the medical physicist should participate along with team members of the medical and administrative areas. The medical physicist

should undertake a systematic literature review, make site visits, confer with colleagues familiar with the new procedure or equipment, and otherwise obtain factual information for use in planning, acquisition, and implementation. Such information may include clinical application, impacts on workflows, equipment, staffing, and space utilization.

Prior to implementation of any procedure, technique, system, or accessory, they must be received, commissioned, and released for clinical use by the medical physicist. In the case of a product (hardware, software, or accessory) the commissioning must include safety testing and verification that the system or device meets the manufacturer's performance standards. Commissioning will also include institution of a quality assurance (QA) program to demonstrate the consistent safety and performance of the system or device.

The quality improvement program associated with any new procedure should be periodically reviewed and updated.

For more information on image-guided radiation therapy, see the [ACR Technical Standard for Medical Physics Performance Monitoring of Image-Guided External Beam Radiation Therapy \(IGRT\)](#) and the [ACR–ASTRO Practice Guideline for Image-Guided Radiation Therapy \(IGRT\)](#) [5,6].

## VII. DOCUMENTATION

The medical physicist is responsible for documenting the following:

1. Procedures for instrument calibration and periodic instrument constancy checks.
2. Procedures to verify the manufacturer's specifications and to establish baseline performance values for radiation therapy equipment.
3. Quality management programs for radiation therapy equipment, simulators, treatment planning systems, and monitor unit calculation algorithms.
4. Monitor units (time) calculation procedures and protocols.
5. Physics chart check protocol for reviewing treatment delivery.
6. Procedures for checking the mechanical and electrical integrity of patient care devices.
7. Radiation protection program as it pertains to radiation oncology.
8. Calculations related to patient dosimetry and/or physics measurements when such needs arise or per clinicians' requests.
9. Consultations requested by the radiation oncologist.

10. Commissioning of new systems and/or equipment introduced into the clinic.

## VIII. PEER REVIEW

The medical physicist should engage in a formalized peer review on a regular basis [7,8].

Physicists engaged in solo practice (being the only qualified medical physicist at a facility, or serving as consultant providing the only medical physicist service to the facility) should follow published AAPM recommendations, including peer review recommendations.[7-14]

## ACKNOWLEDGEMENTS

This standard was revised according to the process described under the heading *The Process for Developing ACR Practice Guidelines and Technical Standards* on the ACR web page (<http://www.acr.org/guidelines>) by the Guidelines and Standards Committee of the Commission on Medical Physics with assistance from the AAPM.

Principal Reviewers:

Martin W. Fraser, MS  
Per H. Halvorsen, MS, FACR  
David L. Vassy, Jr., MS, FACR

### ACR Medical Physics Guidelines and Standards Committee

Richard A. Geise, PhD, FACR, Chair  
Tariq A. Mian, PhD, FACR, Vice Chair  
William K. Breedon, III, MS  
Martin W. Fraser, MS  
Nicholas J. Hangiandreou, PhD  
Bruce E. Hasselquist, PhD  
Mahadevappa Mahesh, MS, PhD, FACR  
James T. Norweck, MS  
Janelle L. Park, MD  
J. Anthony Seibert, PhD, FACR  
James M. Hevezi, PhD, FACR, Chair, Commission

### Comments Reconciliation Committee

Geoffrey S. Ibbott, PhD, Chair, FACR  
Kimberly E. Applegate, MD, MS, FACR  
Laurence E. Court, PhD  
Howard B. Fleishon, MD, MMM, FACR  
Martin W. Fraser, MS  
Richard A. Geise, PhD, FACR  
Per H. Halvorsen, MS, FACR  
James M. Hevezi, PhD  
Alan D. Kaye, MD, FACR  
Paul A. Larson, MD, FACR  
Lawrence A. Liebscher, MD, FACR  
David L. Vassy, Jr., MS, FACR

## REFERENCES

1. Practice guideline for the performance of stereotactic body radiation therapy. *Practice Guidelines and Technical Standards*. Reston, Va: American College of Radiology; 2009.
2. Practice guideline for the performance of stereotactic radiosurgery. *Practice Guidelines and Technical Standards*. Reston, Va: American College of Radiology; 2009.
3. Practice guideline for intensity-modulated radiation therapy (IMRT). *Practice Guidelines and Technical Standards*. Reston, VA: American College of Radiology; 2007.
4. Practice guideline for the performance of total body irradiation. *Practice Guidelines and Technical Standards*. Reston, VA: American College of Radiology; 2006.
5. ACR technical standard for medical physics performance monitoring of image-guided external beam radiation therapy (IGRT). *Practice Guidelines and Technical Standards*. Reston, Va: American College of Radiology; 2009.
6. Practice guideline for image-guided radiation therapy (IGRT). *Practice Guidelines and Technical Standards*. Reston, Va: American College of Radiology; 2009.
7. *The Solo Practice of Medical Physics in Radiation Oncology*. College Park, Md: American Association of Physicists in Medicine; AAPM Report 80 2003.
8. Halvorsen PH, Das IJ, Fraser M, et al. AAPM Task Group 103 report on peer review in clinical radiation oncology physics. *J Appl Clin Med Phys* 2005;6:50-64.
9. *A Guide to Radiological Physics Practice*. Reston, Va.: American College of Radiology; 1997.
10. Fraass B, Doppke K, Hunt M, et al. American Association of Physicists in Medicine Radiation Therapy Committee Task Group 53: quality assurance for clinical radiotherapy treatment planning. *Med Phys* 1998;25:1773-1829.
11. Khan FM, Doppke KP, Hogstrom KR, et al. Clinical electron-beam dosimetry: report of AAPM Radiation Therapy Committee Task Group No. 25. *Med Phys* 1991;18:73-109.
12. Kutcher GJ, Coia L, Gillin M, et al. Comprehensive QA for radiation oncology: report of AAPM Radiation Therapy Committee Task Group 40. *Med Phys* 1994;21:581-618.
13. Nath R, Biggs PJ, Bova FJ, et al. AAPM code of practice for radiotherapy accelerators: report of AAPM Radiation Therapy Task Group No. 45. *Med Phys* 1994;21:1093-1121.
14. Purdy JA, Biggs PJ, Bowers C, et al. Medical accelerator safety considerations: report of AAPM Radiation Therapy Committee Task Group No. 35. *Med Phys* 1993;20:1261-1275.

**Suggested Reading** (Additional articles that are not cited in the document but that the committee recommends for further reading on this topic)

15. *Dosimetry of X-Ray and Gamma-Ray Beams for Radiation Therapy in the Energy Range 10 keV to 50 MeV*. Bethesda, Md.: National Council on Radiation Protection and Measurements; NCRP Report 69; 1981.
16. *Medical Electron Accelerators in the Range MeV-50 MeV; Guidelines for Functional Performance Characteristics*: International Electrotechnical Commission; IEC Publication 977; 1989.
17. *Medical Electron Accelerators: Functional Performance Characteristics*: International Electrotechnical Commission; IEC Publication 1976; 1989.
18. *Medical X-Ray, Electron Beam, and Gamma-Ray Protection for Energies up to 50 MeV (Equipment Design, Performance and Use)*. Bethesda, Md: National Council on Radiation Protection and Measurements; NCRP Report 102; 1989.
19. *Radiation Control and Quality Assurance in Radiation Oncology: A Suggested Protocol*. Reston, Va.: American College of Medical Physics; ACMP Report 2; 1986.
20. *Radiation Oncology in Integrated Cancer Management*: Intersociety Council for Radiation Oncology; 1991.
21. *The Role of a Physicist in Radiation Oncology*. College Park, Md: American Association of Physicists in Medicine; AAPM Report 38; 1993.

---

\*Guidelines and standards are published annually with an effect date of October 1 in the year in which amended, revised or approved by the ACR Council. For guidelines and standards published before 1999, the effective date was January 1 following the year in which the guideline or standard was amended, revised, or approved by the ACR Council.

#### **Development Chronology for this Standard**

2004 (Resolution 19)

Amended 2006 (Resolution 16g)

Revised 2010 (Resolution 7)



ASTRO /ACR GUIDE TO



RADIATION ONCOLOGY  
CODING 2010



## MEDICAL RADIATION PHYSICS: CPT® CODES 77336 AND 77370

The codes for continuing medical radiation physics consultation and special medical radiation physics consultation are distinct and entirely independent services provided during a course of radiation therapy. The continuing medical radiation physics consultation (CPT code 77336) is used to describe the ongoing medical physics assessment provided by a qualified medical physicist to each patient receiving radiation therapy. The special medical radiation physics consultation (CPT code 77370) is used when the radiation oncologist makes a direct request to the qualified medical physicist for a special consultative report or for specific physics services for an individual patient. Both CPT codes 77336 and 77370 are technical-only codes.

Continuing medical radiation physics consultation (CPT code 77336) is used to describe the ongoing medical physics assessment provided by a medical physicist to each patient receiving radiation therapy. CPT code 77336 is reported once for five fractions of external beam radiation therapy, regardless of the actual time period in which services are provided. The services need not be furnished on consecutive days. Multiple fractions representing two or more treatment sessions furnished on the same day may be counted separately as long as there is a distinct break in therapy sessions.

For reporting purposes, CPT code 77336 may be billed by grouping in units of five fractions or treatment sessions, or by reporting on a given day each week. However, total charges may not exceed the number of fractions divided by five, rounded to the nearest integer (e.g., 18 fractions will be billed four times, 17 fractions will be billed three times). CPT code 77336 may be billed once for treatment courses, which consist of only one or two fractions. CPT code 77336 may be reported for the last three or four fractions of external beam treatment. High-dose-rate brachytherapy treatments are each considered one radiation fraction and thus can be added to external beam fraction for calculating the total number of fractions delivered for billing CPT code 77336. For brachytherapy that occurs in a week without associated external beam therapy, the CPT code 77336 may be billed once in each week in which a brachytherapy treatment occurs.

A facility may choose to bill the code on the completion of each set of five fractions (or other fractionation pattern warranting the code) or may bill the code on a particular day of the week established in facility policy, provided the frequency constraints described above are met.

CPT code 77336, continuing medical physics assessment, involves weekly chart reviews, review and analysis of medical physics aspects of changes to the treatment regime, consultation on patient setup and treatment modifications, verification of dose calculation data, reviewing accuracy of the current data record, including review of patient-specific therapist treatment and technical notes, and patient radiation safety. These services are essential and medically necessary and are separate and



distinct services provided to patients undergoing a course of radiation therapy. The medical physicist will review all aspects of the treatment delivery, including correlating the treatment prescription with the technical and medical physics aspects of the treatment, and with the actual execution of the treatment. Appropriate modifications to the technical aspects of the patient treatment are formulated and the medical physicist will recommend implementation of these modifications, as required, in a timely fashion. It should be noted that if this work is not carried out and appropriate modifications to the treatment regime are not instituted, serious harm could come to the patient because of the irreversible nature of the therapeutic radiation delivery. The inherent danger in delivering therapeutic dose levels of radiation to cancer patients is mitigated by the medical physicist's analysis and intervention pertaining to the technical aspects of the treatment process. Documentation of these services should include a signed and dated indication by the medical physicist in the patient's chart that the continuing medical physics consultation has been done.

The following two illustrative vignettes are examples of the specific nature (and importance) of work done under CPT® code 77336, which is not covered under any of the other radiation oncology codes in the 77xxx series. In these vignettes, if the work under CPT code 77336 was not done in a timely and serial manner during the course of therapy (or not done at all), serious consequences for these patients could have ensued due to the irreversible nature of the therapeutic radiation delivery.

**Vignette 1:** John Doe's chart was reviewed and it was determined that the therapists treating the patient performed an inadvertent shift of isocenter based on the plan's digitally reconstructed radiographs. The medical physicist reconstructed an isodose plan based on the inadvertent treatment position for Mr. Doe and consulted with the radiation oncologist on what steps were needed to solve the discrepancy and optimize the remainder of the patient's treatment course. The patient-specific consequences on dosimetry were outlined for the radiation oncologist and the physicist performed needed beam and field setting calculations.

**Vignette 2:** During the weekly chart review for Jane Doe, it was determined by the medical physicist that an improper linear accelerator gantry angle was being used to treat the patient such that the spinal cord, originally prescribed to be out of the radiation field, was now being partially irradiated. The medical physicist calculated the dose that the spinal cord received by this error and consulted with the radiation oncologist regarding changes to the treatment course to minimize its effect.

The special medical radiation physics consultation CPT code 77370 is used when the complexity of the treatment plan is of such magnitude that a written analysis is necessary to address a specific problem, or when the service to be performed requires the expertise of a qualified medical physicist. The clinical indication that justifies the request for the special physics consultation should also be documented.

AMA/Specialty Society RVS Update Committee Summary of Recommendations  
*Services with Stand-Alone PE Procedure Time*

April 2013

**Radiation Treatment Delivery – PE Only**

CPT codes 77372 and 77402-77417 were identified through the Services with Stand-Alone PE Procedure Time screen. In October 2012, the RUC recommended that the PE Subcommittee review the PE direct inputs for these services at the April 2013 meeting. The specialty society is requesting referral to the CPT Editorial Panel for CPT codes 77402-77417.

***77372 Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based***

The PE Subcommittee reviewed the survey results from 18 radiation oncologists and noted that the survey times are higher than the current clinical staff times. Survey respondents indicated significantly higher clinical staff times for the pre-service, service (pre-service) and post-service periods than are currently included. The specialty recommended and the RUC agreed that these times should be maintained at current RUC standards. Since there is no compelling evidence to change the clinical staff time of this procedure, times consistent or below the current inputs are appropriate. The PE Subcommittee noted that the intra-service portion of the service period validates the range of the current PE inputs. Survey respondents did include a dosimetrist in addition to the typical staff of *Radiation Therapist (L050C)* and *Medical Physicist (L152A)*, to *Prepare system for treatment* (line 37); however, the PE Subcommittee agreed that although this additional staff may be used in clinics, it should not be included in the intra-service time. Equipment time for the *SRS system, Lincac* (ER082) was recalculated to include Prepare Machine (line 23). This time is needed prior to the patient entering the office to set up the machine for the service. **The RUC reviewed and approved the direct practice expense inputs with a minor modification as recommended by the Practice Expense Subcommittee.**

The specialty society is requesting referral to the CPT Editorial Panel for CPT codes 77402-77417 because questions regarding the appropriateness of the existing radiation treatment delivery codes to describe current practice have been raised in multiple venues.

- In Table 8 of the 2013 Medicare Physician Final Rule, CMS asked for review of multiple treatment delivery codes.
- The AMA/RUC has raised questions regarding the time associated with IMRT delivery.
- Others have raised the question of the appropriate coding for newer techniques.
- Image guidance that may be used with radiation treatment delivery has also grown. It is sometimes performed with conventional treatments and almost always is used with IMRT, suggesting a bundling solution.

As clinical practice has evolved, several issues have arisen which require CPT clarification. The specialty intends to address a number of interrelated issues and revise the entire treatment delivery family. The RUC recommends CPT codes 77402-77417 be referred to the CPT Editorial Panel for review at the May CPT meeting.

<b>CPT Code (●New)</b>	<b>CPT Descriptor</b>	<b>Global Period</b>	<b>Work RVU Recommendation</b>
77372	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based	XXX	0.00 (No Change) (PE Input Recommendations Only)
77402	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; up to 5 MeV	XXX	Refer to CPT
77403	6-10 MeV	XXX	Refer to CPT
77404	11-19 MeV	XXX	Refer to CPT
77406	20 MeV or greater	XXX	Refer to CPT
77407	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; up to 5 MeV	XXX	Refer to CPT
77408	6-10 MeV	XXX	Refer to CPT
77409	11-19 MeV	XXX	Refer to CPT
77411	20 MeV or greater	XXX	Refer to CPT

77412	Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; up to 5 MeV	XXX	Refer to CPT
77413	6-10 MeV	XXX	Refer to CPT
77414	11-19 MeV	XXX	Refer to CPT
77416	20 MeV or greater	XXX	Refer to CPT
77417	Therapeutic radiology port film(s)	XXX	Refer to CPT



April 2, 2013

Barbara Levy, MD  
Chair, RVS Update Committee  
American Medical Association  
515 N. State St.  
Chicago, IL 60610

Re: Tab 29 Radiation Treatment Delivery (77402-77417)

Dear Dr. Levy:

The Radiation Oncology Treatment Delivery Codes (CPT Codes 77402-77417) were included on the CMS Requests and Relativity Assessment level of interest form (LOI). As we noted on the LOI these codes were included in a CCP submitted February 15, 2013 for the upcoming CPT Panel Meeting. As such, we are not submitting RUC recommendations at this time. If you have any questions, please let us know.

Respectfully,

Najeeb Mohideen, MD  
ASTRO RUC Advisor

cc: Sheila Madhani  
Trisha Crishock

AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs

**Global Period:** XXX

**Meeting Date:** April 2013

**CPT Long Descriptors:**

*77372 Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based*

**1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:**

The Society prepared a practice expense survey and presented it to the research subcommittee. The surveys were sent electronically to 400 radiation oncologists. The specialties convened a consensus panel that included a number of experts familiar with these services to evaluate the survey results and existing direct practice expense inputs for these procedures. The specialties discarded the surveys from the hospital-based respondents, as requested by the research subcommittee. The panel reviewed the office survey results from 18 surveys.

**2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison. You must provide an explanation for the selection of reference codes. Reference Code Rationale:**

CPT code 77372 is currently priced in the office. As such, we have included columns with the existing inputs for reference.

**3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:**

**Pre Service Activities**

*Complete pre-service diagnostic & referral forms & Coordinate pre-surgery services*

A number of insurance companies require preauthorization for SRS. This time is allotted to complete the pre service forms and work with the insurance company on clinical matters.

**Provide pre-service education/obtain consent**

The clinical staff calls the patient prior to arriving for treatment. They will answer any questions regarding the procedure and go over what to expect during treatment. They may ask the patient not to eat or drink anything after midnight. They will discuss medications. They will discuss the need to have a family member or friend must accompany them the day of treatment and should drive them home following the procedure.

**Prepare Delivery System Unit for Treatment**

This line item is included in the service period in the existing inputs. However, it we believe it is more appropriate to include it in the pre service period.

**4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:**

We are not recommending additional clinical times, supplies or equipment from existing inputs. However, when we compute the time for the SRS machine we get 75 minutes, not 51. We included rows 23, 30, 32, 36, 42 and 49. When we compute the time for the pulse oximeter we get 55 minutes not 51. We included rows 30, 32, 36, 42 and 49.

**5. Please describe in detail the clinical activities of your staff:**

Pre-Service Clinical Labor Activities:

The physicist has prepared the machine for treatment prior to patient arriving in the treatment area. To ensure the accuracy of the treatment setup, the physicist then verifies the stereotactic isocenter using the Winston-Lutz phantom test.

Intra-Service Clinical Labor Activities:

The patient is taken into the treatment room, and the physician and the physicist together review the original and new films, the prescription, and the data that was entered into the treatment machine. The nurse is assisting the patient in getting comfortable and then takes the patient's vital signs. Once these vitals have been documented, the patient is then placed on the treatment couch. The nurse then lets the radiation therapist and the physicist position the patient with the appropriate immobilization system, and the head ring is calibrated to the stereotactic isocenter and the tests that were performed to validate the patient setup. Once the patient is then positioned, the nurse then inserts the IV for the patient, and the SRS treatment delivery begins.

During the treatment delivery, the physicist and the radiation therapist are in the control room at all times to monitor the delivery procedure. The nurse monitors the oxygen (O<sub>2</sub>) saturation of the patient. The amount of radiation given is continuously tracked.

The patient is taken out of the immobilization apparatus. (After treatment is complete the neurosurgeon removes the head frame, as described in CPT Code 61793.) The patient is then taken into a separate room for recovery.

Post-Service Clinical Labor Activities:

Phone calls are made by the nurse to follow up on side effects and phone in prescriptions.

AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs

**Global Period:** XXX

**Meeting Date:** April 2013

**CPT Long Descriptors:**

*77372 Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based*

**1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:**

The Society prepared a practice expense survey and presented it to the research subcommittee. The surveys were sent electronically to 400 radiation oncologists. The specialties convened a consensus panel that included a number of experts familiar with these services to evaluate the survey results and existing direct practice expense inputs for these procedures. The specialties discarded the surveys from the hospital-based respondents, as requested by the research subcommittee. The panel reviewed the office survey results from 18 surveys.

**2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison. You must provide an explanation for the selection of reference codes. Reference Code Rationale:**

CPT code 77372 is currently priced in the office. As such, we have included columns with the existing inputs for reference.

**3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:**

**Pre Service Activities**

We are requesting to maintain our pre service clinical time for these XXX services. The Radiation Oncologist typically uses his/her own clinical staff to complete pre-service diagnostic/referral forms and to work with the insurance companies/radiation oncology benefits manager. They ensure all pre authorization forms are completed and forward approved forms to the appropriate personnel. They also coordinate pre-procedure services to ensure that they are completed and that the results are acceptable to proceed with Radiosurgery treatment. Their clinical staff works with the facility to ensure that the facility is available as well as all the necessary supplies. Their clinical staff also answers the patient's questions regarding the treatment and what to expect during and after treatments.

**4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:**

N/A



**5. Please describe in detail the clinical activities of your staff:**

Pre-Service Clinical Labor Activities:

See Question #3

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

N/A

	A	B	C	D	E	F	G	H	I
1	<b>REVISED</b>			Existing Inputs		Survey Data (N=18)		Recommendations	
2	Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever			77372		77372		77372	
3	Meeting Date: April 2013 Tab: 29 Treatment Delivery Specialty: Radiation Oncology	CMS Code	Staff Type	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based					
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			XXX	XXX	XXX	XXX	XXX	XXX
6	TOTAL CLINICAL LABOR TIME			155	12	342	12	151	12
7	TOTAL PRE-SERV CLINICAL LABOR TIME			29	12	74	12	29	12
8		L037D	RN/LPN/MA	9	12	36	12	9	12
9		L152A	MedPhysics	20		38		20	
10	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			123	0	248	0	119	0
11		L037D	RN/LPN/MA	32		65		28	
12		L050C	RT	51		80		51	
13			Dosimetrist			30			
14		L152A	MedPhysics	40		73		40	
15	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MA	3	0	20	0	3	0
16	PRE-SERVICE								
17	Start: Following visit when decision for surgery or procedure made								
18	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MA	3	3	15(18)	3	3	3
19	Coordinate pre-surgery services	L037D	RN/LPN/MA	3	3	8(8)	3	3	3
20	Schedule space and equipment in facility	L037D	RN/LPN/MA		3		3		3
21	Provide pre-service education/obtain consent	L037D	RN/LPN/MA	3	3	13(11)	3	3	3
22	Follow-up phone calls & prescriptions								
23	*Other Clinical Activity - specify: Prepare Machine	L152A	MedPhysics	20		38(38)		20	
24	End: When patient enters office/facility for surgery/procedure								
25	SERVICE PERIOD								
26	Start: When patient enters office/facility for surgery/procedure:								
27	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MA	3		5(8)		3	
28	Obtain vital signs	L037D	RN/LPN/MA	2		5(8)		3	
29	Provide pre-service education/obtain consent	L037D	RN/LPN/MA			10(10)			
30	Prepare room, equipment, supplies	L037D	RN/LPN/MA	2		10(15)		2	
31	Setup scope (non facility setting only)								
32	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MA	2		15(19)		2	
33	Sedate/apply anesthesia								
34	*Other Clinical Activity - specify:								
35	Intra-service			91		188		91	
36		L050C	RT	8		10(19)		8	
37	Prepare system for treatment	L063A	Dosimetrist			30(38)			
38		L152A	MedPhysics	3		5(6)		3	
39	Prepare patient for treatment	L050C	RT	8		10(12)		8	
40		L152A	MedPhysics	5		10(23)		5	
41	Treatment including image guidance	L050C	RT	30		50(48)		30	
42		L152A	MedPhysics	32		45(50)		32	
43	Detach equipment from patient	L050C	RT			5(9)			
44		L152A	MedPhysics						
45	Complete treatment documentation	L050C	RT	5		5(9)		5	
46		L152A	MedPhysics			13(18)			
47	Post-Service								
48	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MA	20		15(28)		15	
49	Clean room/equipment by physician staff	L037D	RN/LPN/MA	3		5(8)		3	
50	Clean Scope								
51	Clean Surgical Instrument Package								
52	Complete diagnostic forms, lab & X-ray requisitions								
53	Review/read X-ray, lab, and pathology reports								
54	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions								
55	*Other Clinical Activity - specify:								
59	End: Patient leaves office								
60	POST-SERVICE Period								
61	Start: Patient leaves office/facility								
62	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MA	3		20(20)		3	
70	*Other Clinical Activity - specify:								
71	End: with last office visit before end of global period								

	A	B	C	D	E	F	G	H	I
1	REVISED			Existing Inputs		Survey Data (N=18)		Recommendations	
2	Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code. <b>**Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever</b>			77372		77372		77372	
3	Meeting Date: April 2013 Tab: 29 Treatment Delivery Specialty: Radiation Oncology	CMS Code	Staff Type	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based					
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			XXX	XXX	XXX	XXX	XXX	XXX
72	MEDICAL SUPPLIES**	CODE	UNIT						
73	pack, minimum multi-specialty visit	SA048	pack						
74	film, x-ray 14in x 17in	SK034	item	2				2	
75	x-ray ID card (flashcard)	SK093	item	2				2	
76	x-ray developer solution	SK089	oz	1				1	
77	x-ray envelope	SK091	item	1				1	
78	x-ray marking pencile	SK094	item	1				1	
79	tape, surgical paper 1in (Micropore)	SG079	inch	10				10	
80	drape, non-sterile, sheet 40in x 60in	SB006	item	1				1	
81	underpad 2ft x 3ft (Chux)	SB044	item	3				3	
82	gloves, non-sterile	SB022	item	4				4	
83	kit, iv starter	SA019	item	1				1	
84	iv tubing (extension)	SC019	foot	1				1	
85	swab-pad, alcohol	SJ053	item	1				1	
86	bandage, strip 0.75in x 3in (Bandaid)	SG021	item	1				1	
87	EQUIPMENT	CODE							
88	Lincac SRS System	ER082		51				75	
89	x-ray view box, 4 panel	ER067		10				10	
90	film processor, x-omat (M6B)	ED027		3				3	
91	pulse oximeter w-printer	EQ211		51				55	

AMA/Specialty Society RVS Update Committee Summary of Recommendations  
*Services with Stand-Alone PE Procedure Time*

April 2013

**Hyperthermia –PE Only**

CPT code 77600 *Hyperthermia, externally generated; superficial (ie, heating to a depth of 4 cm or less)* was identified through the Services with Stand-Alone PE Procedure Time screen. In October 2012, the RUC recommended that the PE Subcommittee review the direct PE inputs for these services at the April 2013 meeting.

The PE Subcommittee reviewed the survey results from 5 radiation oncologist practices and noted that the survey times are higher than the current clinical staff times. The number of responses is low because very few radiation oncologists perform this service resulting in a small pool of potential survey respondents. Survey respondents indicated time in the pre-service period where currently there is none. Respondents also indicated significantly higher time in the service period (pre-service and post-service) and post-service period than is currently included. The specialty recommended and the PE Subcommittee agreed that these times should be maintained at current RUC standards, since there is no compelling evidence to change the clinical staff time of this procedure. The PE Subcommittee noted that the *Treatment* (line 40) time in the intra-service portion of the service period validates the time of the current PE input. **The RUC reviewed and approved the direct practice expense inputs with a minor modification as recommended by the Practice Expense Subcommittee.**

CPT Code (●New)	CPT Descriptor	Global Period	Work RVU Recommendation
77600	Hyperthermia, externally generated; superficial (ie, heating to a depth of 4 cm or less)	XXX	1.56 (No Change) (PE Input Recommendations Only)

AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs

**Global Period:** XXX

**Meeting Date:** April 2013

**CPT Long Descriptors:**

*77600 Hyperthermia, externally generated; superficial (ie, heating to a depth of 4 cm or less)*

**1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:**

The Society prepared a practice expense survey and presented it to the research subcommittee. The surveys were sent electronically to all radiation oncologists with indication of thermal medicine (N=50). The specialties convened a consensus panel that included a number of experts familiar with these services to evaluate the survey results and existing direct practice expense inputs for these procedures. The specialties discarded the surveys from the hospital-based respondents, as requested by the research subcommittee. The panel reviewed the office survey results from 5 surveys.

**2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison. You must provide an explanation for the selection of reference codes. Reference Code Rationale:**

CPT code 77600 is currently priced in the office. As such, we have included columns with the existing inputs for reference.

**3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:**

We are not recommending any times higher than the PE subcommittee standards.

**4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:**

We are not recommending additional clinical times, supplies or equipment from existing inputs.

**5. Please describe in detail the clinical activities of your staff:**

**Pre-Service Clinical Labor Activities:**

Prepare room and equipment for patient according to prescription regarding field size, applicator, water bolus, immobilization devices, microwave and thermal shielding measures, etc. Calibrate thermal sensors and prepare all supplies, waterbolus circulation system, power sources for patient use. Check patient identification, diagnosis, chart, prescription, and clearly explain to the patient the upcoming procedure, expected communications during treatment, and procedures to

follow if an emergency arises during or after treatment. Place thermal sensors appropriately to monitor and document thermal prescription.

Intra-Service Clinical Labor Activities:

The Radiation Oncologist, Hyperthermia Medical Physicist, Nurse and Radiation Therapist apply non-ionizing radiation to the patient in accordance with the treatment plan. This includes: Optimize applicator placement over tumor and adjust as needed throughout treatment, including optimization of waterbolus, immobilization devices, electromagnetic field and thermal blocks, etc. Accurately deliver the prescribed course of hyperthermia therapy, continuously monitoring thermal dosimetry and adjusting treatment for optimum correlation of dose delivery with the prescription. Take vital signs and maintain patient comfort with sedation if necessary. Observe non-ionizing radiation safety measures for patient and personnel, monitoring and recording electromagnetic radiation levels as specified to meet standards. Maintain patient markings and observe patient for unusual reactions. Calculate thermal dose distribution and correlate with ongoing dose prescription.

Post-Service Clinical Labor Activities:

Detach equipment and applicators from patient and remove thermal probes. Replace dressings and give wound/home care instructions. Complete treatment documentation including daily hyperthermia system warm-up. Clean up all equipment, applicators, probes and patient contacting interface. Maintain supplies. Make phone calls to follow up on side effects, and phone in prescriptions.

	A	B	C	D	E	F	G	H	I
1	<b>REVISED</b>			<b>Existing Inputs</b>		<b>Survey Data (N=5)</b>		<b>Recommendations</b>	
2	more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever			77600		77600		77600	
3	Meeting Date: April 2013 Tab: Tab 30 Hyperthermia Specialty: Radiation Oncology	CMS Code	Staff Type	Hyperthermia, externally generated; superficial (ie, heating to a depth of 4 cm or less)					
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			XXX	XXX	XXX	XXX	XXX	XXX
6	TOTAL CLINICAL LABOR TIME			155	0	496	0	145	0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			0	0	90	0	0	0
8			RN	0	0	90	0	0	0
9		L121A	MedPhysics	0		0		0	
10	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			152	0	386	0	142	0
11		L037D	RN/LPN/MA	57		100		47	
12		L050C	RT	77		166		77	
13			RN			45			
14		L121A	MedPhysics	18		75		18	
15	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MA	3	0	20	0	3	0
16	PRE-SERVICE								
17	Start: Following visit when decision for surgery or procedure made								
18	Complete pre-service diagnostic & referral forms	L051A	RN			30(30)			
19	Coordinate pre-surgery services	L051A	RN			30(30)			
20	Schedule space and equipment in facility								
21	Provide pre-service education/obtain consent	L051A	RN			30(30)			
22	Follow-up phone calls & prescriptions								
23	*Other Clinical Activity - specify: Prepare Machine								
24	End: When patient enters office/facility for surgery/procedure								
25	SERVICE PERIOD								
26	Start: When patient enters office/facility for surgery/procedure:								
27	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MA			15(15)			
28	Obtain vital signs	L037D	RN/LPN/MA	5		15(15)		5	
29	Provide pre-service education/obtain consent	L037D	RN/LPN/MA	4		30(24)		4	
30	Prepare room, equipment, supplies	L050C	RT	2		30(30)		2	
31	Setup scope/interstitial thermometry and thermisters	L121A	MedPhysics			23(25)			
32	Prepare and position patient/ monitor patient/ set up IV	L050C	RT			20(20)			
33	Sedate/apply anesthesia								
34	*Other Clinical Activity - specify:								
35	Intra-service			124		320		124	
36	Prepare system for treatment	L050C	RT			18(15)			
37		L121A	MedPhysics	18		30(30)		18	
38	Prepare patient for treatment	L037D	RN/LPN/MA	8		23(23)		8	
39		L121A	MedPhysics			23(23)			
40	Treatment	L050C	RT	75		75(72)		75	
41		L121A	MedPhysics						
42		L037D	RN/LPN/MA	20		60(69)		20	
43	Detach equipment from patient	L037D	RN/LPN/MA	3		23(23)		3	
44		L121A	MedPhysics						
45	Complete treatment documentation	L050C	RT			23(23)			
46		L121A	MedPhysics			45(40)			
47	Post-Service								
48	Monitor pt. following service/check tubes, monitors, drains	L051A	RN			45(57)			
49	Clean room/equipment by physician staff	L037D	RN/LPN/MA	3		15(15)		3	
50	Clean Scope								
51	Clean applicators/catheters, remove debris, sterilize probes	L037D	RN/LPN/MA	10		15(23)		0	
52	Clean Surgical Instrument Package								
53	Complete diagnostic forms, lab & X-ray requisitions								
54	Review/read X-ray, lab, and pathology reports								
55	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MA	4		10(10)		4	
56	*Other Clinical Activity - specify:								
57	End: Patient leaves office								
58	POST-SERVICE Period								
59	Start: Patient leaves office/facility								
60	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MA	3		20(18)		3	
61	*Other Clinical Activity - specify:								

	A	B	C	D	E	F	G	H	I
1	REVISED			Existing Inputs		Survey Data (N=5)		Recommendations	
	Please return a supply with a purchase price of \$1.00 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever								
2				77600		77600		77600	
3	Meeting Date: April 2013 Tab: Tab 30 Hyperthermia Specialty: Radiation Oncology	CMS Code	Staff Type	Hyperthermia, externally generated; superficial (ie, heating to a depth of 4 cm or less)					
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			XXX	XXX	XXX	XXX	XXX	XXX
71	End: with last office visit before end of global period								



	A	B	C	D	E	F	G	H	I
1	REVISED			Existing Inputs		Survey Data (N=5)		Recommendations	
2	more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever			77600		77600		77600	
3	Meeting Date: April 2013 Tab: Tab 30 Hyperthermia Specialty: Radiation Oncology	CMS Code	Staff Type	Hyperthermia, externally generated; superficial (ie, heating to a depth of 4 cm or less)					
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			XXX	XXX	XXX	XXX	XXX	XXX
72	MEDICAL SUPPLIES**	CODE	UNIT						
73	pack, minimum multi-specialty visit	SA048	item	1				1	
74	alcohol isopropyl 70%	SJ001	ML	480				480	
75	bandage, strip 0.75in x 3in	SG021	item	2				2	
76	bacitracin oint (0.9gm uou)	SJ007	item	1				1	
77	bleach	SL020	ml	1137				110	
78	underpad 2ftx3ft (Chux)	SB044	item	2				2	
79	catheter, hyperthermia, closed-end	SC070	item	2				2	
80	catheter, hyperthermia, open-end	SC071	item	2				2	
81	drape, sterile barrier 16in x 29in	SB007	item	1				1	
82	gauze, sterile 2in x 2in	SG053	each	4				4	
83	gauze, sterile 4in x 4in	SG055	each	3				3	
84	gloves, non-sterile	SB022	pair	3				3	
85	gloves, sterile	SB024	pair	1				1	
86	iv tubing (extension)	SC019	item	1				1	
87	kit, iv starter	SA019	item	2				2	
88	lidocaine	SH049	ml	10				10	
89	needle, 18-27g	SC029	item	2				2	
90	needle, 30 guage	SC031	item	2				2	
91	syringe 5-6ml	SC057	item	1				1	
92	tape, surgical paper	SG079	inch	12				12	
93	towels, nonsterile	SB042	item	5				5	
94	needle, flexi, hyperthermia	SC078	item	1				1	
95	povidone soln (Betadine)	SJ041	item	10				10	
96									
97	EQUIPMENT	CODE							
98	Mayo stand	EF015		123				105	
99	Hyperthermia	ER035		123				105	
100									

AMA/Specialty Society RVS Update Committee Summary of Recommendations  
*Services with Stand-Alone PE Procedure Time*

April 2013

**High Dose Rate Brachytherapy–PE Only**

CPT codes 77785-77787 were identified in CMS' final rule through the Services with Stand-Alone PE Procedure Time Screen. In October 2012, the RUC recommended that the PE Subcommittee review the PE direct inputs for these services at the April 2013 meeting. As CMS requested for this screen, a practice expense survey for clinical staff time only was conducted for the family. The specialty societies convened a consensus panel that included a number of experts familiar with these services to evaluate the survey results and existing direct practice expense inputs for these procedures.

***77785 Remote afterloading high dose rate radionuclide brachytherapy; 1 channel***

The RUC reviewed the survey results from 37 radiation oncologists and noted that the survey times were either higher than the current clinical staff times or exceeded PE Subcommittee standards. The RUC agreed with the expert panel that the respondents overestimated the clinical staff time involved in many elements of the service. The specialty recommends and the RUC agrees that an *emergency service container safety kit* should be added to this service as it is missing from the direct PE equipment inputs. An invoice is included with this submission. In addition, the RUC recommends that for brachytherapy procedures additional activities beyond the PE Subcommittee standards should be included in the equipment time calculations. These procedures require extensive room/procedure preparation and use a live radiation source. There are federal guidelines for handling the source, documentation, etc. Many of the activities that are performed before/after the procedure need to be done in the room because of contamination potentials (i.e. room survey, transfer tube cleaning, etc.). The RUC recommends the following activities to be included in equipment time calculations:

- Prepare room (Line 30)
- Set up remote monitoring (Line 31)
- Position patient (Line 32)
- Intra time (Lines 36-49 accounting for concurrent activities)
- Monitor patient (Line 51)
- Clean room (Line 52)
- Clean transfer tubes (Line 53)

**77786 Remote afterloading high dose rate radionuclide brachytherapy; 2-12 channels**

The RUC reviewed the survey results from 39 radiation oncologists and noted that the survey times were either higher than the current clinical staff times or exceeded PE Subcommittee standards. The RUC agreed with the expert panel that the respondents overestimated the clinical staff time involved in many elements of the service. The specialty recommends and the RUC agrees that an *emergency service container safety kit* should be added to this service as it is missing from the direct PE equipment inputs. An invoice is included with this submission. In addition, the RUC recommends that for brachytherapy procedures additional activities beyond the PE Subcommittee standards should be included in the equipment time calculations. These procedures require extensive room/procedure preparation and use a live radiation source. There are federal guidelines for handling the source, documentation, etc. Many of the activities that are performed before/after the procedure need to be done in the room because of contamination potentials (i.e. room survey, transfer tube cleaning, etc.). The RUC recommends the following activities to be included in equipment time calculations:

- Prepare room (Line 30)
- Set up remote monitoring (Line 31)
- Position patient (Line 32)
- Intra time (Lines 36-49 accounting for concurrent activities)
- Monitor patient (Line 51)
- Clean room (Line 52)
- Clean transfer tubes (Line 53)

**77787 Remote afterloading high dose rate radionuclide brachytherapy; over 12 channels**

The RUC reviewed the survey results from 34 radiation oncologists and noted that the survey times were either higher than the current clinical staff times or exceeded PE Subcommittee standards. The RUC agreed with the expert panel that the respondents overestimated the clinical staff time involved in many elements of the service. The specialty recommends and the RUC agrees that an *emergency service container safety kit* should be added to this service as it is missing from the direct PE equipment inputs. An invoice is included with this submission. In addition, the RUC recommends that for brachytherapy procedures additional activities beyond the PE Subcommittee standards should be included in the equipment time calculations. These procedures require extensive room/procedure preparation and use a live radiation source. There are federal guidelines for handling the source, documentation, etc. Many of the activities that are performed before/after the procedure need to be done in the room because of contamination potentials (i.e. room survey, transfer tube cleaning, etc.). The RUC recommends the following activities to be included in equipment time calculations:

- Prepare room (Line 30)
- Set up remote monitoring (Line 31)
- Position patient (Line 32)
- Intra time (Lines 36-49 accounting for concurrent activities)
- Monitor patient (Line 51)

- Clean room (Line 52)
- Clean transfer tubes (Line 53)

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

<b>CPT Code (•New)</b>	<b>CPT Descriptor</b>	<b>Global Period</b>	<b>Work RVU Recommendation</b>
77785	Remote afterloading high dose rate radionuclide brachytherapy; 1 channel	XXX	1.42 (No Change) (PE Input Recommendations Only)
77786	2-12 channels	XXX	3.25 (No Change) (PE Input Recommendations Only)
77787	over 12 channels	XXX	4.89 (No Change) (PE Input Recommendations Only)

AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs

Global Period: XXX

Meeting Date: April 2013

CPT Long Descriptors:

*77785 Remote afterloading high dose rate radionuclide brachytherapy; 1 channel*

*77786 Remote afterloading high dose rate radionuclide brachytherapy; 2-12 channels*

*77787 Remote afterloading high dose rate radionuclide brachytherapy; over 12 channels*

**1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:**

The multispecialty organizations (ASTRO and ACR) prepared practice expense surveys and presented them to the research subcommittee. The surveys were sent electronically to 1000 radiation oncologists. The specialties convened a consensus panel that included a number of experts familiar with these services to evaluate the survey results and existing direct practice expense inputs for these procedures. The specialties discarded the surveys from the hospital-based respondents, as requested by the research subcommittee. The panel reviewed the office survey results from 37, 39 and 34 respectively.

**2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison. You must provide an explanation for the selection of reference codes. Reference Code Rationale:**

The HDR codes are currently priced in the office. As such, we have included columns with the existing inputs for reference.

**3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:**

We are requesting to maintain our pre service clinical time for these XXX services. The Radiation Oncologists' clinical staff must complete pre-service diagnostic/referral forms and work with the insurance companies/radiation oncology benefits manager. They ensure all pre authorization forms are completed. They also coordinate pre-procedure services to ensure that they are completed and that the results are acceptable to proceed with brachytherapy treatment. Their clinical staff also answers the patient's questions regarding the brachytherapy treatment and what to expect during and after treatments.

Monitor pt. following service/check tubes, monitors, drains

We recommend maintaining the clinical staff time for post procedure monitoring. Although we do not typically use conscious sedation for 77785 or 77786 we have included 2 and 7 minutes

respectively for monitoring. The patients have to be watched after the procedure for vital signs, bleeding, etc.

#### Equipment Times

For these brachytherapy procedures we have included activities in the equipment time calculations above the recommended [=set up + intraservice + clean up times]. These procedures require extensive room/procedure preparation. These procedures use a live radiation source. There are federal guidelines for handling the source, documentation, etc. Many of the activities that are performed before/after the procedure need to be done in the room because of contamination potentials (i.e. room survey, transfer tube cleaning, etc). As such we have included the following activities in our equipment time calculations:

- Prepare room (Line 30)
- Set up remote monitoring (Line 31)
- Position patient (Line 32)
- Intra time (Lines 36-49 accounting for concurrent activities)
- Monitor patient (Line 51)
- Clean room (Line 52)
- Clean transfer tubes (Line 53)

#### **4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:**

We are not recommending additional clinical staff times or supplies for these three procedures.

We are recommending additional equipment items be added to the direct PE inputs. We do not believe the procedure has changed since these were last reviewed (Oct 2009) but we do believe there are items missing from the direct PE equipment inputs.

We have added the following items:

- Emergency service container-safety kit
- HDR shielding

#### **5. Please describe in detail the clinical activities of your staff:**

##### Pre-Service Clinical Labor Activities:

The Radiation Oncologists' clinical staff completes pre-service diagnostic & referral forms and coordinates pre-surgery services. They provide pre-service education/obtain consent from the patient. The physicist prepares the HDR brachytherapy afterloader for treatment.

##### Intra-Service Clinical Labor Activities:

###### 77785

*The patient is taken into the shielded HDR treatment room,. The HDR machine is tested, validated and prepared for treatment by the physicist. The implant channel is cleaned and source cables are attached by the therapist. The source transfer cable is attached to the applicator and the HDR afterloader. The radiation prescription is verified and the treatment time and dwell positions are checked by the physicist. The test cable run is*

*performed to assure an unobstructed transfer. While the physicist is performing these steps and procedures, the ORN is present and immediately available, connecting the patient to the remote monitors, assessing pain, and tracking vital signs. After the system has been connected, checked, and the dwell times and doses verified, and the patient has been positioned for remote monitoring, the staff leave the treatment room and the room is closed. The HDR machine is then armed and the source released. The HDR treatment lasts approximately fifteen minutes as the source moves in and out of the transfer cable into the indwelling applicator channel. Supervision is personal for the physician, physicist, oncology nurse, and radiation therapist. The RTT monitors the dwell position times and verifies the overall treatment time. The nurse is monitoring the patient's vital signs and general condition, the physicist monitors the source exchange and is immediately available to assist the physician to troubleshoot any treatment console system error codes, and the physician is present for the entire treatment delivery. After the HDR treatment, the radiation source is secured and the room is entered. The room and patient are surveyed and the source transfer tube is disconnected from the patient and the HDR afterloader. The physician removes the cylinder.*

77786

*The patient is taken into the shielded HDR treatment room. The HDR machine is tested, validated and prepared for treatment by the physicist. The implant channel is cleaned and source cables are attached by the therapist. The brachytherapy channels are cleaned and the catheters are trimmed to their final length by the physicist/ dosimetrist. The source transfer cables, each individually numbered and cross referenced to the computerized treatment plan, are attached one at a time and double checked. The radiation prescription is verified and the treatment time and dwell positions are checked by the physicist. The test cable run is performed, as each catheter must be checked to assure an unobstructed transfer. While the physicist is performing these procedures, the Oncology Registered Nurse (ORN) is present and immediately available, connecting the patient to the remote monitors, assessing pain, and tracking vital signs. After the system has been connected, checked, and the dwell times and doses verified, and the patient has been positioned for remote monitoring, the staff leave the treatment room and the room is closed. The HDR machine is then armed and the source released. The HDR treatment lasts approximately twenty five minutes as the source moves in and out of the transfer cables into the matrix of brachytherapy channel dwell positions for precisely prescribed periods of time. Supervision is personal for the physician, MP, ORN, and RTT. The RTT monitors the dwell position times and verifies the total treatment time, the nurse is monitoring the patient's vital signs and oxygen saturation status, the physicist monitors the source exchange and is immediately available to assist the physician to troubleshoot any error codes, and the physician is present for the entire exposure. After the last transfer, the radiation source is secured and the room is entered. The room and patient are surveyed and the source transfer tubes are disconnected from the patient and the HDR afterloader. The implant is removed. The nurse assists the physician with the implant removal, which takes about fifteen minutes, including the time to apply direct pressure to the implant catheter sites to obtain hemostasis and to manage the patient's airway. After the bleeding has been controlled and airway is deemed stable, the nurse monitors the patient's vital signs, and ensures complete recovery after the procedure.*

77787

*The patient is taken into the shielded HDR treatment room,. The HDR machine is tested, validated and prepared for treatment by the physicist. The implant channel is cleaned and source cables are attached by the therapist. The brachytherapy channels are cleaned and the catheters are trimmed to their final length by the physicist/ dosimetrist. The source transfer cables, each individually numbered and cross referenced to the computerized treatment plan, are attached one at a time and double checked. The radiation prescription is verified and the treatment time and dwell positions are checked by the physicist. The test cable run is performed, as each catheter must be checked to assure an unobstructed transfer. While the physicist is performing these procedures, the ORN is present and immediately available, connecting the patient to the remote monitors, assessing pain, and tracking vital signs. The nurse administers intravenous pain meds as needed as directed by the physician. After the system has been connected, checked, and the dwell times and doses verified, and the patient has been positioned for remote monitoring, the staff leave the treatment room and the room closed. The HDR machine is then armed and the source released. The HDR treatment lasts approximately forty minutes as the source moves in and out of the transfer cables into the matrix of brachytherapy channel dwell positions for precisely prescribed periods of time. Supervision is personal for the physician, MP, ORN, and RTT. The RTT monitors the dwell times and verifies the treatment times, the nurse is monitoring the patient's vital signs and oxygen saturation status, the physicist monitors the source exchange and is immediately available to assist the physician to troubleshoot any error codes, and the physician is present for the entire exposure. After the last radiation transfer, the source is secured and the room is entered. The room and patient are surveyed and the source transfer tubes are disconnected from the patient and the HDR afterloader. The implant is removed. The nurse assists the physician with the implant removal, which takes about fifteen minutes, including the time to apply direct pressure on the perineum to obtain hemostasis. After the implant site and urinary bleeding have been controlled, the nurse removes the foley catheter, monitors the patient's vital signs, and ensures complete recovery after the procedure.*

Post-Service Clinical Labor Activities:

Nurse removes the IV, cleans the implant site, applies a dressing, assists the patient out of bed, monitors vital signs, and provides post treatment education and schedules the follow up appointments. Phone calls are made by the nurse to follow up and phone in prescriptions.



AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs

**Global Period:** XXX

**Meeting Date:** April 2013

**CPT Long Descriptors:**

*77785 Remote afterloading high dose rate radionuclide brachytherapy; 1 channel*

*77786 Remote afterloading high dose rate radionuclide brachytherapy; 2-12 channels*

*77787 Remote afterloading high dose rate radionuclide brachytherapy; over 12 channels*

**1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:**

For the non-facility direct practice expense inputs the multispecialty organizations (ASTRO and ACR) prepared practice expense surveys and presented them to the research subcommittee. Then surveys were sent electronically to 1000 radiation oncologists. The specialties convened a consensus panel that included a number of experts familiar with these services to evaluate the survey results and existing direct practice expense inputs for these procedures. The specialties discarded the surveys from the hospital-based respondents, as requested by the research subcommittee. The consensus panel reviewed the existing facility inputs and made these facility-setting recommendations.

**2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison. You must provide an explanation for the selection of reference codes. Reference Code Rationale:**

The HDR codes are currently have facility inputs. As such, we have included columns with the existing inputs for reference.

**3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:**

We are requesting to maintain our pre service clinical time for these XXX services. The Radiation Oncologist typically uses his/her own clinical staff to complete pre-service diagnostic/referral forms and to work with the insurance companies/radiation oncology benefits manager. They ensure all pre authorization forms are completed and forward approved forms to the appropriate personnel. They also coordinate pre-procedure services to ensure that they are completed and that the results are acceptable to proceed with brachytherapy treatment. Their clinical staff works with the facility to ensure that the brachytherapy suite is available as well as all the necessary supplies. Their clinical staff also answers the patient's questions regarding the brachytherapy treatment and what to expect during and after treatments.

**4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:**

We are not recommending additional clinical staff time, supplies or equipment for these procedures.

**5. Please describe in detail the clinical activities of your staff:**

Pre-Service Clinical Labor Activities:

The Radiation Oncologists' clinical staff completes pre-service diagnostic & referral forms and coordinates pre-surgery services. They work with all involved parties to schedule this service. Finally, they also provide pre-service education/obtain consent.

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

N/A

	A	B	C	D	E	F	G	H	I
1	<b>REVISED</b>			<b>Existing Inputs</b>		<b>Survey Data (N=37)</b>		<b>Recommendations</b>	
2	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.			<b>77785</b>		<b>77785</b>		<b>77785</b>	
3	<b>Meeting Date: April 2013</b> <b>Tab: Tab 32 High Dose Rate Brachytherapy</b> <b>Specialty: Radiation Oncology and Radiology</b>	<b>CMS Code</b>	<b>Staff Type</b>	Remote afterloading high dose rate radionuclide brachytherapy; 1 channel					
4	<b>LOCATION</b>			<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>
5	<b>GLOBAL PERIOD</b>			<b>XXX</b>		<b>XXX</b>		<b>XXX</b>	
6	<b>TOTAL CLINICAL LABOR TIME</b>			<b>73</b>	<b>12</b>	<b>224</b>	<b>0</b>	<b>72</b>	<b>12</b>
7	<b>TOTAL PRE-SERV CLINICAL LABOR TIME</b>			<b>9</b>	<b>12</b>	<b>50</b>	<b>0</b>	<b>9</b>	<b>12</b>
8		L037D	RN/LPN/MTA	6	12	30		6	12
9		L107A	Med Dos/Med Phys	3	0	20		3	0
10	<b>TOTAL SERVICE PERIOD CLINICAL LABOR TIME</b>			<b>64</b>	<b>0</b>	<b>174</b>	<b>0</b>	<b>63</b>	<b>0</b>
11		L037D	RN/LPN/MTA	10	0	28		10	0
12		L050C	RadTher	22		75		22	0
13		L051A	RN	3	0	15		3	0
14		L152A	MedPhys	29		56		28	0
15	<b>TOTAL POST-SERV CLINICAL LABOR TIME</b>			<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
16	<b>PRE-SERVICE</b>								
17	<b>Start: Following visit when decision for surgery or procedure made</b>								
18	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	2	3	10(13)		2	3
19	Coordinate pre-surgery services	L037D	RN/LPN/MTA	2	3	10(15)		2	3
20	Schedule space and equipment in facility				3				3
21	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	2	3	10(15)		2	3
22	Follow-up phone calls & prescriptions								
23	*Other Clinical Activity - specify: Prepare afterloader unit for treatment	L107A	Med Dos/Med Phys	3		20(21)		3	
24	<b>End: When patient enters office/facility for surgery/procedure</b>								
25	<b>SERVICE PERIOD</b>								
26	<b>Start: When patient enters office/facility for surgery/procedure:</b>								
27	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	3		7(10)		3	
28	Obtain vital signs	L037D	RN/LPN/MTA	3		6(8)		3	
29	Provide pre-service education/obtain consent					10(10)			
30	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2		10(10)		2	
31	Setup scope (non facility setting only) Setup remote monitoring and radiation protection equipment (non facility setting only)	L050C	RadTher	2		5(5)		2	
32	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	2		5(8)		2	
33	Sedate/apply anesthesia								
34	*Other Clinical Activity - specify:								
35	<b>Intra-service</b>			<b>46</b>		<b>111</b>		<b>45</b>	
36	Prepare system for treatment (enter treatment plans, source coordinates, etc)	L050C	RadTher	4		10(12)		4	
37		L152A	MedPhys	9		16(22)		9	
38	Prepare patient for treatment (attach cables, additional positioning, verification, etc)	L050C	RadTher			10(12)			
39		L152A	MedPhys	2		10(11)		2	
40		L050C	RadTher	10		15(16)		10	
41	Treatment	L152A	MedPhys	10		15(15)		10	
42		L051A	RN						
43		L050C	RadTher	1		5(7)		1	
44	Detach equipment from patient/implant removal	L152A	MedPhys						
45		L051A	RN	1		5(6)		1	
46		L050C	RadTher						
47	Patient, unit and room surveys	L152A	MedPhys	6		5(6)		5	
48		L050C	RadTher	1		10(10)		1	
49	Complete treatment documentation	L152A	MedPhys	2		10(10)		2	
50	<b>Post-Service</b>								
51	Monitor pt. following service/check tubes, monitors, drains	L051A	RN	2		10(15)		2	
52	Clean room/equipment by physician staff	L050C	RadTher	2		10(9)		2	
53	Clean Scope/Clean transfer tube(s) & connection devices Clean transfer tube(s) & connection devices	L050C	RadTher	2		10(8)		2	
57	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions								
58	*Other Clinical Activity - specify:								
62	<b>End: Patient leaves office</b>								
63	<b>POST-SERVICE Period</b>								
64	<b>Start: Patient leaves office/facility</b>								
65	Conduct phone calls/call in prescriptions								
73	*Other Clinical Activity - specify:								
74	<b>End: with last office visit before end of global period</b>								

	A	B	C	D	E	F	G	H	I
1	REVISED			Existing Inputs		Survey Data (N=37)		Recommendations	
2	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.			77785		77785		77785	
3	Meeting Date: April 2013 Tab: Tab 32 High Dose Rate Brachytherapy Specialty: Radiation Oncology and Radiology	CMS Code	Staff Type	Remote afterloading high dose rate radionuclide brachytherapy; 1 channel					
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			XXX		XXX		XXX	
75	MEDICAL SUPPLIES**	CODE	UNIT						
76	pack, minimum multi-specialty visit	SA048	pack						
77	gloves, non-sterile	SB022	pair	3					
78	gloves, sterile	SB024	pair						
79	gown, patient	SB026	item	1					
80	towel, non-sterile	SB042	item	1					
81	glutaraldehyde 3.4% (Cidex, Maxide, Wavicide)	SM018	oz	13					
82	kit, scissors and clamp	SA027	kit	1					
83	tincture of benzion, liquid	SJ059	ml	5					
84	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item						
85	gauze, sterile 4in x 4in	SG055	item						
86	tape, surgical paper 1in (Micropore)	SG077	inch	12					
87	swab-pad, alcohol	SJ053	item	5					
88	underpad 2ft x 3ft (Chux)	SB044	item	1					
89	mask, surgical, with face shield	SB034	item	2					
90	paper, laser printing (each sheet)	SK057	item	4					
91	tray, catheter insertion (w-o catheter)	SA063	tray	1					
92									
93	EQUIPMENT	CODE							
94	Table, brachytherapy treatment	EF021		50					
95	HDR Afterloader System, Nucletron	ER003		50					
96	electrometer, PC-based, dual channel	ER028		50					
97	radiation survey meter	ER054		50					
98	source, 10 Ci Ir 192	ER060		50					
99	Area Radiation Monitor	ER073		50					
100	Stirrups for brachytherapy table	ER062		50					
101	Applicator Base Plate	EQ292		50					
102	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011							
103	Video Camera (patient monitor)	ED045		11					
104	Video Camera (machine monitor)	ED044		11					
105	Computer system, record and verify	ED011		5					
106	stretcher	EF018		2					
107	Emergency service container-safety kit	NEW							
108	HDR sheilding	DELETED							

	A	B	C	J	K	L	M	N	O
1	<b>REVISED</b>			<b>Existing Inputs</b>		<b>Survey Data (N=39)</b>		<b>Recommendations</b>	
2	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.			<b>77786</b>		<b>77786</b>		<b>77786</b>	
3	<b>Meeting Date: April 2013</b> <b>Tab: Tab 32 High Dose Rate Brachytherapy</b> <b>Specialty: Radiation Oncology and Radiology</b>	<b>CMS Code</b>	<b>Staff Type</b>	Remote afterloading high dose rate radionuclide brachytherapy; 2-12 channels					
4	<b>LOCATION</b>			<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>
5	<b>GLOBAL PERIOD</b>			<b>XXX</b>		<b>XXX</b>		<b>XXX</b>	
6	<b>TOTAL CLINICAL LABOR TIME</b>			<b>148</b>	<b>12</b>	<b>336</b>	<b>0</b>	<b>146</b>	<b>12</b>
7	<b>TOTAL PRE-SERV CLINICAL LABOR TIME</b>			<b>12</b>	<b>12</b>	<b>63</b>	<b>0</b>	<b>12</b>	<b>12</b>
8		L037D	RN/LPN/MTA	9	12	45		9	12
9		L107A	Med Dos/Med Phys	3	0	18		3	0
10	<b>TOTAL SERVICE PERIOD CLINICAL LABOR TIME</b>			<b>136</b>	<b>0</b>	<b>273</b>	<b>0</b>	<b>134</b>	<b>0</b>
11		L037D	RN/LPN/MTA	12	0	40		10	0
12		L050C	RadTher	53		105		53	0
13		L051A	RN	17	0	52		17	0
14		L152A	MedPhys	54		76		54	0
15	<b>TOTAL POST-SERV CLINICAL LABOR TIME</b>			<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
16	<b>PRE-SERVICE</b>								
17	<b>Start: Following visit when decision for surgery or procedure made</b>								
18	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	3	3	10(13)		3	3
19	Coordinate pre-surgery services	L037D	RN/LPN/MTA	3	3	15(15)		3	3
20	Schedule space and equipment in facility				3				3
21	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	3	3	20(22)		3	3
22	Follow-up phone calls & prescriptions								
23	*Other Clinical Activity - specify: Prepare afterloader unit for treatment	L107A	Med Dos/Med Phys	3		18(21)		3	
24	<b>End: When patient enters office/facility for surgery/procedure</b>								
25	<b>SERVICE PERIOD</b>								
26	<b>Start: When patient enters office/facility for surgery/procedure:</b>								
27	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	3		7(10)		3	
28	Obtain vital signs	L037D	RN/LPN/MTA	5		5(8)		3	
29	Provide pre-service education/obtain consent					15(18)			
30	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2		15(21)		2	
31	Setup scope (non facility setting only) Setup remote monitoring and radiation protection equipment (non facility setting only)	L050C	RadTher	5		5(6)		5	
32	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	2		13(15)		2	
33	Sedate/apply anesthesia					10(27)			
34	*Other Clinical Activity - specify:								
35	<b>Intra-service</b>			<b>104</b>		<b>193</b>		<b>104</b>	
36	Prepare system for treatment	L050C	RadTher	10		15(19)		10	
37	(enter treatment plans, source coordinates, etc)	L152A	MedPhys	17		20(47)		17	
38	Prepare patient for treatment	L050C	RadTher	4		20(20)		4	
39	(attach cables, additional positioning, verification, etc)	L152A	MedPhys	7		15(15)		7	
40		L050C	RadTher	20		25(26)		20	
41	Treatment	L152A	MedPhys	20		25(29)		20	
42		L051A	RN	5		22(23)		5	
43		L050C	RadTher	3		10(12)		3	
44	Detach equipment from patient/implant removal	L152A	MedPhys						
45		L051A	RN	5		15(15)		5	
46		L050C	RadTher						
47	Patient, unit and room surveys	L152A	MedPhys	6		6(7)		6	
48		L050C	RadTher	3		10(10)		3	
49	Complete treatment documentation	L152A	MedPhys	4		10(14)		4	
50	<b>Post-Service</b>								
51	Monitor pt. following service/check tubes, monitors, drains	L051A	RN	7		15(23)		7	
52	Clean room/equipment by physician staff	L050C	RadTher	3		10(13)		3	
53	Clean Scope/Clean transfer tube(s) & connection devices Clean transfer tube(s) & connection devices	L050C	RadTher	5		10(10)		5	
57	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions								
58	*Other Clinical Activity - specify:								
62	<b>End: Patient leaves office</b>								
63	<b>POST-SERVICE Period</b>								
64	<b>Start: Patient leaves office/facility</b>								
65	Conduct phone calls/call in prescriptions								
73	*Other Clinical Activity - specify:								
74	<b>End: with last office visit before end of global period</b>								



	A	B	C	J	K	L	M	N	O
1	REVISED			Existing Inputs		Survey Data (N=39)		Recommendations	
2	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.			77786		77786		77786	
3	Meeting Date: April 2013 Tab: Tab 32 High Dose Rate Brachytherapy Specialty: Radiation Oncology and Radiology	CMS Code	Staff Type	Remote afterloading high dose rate radionuclide brachytherapy; 2-12 channels					
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			XXX		XXX		XXX	
75	MEDICAL SUPPLIES**	CODE	UNIT						
76	pack, minimum multi-specialty visit	SA048	pack						
77	gloves, non-sterile	SB022	pair	6				6	
78	gloves, sterile	SB024	pair	3				3	
79	gown, patient	SB026	item	1				1	
80	towel, non-sterile	SB042	item	6				6	
81	glutaraldehyde 3.4% (Cidex, Maxide, Wavicide)	SM018	oz	13				13	
82	kit, scissors and clamp	SA027	kit	1				1	
83	tincture of benzion, liquid	SJ059	ml	5				5	
84	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item	1				1	
85	gauze, sterile 4in x 4in	SG055	item	5				5	
86	tape, surgical paper 1in (Micropore)	SG077	inch	12				12	
87	swab-pad, alcohol	SJ053	item	5				5	
88	underpad 2ft x 3ft (Chux)	SB044	item	1				1	
89	mask, surgical, with face shield	SB034	item	2				2	
90	paper, laser printing (each sheet)	SK057	item	6				6	
91	tray, catheter insertion (w-o catheter)	SA063	tray	1				1	
92									
93	EQUIPMENT	CODE							
94	Table, brachytherapy treatment	EF021		125				86	
95	HDR Afterloader System, Nucletron	ER003		125				86	
96	electrometer, PC-based, dual channel	ER028		125				86	
97	radiation survey meter	ER054		125				86	
98	source, 10 Ci Ir 192	ER060		125				86	
99	Area Radiation Monitor	ER073		125				86	
100	Stirrups for brachytherapy table	ER062							
101	Applicator Base Plate	EQ292		125				86	
102	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011		125				86	
103	Video Camera (patient monitor)	ED045		23				23	
104	Video Camera (machine monitor)	ED044		23				23	
105	Computer system, record and verify	ED011		8				8	
106	stretcher	EF018		7				7	
107	Emergency service container-safety kit	NEW						0	
108	HDR sheilding	DELETED							

	A	B	C	P	Q	R	S	T	U
1	<b>REVISED</b>			<b>Existing Inputs</b>		<b>Survey Data (N=34)</b>		<b>Recommendations</b>	
2	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.			<b>77787</b>		<b>77787</b>		<b>77787</b>	
3	<b>Meeting Date: April 2013</b> <b>Tab: Tab 32 High Dose Rate Brachytherapy</b> <b>Specialty: Radiation Oncology and Radiology</b>	<b>CMS Code</b>	<b>Staff Type</b>	Remote afterloading high dose rate radionuclide brachytherapy; over 12 channels					
4	<b>LOCATION</b>			<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>
5	<b>GLOBAL PERIOD</b>			<b>XXX</b>		<b>XXX</b>		<b>XXX</b>	
6	<b>TOTAL CLINICAL LABOR TIME</b>			<b>266</b>	<b>12</b>	<b>441</b>	<b>0</b>	<b>264</b>	<b>12</b>
7	<b>TOTAL PRE-SERV CLINICAL LABOR TIME</b>			<b>12</b>	<b>12</b>	<b>70</b>	<b>0</b>	<b>12</b>	<b>12</b>
8		L037D	RN/LPN/MTA	9	12	50		9	12
9		L107A	Med Dos/Med Phys	3	0	20		3	0
10	<b>TOTAL SERVICE PERIOD CLINICAL LABOR TIME</b>			<b>254</b>	<b>0</b>	<b>371</b>	<b>0</b>	<b>252</b>	<b>0</b>
11		L037D	RN/LPN/MTA	12	0	42		10	0
12		L050C	RadTher	91		153		91	0
13		L051A	RN	60	0	73		60	0
14		L152A	MedPhys	91		103		91	0
15	<b>TOTAL POST-SERV CLINICAL LABOR TIME</b>			<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
16	<b>PRE-SERVICE</b>								
17	<b>Start: Following visit when decision for surgery or procedure made</b>								
18	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	3	3	15(15)		3	3
19	Coordinate pre-surgery services	L037D	RN/LPN/MTA	3	3	15(31)		3	3
20	Schedule space and equipment in facility				3				3
21	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	3	3	20(26)		3	3
22	Follow-up phone calls & prescriptions								
23	*Other Clinical Activity - specify: Prepare afterloader unit for treatment	L107A	Med Dos/Med Phys	3		20(27)		3	
24	<b>End: When patient enters office/facility for surgery/procedure</b>								
25	<b>SERVICE PERIOD</b>								
26	<b>Start: When patient enters office/facility for surgery/procedure:</b>								
27	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	3		7(12)		3	
28	Obtain vital signs	L037D	RN/LPN/MTA	5		10(9)		3	
29	Provide pre-service education/obtain consent					15(25)			
30	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2		15(22)		2	
31	Setup scope (non facility setting only) Setup remote monitoring and radiation protection equipment (non facility setting only)	L050C	RadTher	5		5(9)		5	
32	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	2		10(21)		2	
33	Sedate/apply anesthesia					13(35)			
34	*Other Clinical Activity - specify:								
35	<b>Intra-service</b>			<b>214</b>		<b>281</b>		<b>214</b>	
36	Prepare system for treatment (enter treatment plans, source coordinates, etc)	L050C	RadTher	17		20(27)		17	
37		L152A	MedPhys	24		23(53)		24	
38	Prepare patient for treatment (attach cables, additional positioning, verification, etc)	L050C	RadTher	8		30(32)		8	
39		L152A	MedPhys	15		24(24)		15	
40		L050C	RadTher	40		45(42)		40	
41	Treatment	L152A	MedPhys	40		40(36)		40	
42		L051A	RN	40		40(41)		40	
43		L050C	RadTher	4		15(16)		4	
44	Detach equipment from patient/implant removal	L152A	MedPhys						
45		L051A	RN	10		15(16)		10	
46		L050C	RadTher						
47	Patient, unit and room surveys	L152A	MedPhys	6		6(7)		6	
48		L050C	RadTher	4		13(18)		4	
49	Complete treatment documentation	L152A	MedPhys	6		10(18)		6	
50	<b>Post-Service</b>								
51	Monitor pt. following service/check tubes, monitors, drains	L051A	RN	10		18(33)		10	
52	Clean room/equipment by physician staff	L050C	RadTher	3		15(16)		3	
53	Clean Scope/Clean transfer tube(s) & connection devices Clean transfer tube(s) & connection devices	L050C	RadTher	10		10(15)		10	
57	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions								
58	*Other Clinical Activity - specify:								
62	<b>End: Patient leaves office</b>								
63	<b>POST-SERVICE Period</b>								
64	<b>Start: Patient leaves office/facility</b>								
65	Conduct phone calls/call in prescriptions								
73	*Other Clinical Activity - specify:								
74	<b>End: with last office visit before end of global period</b>								

	A	B	C	P	Q	R	S	T	U
1	<b>REVISED</b>			Existing Inputs		Survey Data (N=34)		Recommendations	
2	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.			77787		77787		77787	
3	<b>Meeting Date: April 2013</b> <b>Tab: Tab 32 High Dose Rate Brachytherapy</b> <b>Specialty: Radiation Oncology and Radiology</b>	CMS Code	Staff Type	Remote afterloading high dose rate radionuclide brachytherapy; over 12 channels					
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			XXX		XXX		XXX	
75	<b>MEDICAL SUPPLIES**</b>	<b>CODE</b>	<b>UNIT</b>						
76	pack, minimum multi-specialty visit	SA048	pack						
77	gloves, non-sterile	SB022	pair	6				6	
78	gloves, sterile	SB024	pair	4				4	
79	gown, patient	SB026	item	1				1	
80	towel, non-sterile	SB042	item	6				6	
81	glutaraldehyde 3.4% (Cidex, Maxide, Wavicide)	SM018	oz	13				13	
82	kit, scissors and clamp	SA027	kit	1				1	
83	tincture of benzoin, liquid	SJ059	ml	5				5	
84	sodium chloride 0.9% inj (250-1000ml uou)	SH067	item	1				1	
85	gauze, sterile 4in x 4in	SG055	item	6				6	
86	tape, surgical paper 1in (Micropore)	SG077	inch	12				12	
87	swab-pad, alcohol	SJ053	item	5				5	
88	underpad 2ft x 3ft (Chux)	SB044	item	1				1	
89	mask, surgical, with face shield	SB034	item	2				2	
90	paper, laser printing (each sheet)	SK057	item	8				8	
91	tray, catheter insertion (w-o catheter)	SA063	tray	1				1	
92									
93	<b>EQUIPMENT</b>	<b>CODE</b>							
94	Table, brachytherapy treatment	EF021		236				137	
95	HDR Afterloader System, Nucletron	ER003		236				137	
96	electrometer, PC-based, dual channel	ER028		236				137	
97	radiation survey meter	ER054		236				137	
98	source, 10 Ci Ir 192	ER060		236				137	
99	Area Radiation Monitor	ER073		236				137	
100	Stirrups for brachytherapy table	ER062		236				137	
101	Applicator Base Plate	EQ292		236				137	
102	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011		236				137	
103	Video Camera (patient monitor)	ED045		45				45	
104	Video Camera (machine monitor)	ED044		45				45	
105	Computer system, record and verify	ED011		10				10	
106	stretcher	EF018		10				10	
107	Emergency service container-safety kit	NEW						0	
108	<b>HDR sheilding</b>	<b>DELETED</b>							



AMA/Specialty Society RVS Update Committee Summary of Recommendations  
*CMS High Expenditure Procedural Codes Screen*

April 2013

**Cytopathology**

CPT code 88112 was identified through the CMS High Expenditure Procedural Codes screen. The RUC recommended survey of physician work and review of practice expense for this service at the April 2013 RUC meeting.

***88112 Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal***

In April 2003, The RUC reviewed the survey results for new service CPT code 88112. At that time the code was surveyed for pre-and post-service time in addition to intra-service time and the total time was 43 minutes including with a work value of 1.18. At that time the RUC determined that the new service required more physician time and a higher level of intensity than CPT codes 88104 *Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation* (work RVU=0.56) and 88108 *Cytopathology, concentration technique, smears and interpretation (eg, Saccomanno technique)* (work RVU= 0.44). In the subsequent years the service has changed considerably, pre- and post-service times are no longer included in the physician work as they previously would have been. Also the vignette has changed and urinary specimen is now typical for this service.

The RUC reviewed the survey results from 194 pathologists and recommends 15 minutes of intra-service physician time for this service. The RUC reviewed the survey and determined that the 25<sup>th</sup> percentile work RVU of 0.56 is appropriate for this service. To validate this work value the RUC compared the surveyed code to key reference service 88104 *Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation* (work RVU=0.56, 24 minute intra-service) and noted that 88112 is more intense and is often used on more complicated specimens due to the use of concentration technique which allows the instrument to remove cellular “junk” and the physician to review a greater magnitude of cells in close detail. Although code 88104 requires more physician time to perform, the higher intensity of 88112 justifies the identical work value. The RUC also compared the 88112 to CPT code 88108 *Cytopathology, concentration technique, smears and interpretation (eg, Saccomanno technique)* (work RVU=0.44, 19 minutes intra-service) which is also a concentration technique, but an older technique. The RUC original recommendation for CPT code 88108 was a work RVU of 0.56 and it was subsequently reduced to 0.44 by CMS. The RUC continues to support the recommendation of 0.56 for CPT code 88108, and determined that 88112 should have a work value of 0.56 as well. The RUC notes that this recommendation reflects a significant reduction from the current value of 1.18. **The RUC recommends a work RVU of 0.56 for CPT code 88112.**

### Practice Expense

Equipment time elements for each equipment item on the RUC practice expense recommendations made prior to CPT 2011 were determined by CMS. At its April 2010 meeting, the RUC changed policy and specialties now provide the actual number of minutes that the equipment item is used for each service. The specialty discovered an error in the current CMS equipment direct practice expense inputs file for 88112. All equipment items for this service are shown as being used for one minute. This is clearly a data input error as it is impossible to perform this service using all of the equipment items for only one minute. The RUC recommends that equipment direct PE inputs be corrected to reflect the times recommended by the PE Subcommittee in the attached spreadsheet.

The specialty society has submitted comments to CMS stating that they do not agree that courier transportation costs, specimen disposal costs, copath system, software, and laboratory information system maintenance contracts are indirect PE expenses. This is an ongoing issue between CMS and the specialty, and the RUC is maintaining the items on the spreadsheet simply to acknowledge the unresolved issue and will not comment on the inclusion or exclusion of these PE inputs or the pricing proposed by the specialty at this time. **The RUC reviewed and approved the direct practice expense inputs with minor modifications as recommended by the Practice Expense Subcommittee.**

### Work Neutrality

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

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
88112	Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal  (Do not report 88112 with 88108)	XXX	0.56

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:88112	Tracking Number	Original Specialty Recommended RVU: <b>0.70</b>
		Presented Recommended RVU: <b>0.70</b>
Global Period: XXX		RUC Recommended RVU: <b>0.56</b>

CPT Descriptor: Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal (Do not report 88112 with 88108)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: An elderly male with a history of High Grade Papillary Urothelial Carcinoma who is post BCG therapy has submitted a surveillance urine specimen. A cellular enhancement preparation is processed from the urine sediment.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: NA

Description of Intra-Service Work: Obtaining and reviewing the history and results of other diagnostic studies, including examination of previous/additional slides and/or reports, during the gross and microscopic interpretation of the histologic specimen and/or cellular material; comparison to previous study reports; identification of clinically meaningful findings; consultation with other professionals regarding the specimen; any review of literature or research during examination of the specimen; any dictation, preparation and finalization of the report.

Description of Post-Service Work: NA

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Jonathan Myles, M.D., Michael McEachin M.D., Marina Mosunjac, M.D., Emily Volk, M.D, Christine Booth, M.D.				
<b>Specialty(s):</b>	College of American Pathologists and American Society of Cytopathology				
<b>CPT Code:</b>	88112				
<b>Sample Size:</b>	2400	<b>Resp N:</b>	194	<b>Response:</b> 8.0 %	
<b>Description of Sample:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	20.00	200.00	<b>300.00</b>	700.00	2000.00
<b>Survey RVW:</b>	0.50	0.56	<b>0.70</b>	0.85	1.50
<b>Pre-Service Evaluation Time:</b>			<b>0.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>0.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>0.00</b>		
<b>Intra-Service Time:</b>	5.00	10.00	<b>15.00</b>	20.00	30.00
<b>Immediate Post Service-Time:</b>	<b>0.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x <b>0.00</b> 99292x <b>0.00</b>			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x <b>0.00</b> 99232x <b>0.00</b> 99233x <b>0.00</b>			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x <b>0.00</b> 99239x <b>0.00</b> 99217x <b>0.00</b>			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x <b>0.00</b> 12x <b>0.00</b> 13x <b>0.00</b> 14x <b>0.00</b> 15x <b>0.00</b>			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x <b>0.00</b> 55x <b>0.00</b> 56x <b>0.00</b> 57x <b>0.00</b>			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x <b>0.00</b> 99225x <b>0.00</b> 99226x <b>0.00</b>			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

<b>CPT Code:</b>	88112	<b>Recommended Physician Work RVU: 0.56</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>15.00</b>		
<b>Immediate Post Service-Time:</b>	<b>0.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x <b>0.00</b> 99292x <b>0.00</b>		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x <b>0.00</b> 99232x <b>0.00</b> 99233x <b>0.00</b>		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x <b>0.0</b> 99239x <b>0.0</b> 99217x <b>0.00</b>		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x <b>0.00</b> 12x <b>0.00</b> 13x <b>0.00</b> 14x <b>0.00</b> 15x <b>0.00</b>		
<b>Prolonged Services:</b>	<b>0.00</b>	99354x <b>0.00</b> 55x <b>0.00</b> 56x <b>0.00</b> 57x <b>0.00</b>		

Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00
---------------	-------------	-------------	-------------	-------------

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
88104	XXX	0.56	RUC Time

CPT Descriptor Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
76815	XXX	0.65	RUC Time	15,385

CPT Descriptor 1 Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99231	XXX	0.76	RUC Time	12,406,602

CPT Descriptor 2 Subsequent hospital care, per day, for the evaluation and management of a patient,...

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
77057	XXX	0.70	RUC Time

CPT Descriptor Screening mammography, bilateral (2-view film study of each breast)**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 123      % of respondents: 63.4 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 88112</b>	<b>Key Reference CPT Code: 88104</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	15.00	24.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>15.00</b>	<b>24.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.73	3.66
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.51	3.41
--	------	------

Urgency of medical decision making	3.33	3.46
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.97	3.83
--------------------------	------	------

Physical effort required	2.97	3.07
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.63	3.64
---	------	------

Outcome depends on the skill and judgment of physician	4.20	4.02
--	------	------

Estimated risk of malpractice suit with poor outcome	3.84	3.81
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity		
----------------------------------	--	--

Intra-Service intensity/complexity	3.47	3.45
------------------------------------	------	------

Post-Service intensity/complexity		
-----------------------------------	--	--

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUR analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

In the July 19, 2011, Proposed Rule for 2012, CMS requested that the RUC review a list of 70 high PFS expenditure procedural codes representing services furnished by an array of specialties. CMS selected these codes based on the fact that they have not been reviewed for at least 6 years, and in many cases the last review occurred more than 10 years ago. CPT Code 88112 was on CMS' list of 70 codes.

When 88112 was first RUC surveyed for physician work in 2003, survey participants were asked to provide estimates of both pre-service and post-service work and time. The survey results indicated a pre-service time of 8 minutes and a post service time of 10 minutes. This work was extracted from this most recent survey as it is not typically performed by the pathologist at this time. The College only surveyed for the intra-service work for this service.

In addition, while preparing for survey the CAP recognized that the typical patient had changed. The typical patient specimen when 88112 originally was valued by the RUC was for the examination of common bile duct brushings and today the typical vignette involves a urine specimen. The RUC's Research Subcommittee approved the vignette change for 88112 at its last meeting in February 2013.

2013 - 88112 Vignette - A 72 year old male with a history of High Grade Papillary Urothelial Carcinoma who is post BCG therapy has submitted a surveillance urine specimen. A cellular enhancement preparation is processed from the urine sediment.

### **Survey Effort and Results**

The College of American Pathologists (CAP) and the American Society of Cytopathology (ASC) performed a random survey of 1,200 members each for a total of 2,400 potential survey respondents. The survey yielded 194 respondents in total, 125 from ASC members and 69 from CAP members. Survey data between the two groups were very similar. Data from both societies are shown on this form.

CAP's expert panel reviewed the survey and developed its recommendations. The expert panel included CAP's CPT/RUC Workgroup, an ASC representative, and other representatives from general and academic pathology practice settings. The expert panel reviewed the survey results from the 194 respondents and compared the recommended RVW, time and intensity/complexity of 88112 to the key reference service (88104) and other pathology codes such as 88173 - Cytopathology, evaluation of fine needle aspirate; interpretation and report.

The median RVW was 0.70 and a survey median time of 15 minutes. The expert panel felt the survey respondents appropriately estimated the physician work at an RVU of 0.70, with the change in the typical specimen, and the physician time considering the change in the survey instrument (elimination of the pre and post work). With 194 respondents, CAP and ASC experts agreed that the survey statistics are very good and reflect the physician work and time of 88112.

Panel members agreed that the median RVW and time, as reflected in the robust survey results, accurately reflects the physician work involved in 88112. The expert panel did feel that the survey respondents had underestimated the intensity of the work in the current survey in comparison with the reference code, and thus recommend the median value of 0.70 RVUs. The expert panel concluded that given the robustness of the survey, the survey median RVU of 0.70 accurately reflects the relative value of the service.

During the development of our recommendation, the expert panel also reviewed the survey results and compared the physician work to previously RUC valued services which include:

1. 77057 -Screening mammography, bilateral (2-view film study of each breast) (Work RVU = 0.70, RUC Reviewed – April 2002, Total time = 12 minutes, 5 intra – XXX day global)

2. 76815 - Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses (April 2002 RUC reviewed, 0.65 RVW, with 15.5 total time, XXX day global).
3. 20552 - Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s) ( Work RVU = 0.66, RUC Reviewed- April 2002, 13.5 minutes total time.000 day global.
4. 67820 – Correction of trichiasis; epilation, by forceps only (Work RVU = 0.71, RUC Reviewed – August 2005, total time= 15 minutes, 000 day global
5. 99231 - Subsequent hospital care, per day, for the evaluation and management of a patient,... (RUC Reviewed Feb 2006, 0.76 RVW, 10 minutes intra, 20 minutes total time, XXX day global)
6. 76817 - Ultrasound, pregnant uterus, real time with image documentation, transvaginal (RUC Reviewed April 2002, 0.75 RVW, 10 intra, 23 total time, XXX day global)

### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

### FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 88112

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology                      How often? Sometimes

Specialty Independent laboratory                      How often? Sometimes

Specialty Urology                      How often? Rarely



Estimate the number of times this service might be provided nationally in a one-year period? 2026790

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare represents approximately 50% of the total utilization. Medicare 2011 global utilization - RUC Database 2013 v1, multiplied by two.

Specialty Pathology	Frequency 950767	Percentage 46.90 %
Specialty Independent laboratory	Frequency 911042	Percentage 44.94 %
Specialty Urology/other	Frequency 164981	Percentage 8.14 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,013,395 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2011 global utilization - RUC Database 2013 v1

Specialty Pathology	Frequency 475384	Percentage 46.91 %
Specialty Clinical Laboratory	Frequency 455521	Percentage 44.94 %
Specialty Urology/other4	Frequency 82490	Percentage 8.13 %

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 88112

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

## SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN			
3	ISSUE: Cytopathology																																										
4	TAB: 33																																										
5						RVW				Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day						FAC-obs				Office					Prolonged								
6	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57			
7	REF	88104	Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation	88	0.023			0.56			24						24																										
8	CURRENT	88112	Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or	31	0.031			1.18			43	8					25			10																							
9	SVY	88112	Cytopathology, selective cellular enhancement technique	194	0.047	0.50	0.56	0.70	0.85	1.50	15						15																										
10	REC	88112	Cytopathology, selective cellular enhancement technique		0.037			0.56			15						15																										
11																																											
12																																											
13																																											
14																																											
15																																											
16																																											



April 1, 2013

Scott Manaker, M.D., Ph.D.  
Chair, Practice Expense Subcommittee  
AMA/Specialty Society Relative Value Update Society  
American Medical Association  
515 North State Street  
Chicago, IL 60654

RE: Current Direct Practice Expense Equipment Inputs - 88112

Dear Doctor Manaker;

While preparing the College of American Pathologists (CAP) practice expense recommendation for CPT code 88112 - *Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal* we noticed an obvious error in the CMS' existing direct practice expense inputs file. The CAP believes this is an important error that should be recognized and understood by the practice expense subcommittee and the RUC. This error may exist with other CPT codes.

You recall that for RUC practice expense recommendations made prior to CPT 2011, the equipment time elements for each equipment item on the practice expense recommendations were determined by CMS staff. The RUC had simply indicated that the equipment was typically used by placing a numerical "1" or "X" on the recommendation spreadsheet or template to indicate the typical use of that equipment item. At its April 2010 meeting, the RUC's practice expense subcommittee discussed and made its recommendation to the RUC for the more detailed equipment recommendation using minutes. This process change was approved by the RUC at the same meeting and specialties now provide the actual number of minutes that the equipment item is used for each service.

The error that currently exists is within CMS' equipment direct practice expense inputs file for 88112. All equipment items for this service are shown as being used for one minute. This is clearly a data input error as it is impossible to perform this service using all of the equipment items for only one minute. Below is the original equipment practice expense RUC recommendation for 88112 which demonstrates the way the RUC previously recommended equipment use to CMS (column 3 labeled "No. of units in practice").

Table from the RUC's 2003 88112 recommendation to CMS

HCFA's Equipment Code*	Procedure Specific Medical Equipment	No. of units in practice	Cost Estimate and Source (if applicable)
No Code	Biohazard hood	1	
E13601	Microscope, compound	1	
E13642	Robotic cover slipper	1	
E13645	Slide etcher	1	

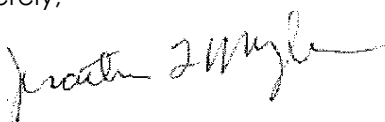
## College of American Pathologists

E13648	Vortex mixer	1	
E13657	Cytology ThinPrep™ Processor	1	
E13644	Slide dryer oven	1	
E13649	Tissue processing fume hood	1	
E91003	Ventilator hood & blower	1	
E13643	Routine Pap stainer	1	

The CAP appreciates the opportunity to correct this error with the refinement of the all of the direct practice expense inputs for 88112 at the April 2013 RUC meeting.

If you have any questions or concerns, please contact, Todd Klemp, Assistant Director of Economic and Regulatory Affairs at (847) 832-7403 or tklemp@cap.org.

Sincerely,



Jonathan L. Myles, MD, FCAP  
RUC Advisor  
College of American Pathologists

cc: Edith Hambrick, MD, JD, CMS  
Sherry Smith, AMA  
Rosa Karbowiak, AMA  
Pam Johnson, CAP Staff  
Todd Klemp, CAP Staff  
Ayanna Wooding, CAP Staff

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor:

Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal

(Do not report 88112 with 88108)

Global Period: XXX Meeting Date: April 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:  
Individuals with expertise in this service were consulted through a series of conference calls in order to develop the typical practice expense inputs. CAP's expert panel reviewed and compiled PE inputs and made adjustments to the clinical labor, supplies, and equipment. These inputs were further refined with individual pathologists who perform this service.
2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale: Current direct inputs for 88112 were used as a reference.
3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time: None greater than standards
4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:
  - Clinical Labor - The total clinical labor time recommended represents a decrease of 22.50 minutes (-38%)
  - Medical Supplies - The typical laboratory processes have changed to reflect greater clinical accuracy and efficiencies, and therefore the array of medical supplies has changed and current input quantities have either decreased or remained the same.
  - Equipment – Current CMS equipment time was incorrectly entered into CMS direct inputs database in 2003. The number of units were entered (1) instead of minutes. At that time the number of minutes for each equipment item were not compiled as they are today. In 2003, PEAC recommendations for equipment were only listed as typically used and the minutes were compiled by CMS. The equipment time minutes currently in CMS' database are clearly in error. Typical time for each equipment item is clearly stated on the spreadsheet.
5. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

**CPT Code: 88112**

**Specialty Society('s) \_\_ College of American Pathologists**

The laboratory technician handles the ordering, restocking, and distribution of specimen containers with requisition forms. A technician also accession the specimen in laboratory information system including the following: Unwrapping and/or remove specimen bottle and requisition slip from plastic bag. Check demographics to ensure they are correct and to ensure proper billing. Check requisition slip against bottle to see if patient name and/or specimen location (s) match each other. Distribute requisition form and specimen to grossing station. Then describes and documents the grossing of the specimen in laboratory information system.

A histotechnologist processes specimen for slide preparation (includes centrifuging, monolayer preparation, slide quality control function, maintaining specimen tracking, logs and labeling). Specifically, during this step, the histotechnologist centrifuges specimen; hand label filters and centrifuge tubes; pour off supernatant; add cytolyte to centrifuge tube; vortex 5 sec; pour specimen into container; hand label purchased slides (paper label will not survive); remove lid from slide capture container; load specimen on processor; load non-gyn filter; load slide; hit start; (2-3 min); remove slide from slide capture container and put in stain rack; clean filter cap with kimwipes; print labels and add label to slide prior to staining, cover slipping.

In addition the histotechnologist then prepares the automated stainer with solutions and loads microscopic slides and sets and confirms the stainer program.

A histotechnologist also prepares the automated coverslipper, removes the slides from stainer and places them on automated coverslipper.

A cytotechnologist confirms the patient ID, organizes work for pathologist, verifies and reviews the specimen/patient history. The cytotechnologist also enters the screening diagnosis in laboratory information system, and completes the workload recording logs and assembles and delivers slides with paperwork to pathologist.

Intra-Service Clinical Labor Activities:

No Clinical Labor Activities

Post-Service Clinical Labor Activities:

A laboratory technician prepares, packs, and transports slides and records for in-house storage and external storage (where applicable). A laboratory technician also disposes of and/or stores remaining specimens, spent chemicals/other consumable, and hazardous waste. A laboratory technician cleans room/grossing area/equipment following procedure (including any equipment maintenance that must be done after the procedure). The laboratory technician also recycles the xylene from the stainer.

A cytotechnologist manages any relevant utilization review/quality assurance activities and regulatory compliance documentation.

	A	B	C	D	E	F	G
1	<b>REVISED - by PE Subcommittee - April 25, 2013</b>			<b>April 2003 RUC Rec</b>			
2				<b>88112</b>		<b>88112 REVISED</b>	
3	Meeting Date: April 2013 Tab: 33 Specialty: Pathology	CMS Code	Staff Type	Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal (Do not report 88112 with 88108)		Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal (Do not report 88112 with 88108)	
4	LOCATION			Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			XXX	XXX	XXX	XXX
6	TOTAL CLINICAL LABOR TIME			60.0	0.0	26.0	0.0
7	Total Time - Lab Technician	L033A	Lab Technician	10.0	0.0	12.0	0.0
8	Total Time - Histotechnologist	L037B	Histotechnologist	23.0	0.0	14.0	0.0
9	Total Time - Cytotechnologist	L045A	Cytotechnologist	27.0	0.0	0.0	0.0
10	TOTAL PRE-SERV CLINICAL LABOR TIME			54.0	0.0	22.0	0.0
11	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			1.0	0.0	0.0	0.0
12	TOTAL POST-SERV CLINICAL LABOR TIME			5.0	0.0	4.0	0.0
13	<b>PRE-SERVICE</b>						
14	<b>Start: Following visit when decision for surgery or procedure made</b>						
15	Prepare specimen containers/preload fixative/label containers/distribute requisition form(s) to physician	L035A	Lab Technician	2			
16	Order, restock, and distribute specimen containers with requisition forms.	L035A	Lab Technician			0	
17	Accession specimen/prepare for examination	L035A	Lab Technician	4			
18	Accession specimen in laboratory information system including the following:Unwrap and/or remove specimen bottle and requisition slip from plastic bag. Check demographics to ensure they are correct and to ensure proper billing. Check requisition slip against bottle to see if patient name and/or specimen location (s) match each other. Distribute requisition form and specimen to grossing station.	L035A	Lab Technician			4	
19	Describe and document gross specimen in laboratory information system	L035A	Lab Technician			2	
20	Perform screening function (where applicable)	L033A	Lab Technician	1			
21	Other Clinical Activity (please specify) Process specimen for slide preparation (includes processing, embedding, sectioning and recuts, staining, coverslipping, quality control function, maintaining specimen tracking, logs and labeling)	L037B	Histotechnologist	23			
22	Other Clinical Activity (please specify) Process specimen for slide preparation (includes,centrifuging, monolayer preparation, slide quality control function, maintaining specimen tracking , logs and labeling).	L037B	Histotechnologist			12	
23	Prepare automated stainer with solutions and load microscopic slides. Set and confirm stainer program.	L037B	Histotechnologist			1	
24	Prepare automated coverslipper, remove slides from stainer and place on coverslipper	L037B	Histotechnologist			1	
25	Other Clinical Activity (please specify): Remove slide from coverslipper; confirm patient ID, organize work, send slides to cytotech for screening.	L033A	Lab Technician			2	
26	Other Clinical Activity (please specify): Retrieve prior material, confirm patient ID, organize work, verify and review history	L045A	Cytotechnologist	8			
27	Perform screening function (where applicable)	L045A	Cytotechnologist	16		0	
28	Other Clinical Activity: <b>(detailed on the two lines below, A+B)</b>	L045A	Cytotechnologist			0	
29	A. Confirm patient ID, organize work, verify and review history	L045A	Cytotechnologist			0	
30	B: Enter screening diagnosis in laboratory information system, complete workload recording logs, manage any relevant utilization review/quality assurance activities and regulatory compliance documentation and assemble and deliver slides with paperwork to pathologist	L045A	Cytotechnologist			0	
31	<b>End: When patient enters office/facility for surgery/procedure</b>						

	A	B	C	D	E	F	G
3	<b>Meeting Date: April 2013</b> <b>Tab: 33</b> <b>Specialty: Pathology</b>	<b>CMS Code</b>	<b>Staff Type</b>	Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal (Do not report 88112 with 88108)		Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal (Do not report 88112 with 88108)	
4	<b>LOCATION</b>			<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>
5	<b>GLOBAL PERIOD</b>			<b>XXX</b>	<b>XXX</b>	<b>XXX</b>	<b>XXX</b>
32	<b>SERVICE PERIOD</b>						
33	<b>Start: When patient enters office/facility for surgery/procedure:</b>						
34	Assemble and deliver slides with paperwork to pathologist	L045A	Cytotechnologist	<b>1</b>			
35	<b>Intra-service</b>						
36	<b>Post-Service</b>						
37	<b>End: Patient leaves office</b>						
38	<b>POST-SERVICE Period</b>						
39	<b>Start: Patient leaves office/facility</b>						
40	Prepare, pack and transport slides and records for in-house storage and external storage (where applicable)	L033A	Lab Technician	<b>1</b>		<b>1</b>	
41	Dispose and/or storage of remaining specimens, spent chemicals/other consumable, and hazardous waste	L033A	Lab Technician	<b>1</b>		<b>1</b>	
42	Clean room/grossing area/equipment following procedure (including any equipment maintenance that must be done after the procedure)	L033A	Lab Technician	<b>1</b>		<b>1</b>	
43	Manage any relevant utilization review/quality assurance activities and regulatory compliance documentation.	L045A	Cytotechnologist	<b>2</b>			
44	Recycle xylene from stainer	L033A	Lab Technician			<b>1</b>	
45	Other Clinical Activity - <i>specify:</i>						
46	<b>End: with last office visit before end of global period</b>						
47	<b>MEDICAL SUPPLIES</b>	<b>CODE</b>	<b>UNIT</b>				
48	biohazard specimen transport bag	SM008	item	1			
49	bleach	SL020	ml	50		<b>50</b>	
50	centrifuge tube	SL024	item	1		<b>1</b>	
51	clearing agent (Histo-clear)	SL026	ml	8			
52	cover slip, glass	SL030	item	2		<b>1</b>	
53	cytology, lysing soln (CytoLyt)	SL039	ml	30		<b>30</b>	
54	cytology, preservative and vial (Preserv-cyt)	SL040	item	1			
55	cytology, specimen filter (Transcyt)	SL041	item	2			
56	cytology, transport prefilled container	SL042	item	1			
57	ThinPrep UroCyte filter	SL256	item			<b>1</b>	
58	ThinPrep UroCyte Urine Collection Kit	SA104	kit			<b>1</b>	
59	eye shield, splash protection	SM016	item	1		<b>1</b>	
60	filter paper, qualitative, 18.5cm	SL065	item	2			
61	gloves, non-sterile	SB022	pair	1		<b>1</b>	
62	lab coat, staff	SB030	item	1			
63	gown, staff, impervious	SB027	item			<b>1</b>	
64	label for microscope slides	SL085	item	2		<b>1</b>	
65	mounting media (Histomount)	SL095	ml	0.4		<b>0.2</b>	
66	pipette, transfer 23ml	SL109	item	2		<b>1</b>	
67	slide specimen mailer (1-5 microscope slides)	SL121	item	1		<b>1</b>	
68	slide, microscope	SL122	item	2			
69	microscopic slide, cytology liquid based preparation	Invoice	item			<b>1</b>	
70	stain, PAP toluidine blue O	SL138	ml	1			
71	stain, hematoxylin	SL135	ml			<b>4</b>	
72	stain, PAP OG-6	invoice	ml			<b>4</b>	
73	stain, PAP EA-50	SL137	ml			<b>4</b>	
74	ethanol 95% 7 changes	SL248	ml			<b>90</b>	
75	xylene 3 changes (10 ml each)	SL151	ml			<b>10</b>	
76	stain, quick differential (5ml per slide)	SL139	ml	5			
77	Courier Transportation costs	invoices and i	item			<b>\$0.00</b>	
78	kimwipes	SM027	item			<b>4</b>	
79	Specimen, solvent, and formalin disposal cost	cost sht/invoices	dollars			<b>0</b>	



	A	B	C	D	E	F	G
3	<b>Meeting Date: April 2013</b> <b>Tab: 33</b> <b>Specialty: Pathology</b>	<b>CMS Code</b>	<b>Staff Type</b>	Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal (Do not report 88112 with 88108)		Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal (Do not report 88112 with 88108)	
4	<b>LOCATION</b>			<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>
5	<b>GLOBAL PERIOD</b>			<b>XXX</b>	<b>XXX</b>	<b>XXX</b>	<b>XXX</b>
80	<b>EQUIPMENT CODE</b>						
81	cytology thinlayer processor (ThinPrep)	EP008		<b>1</b>		<b>5</b>	
82	slide coverslipper, robotic	EP033		<b>1</b>		<b>1</b>	
83	slide etcher-labeler	EP035		<b>1</b>		<b>1</b>	
84	slide stainer, automated, high-volume throughput	EP036		<b>1</b>		<b>8</b>	
85	microscope, compound	EP024		<b>1</b>		<b>23</b>	
86	hood, biohazard	EP016		<b>1</b>		<b>3</b>	
87	hood, fume	EP017		<b>1</b>		<b>1</b>	
88	hood, ventilator with blower	EP019		<b>1</b>			
89	slide dryer	EP034		<b>1</b>			
90	Laboratory Information System with maintenance contract	invoices and info submitted recently				<b>0</b>	
91	Copath System Software	invoices and info submitted recently				<b>0</b>	
92	centrifuge, cytospin	EP044				<b>5</b>	
93	Thin Prep Vortexer	invoice				<b>1</b>	
94	solvent recycling system	EP038				<b>1</b>	

AMA/Specialty Society RVS Update Committee Summary of Recommendations  
*CMS Request Final Rule for 2013*

April 2013

**In Situ Hybridization**

For the NPRM for 2012, CMS received comments that unlike the new FISH codes for urinary tract specimens (88120 and 88121), the existing codes (88365-88368) still allow for multiple units of each code as these codes are reported per probe. CMS stated that they reviewed the current work and practice expense (PE) costs associated with 88120 and 88121 and agree at this time that they are accurate. However, the first 6 months of 2011 claims data were shared with the RUC and CMS requests that additional review of these data be considered to determine if further action is warranted. CMS requested that the RUC review both the direct PE inputs and the work values for codes 88365, 88367 and 88368. The RUC determined that these services should be tabled until January 2012 in order to review 2011 diagnosis claims data from CMS. In January 2012, the RUC reviewed 2011 diagnosis claims data, and the American College of Pathologists indicated that they will develop a CPT Assistant article to direct physicians to use the new FISH codes for urinary tract infections (CPT codes 88120 and 88120). The RUC indicated that the specialty should specify the number of probes utilized for these services in the CPT Assistant article. The RUC recommended that it re-review codes 88365, 88367 and 88368 in 1 year after 2012 utilization is available (January 2013). The RUC agreed with the specialty society to maintain current values, but also recommended reviewing 3 more years of data for CPT codes 88120 and 88121 to determine if utilization has shifted from 88365, 88367 and 88368 to these codes. The RUC recommended resurveying the work and develop PE inputs for 88365, 88367 and 88368 for review at the April 2013 RUC meeting.

In April 2013, the College of American Pathologists (CAP) noted that while preparing to survey these services they discovered that the vignette for 88365 required revision. Additionally, the code descriptors for 88365, 88367 and 88368 required revision to describe the typical practice of these services, such as specifying each separately identifiable antibody, cytologic preparation or hematologic smear as was revised in the recent immunohistochemistry services. **The RUC recommends that CPT codes 88365, 88367 and 88368 be referred to the CPT Editorial Panel for revision.**

<b>CPT Code (●New)</b>	<b>CPT Descriptor</b>	<b>Global Period</b>	<b>Work RVU Recommendation</b>
88365	In situ hybridization (eg, FISH), each probe  (Do not report 88365 in conjunction with 88367, 88368 for the same probe)	XXX	Referral to CPT Editorial Panel
88367	Morphometric analysis, in situ hybridization (quantitative or semi-quantitative) each probe; using computer-assisted technology	XXX	Referral to CPT Editorial Panel
88368	manual  (For morphometric in situ hybridization evaluation of urinary tract cytologic specimens, see 88120, 88121)	XXX	Referral to CPT Editorial Panel

AMA/Specialty Society RVS Update Committee Summary of Recommendations  
*CMS High Expenditure Procedural Codes Screen and CMS Request: Final Rule for 2013*

April 2013

**Psychotherapy for Crisis and Interactive Complexity**

Specific psychotherapy codes were identified through the CMS High Expenditure Procedural codes screen. However, the specialties were already in the process of revising this entire section as indicated from the Fourth Five-Year Review. In April 2012, the specialty societies indicated and the RUC agreed that codes 90785, 90839 and 90840 be carrier priced to allow for education and experience with a significantly different coding structure. This would allow providers to gain experience with the codes prior to conducting a RUC survey. After a year of experience with the new coding structure the specialties would conduct RUC surveys for these services for review of work and direct PE inputs at the April 2013 RUC meeting. In the Final Rule for 2013 CMS assigned interim values to the new psychotherapy codes and indicated that they will re-review all assumptions when they review all recommended values for this family of CPT codes. CMS requested review of the psychotherapy for crisis and interactive complexity codes prior to a review of the work and practice expense of all the new psychology codes. **The RUC reaffirms its April 2012 recommendations for the new psychotherapy codes. The RUC requests that CMS review all the psychotherapy services (all recommendations attached) for consideration in 2014.**

The psychotherapy for crisis codes are timed codes for patients whose presenting problems are typically life threatening and require immediate attention so the crisis is diffused and the safety of the patient and/or others is restored. CPT code 90785 *Interactive complexity* may not be reported with the psychotherapy for crisis codes.

**90839 Psychotherapy for crisis; first 60 minutes**

The RUC reviewed the survey data from 60 adult and child psychiatrists, psychologists and social workers for CPT code 90839 and determined that the median survey work RVU of 3.13 appropriately accounts for the work required to perform this service. The RUC determined that the survey median of 10 minutes pre-service, 60 minutes intra-service and 20 minutes immediate post-service time is appropriate to perform this service. The RUC compared the surveyed code to specialty society survey key reference code 99215 *Evaluation and Management Office Visit* (work RVU = 2.11 and 35 minutes intra-service time) and determined that 90839 requires significantly more time to complete (25 minutes more intra-time), and therefore appropriately requires more physician work to perform. For additional support, the RUC also compared the surveyed service to similar services 99205 *Evaluation and Management office visit, new patient* (work RVU = 3.17 and 45 minutes intra-service time) and 99235 *Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date* (work RVU = 3.24 and 50 minutes intra-service time). The RUC also noted that RUC recommended services 90791 *Psychiatric diagnostic*

*evaluation* (RUC recommended work RVU = 3.00) and 90792 *Psychiatric diagnostic evaluation with medical services* (RUC recommended work RVU = 3.25) require similar work and the same physician times (10 minutes pre-service, 60 minutes intra-service and 20 minutes immediate post-service time). The RUC determined that the recommended physician work and time place this service in the proper rank order relative to codes in the psychotherapy family and other services on the physician payment schedule. **The RUC recommends a work RVU of 3.13 for CPT code 90839.**

**90840 Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)**

The RUC reviewed the survey data from 60 adult and child psychiatrists, psychologists and social workers for CPT code 90840 and determined that the survey 25<sup>th</sup> percentile work RVU of 1.50 appropriately accounts for the work required to perform this service. The RUC determined that 30 minutes intra-service time is appropriate to perform this service. The RUC compared the surveyed code to key reference code 99355 *Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes* (work RVU = 1.77) and determined that 90840 requires similar physician work to perform. For additional support, the RUC also compared the surveyed service to similar service 99215 *Evaluation and Management office visit, established patient* (work RVU = 1.50 and 40 minutes total time) and RUC recommended services 90832 *Psychotherapy, 30 minutes with patient and/or family member* (RUC recommended work RVU = 1.50) and 90833 *Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)* (RUC recommended work RVU = 1.50) and determined that the recommended physician work and time place this service in the proper rank order relative to other services. Finally, the RUC noted that the recommendation for this add-on procedure is accurately valued slightly less than half of the base procedure, 90839, given that 90840 requires half the intra-service time as the base code and does not include any pre-service or immediate post-service work. **The RUC recommends a work RVU of 1.50 for CPT code 90840.**

**90785 Interactive complexity (List separately in addition to the code for primary procedure)**

CPT code 90785 was created to capture additional work that occurs during diagnostic psychiatric evaluation, psychotherapy, psychotherapy performed with an Evaluation and Management service and group psychotherapy sessions. CPT 90785 may only be reported once with one of the nine codes for the aforementioned services. If 90785 is conducted with group therapy it would be reported with only the individual patients that require this additional complexity, not necessarily all patients in the group. This service may not be reported with the psychotherapy for crisis codes or in conjunction with an E/M service when no psychotherapy service is reported.

CPT code 90785 replaces a series of procedures under the old framework describing play services or services that required an interpreter or translator. The new interactive complexity service refers to specific communication factors that complicate the delivery of a psychiatric/psychotherapy procedure. Common factors include more difficult communication with discordant or emotional family members and engagement of young or underdeveloped patients. The interactive complexity code is intended to only capture the increased intensity of work performed and capture post-service time. The RUC noted that this interactive complexity code was created because the CPT Editorial Panel

recognized this as a frequent scenario seen in this specialty, and constant use of a -22 *Increased procedural services* modifier would create an administrative burden. CPT code 90785 replaces a series of add-on codes such as 90802 *Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication* (deleted service), which included interactive complexity, that was not used routinely, but more commonly with children.

The RUC reviewed the survey data from 116 adult and child psychiatrists, psychologists and social workers for CPT code 90785 and determined that the survey 25<sup>th</sup> percentile work RVU of 0.33 appropriately accounts for the physician work to perform this service. The RUC noted that the survey median immediate post-service time of 16 minutes to perform this interactive complexity service was overestimated, therefore the RUC recommends the survey 25<sup>th</sup> percentile of 11 minutes, all reflected in the post-service period. The RUC compared 90785 to the similar services MPC and ZZZ code 95874 *Needle electromyography for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)* (work RVU = 0.37 and total time of 20 minutes); 36400 *Venipuncture, younger than age 3 years, necessitating the skill of a physician or other qualified health care professional, not to be used for routine venipuncture; femoral or jugular vein* (work RVU = 0.38 and total time of 20 minutes); and 36405 *Venipuncture, younger than age 3 years, necessitating the skill of a physician or other qualified health care professional, not to be used for routine venipuncture; scalp vein* (work RVU= 0.31 and total time of 18 minutes) and determined that the recommended physician work and time places this service in the proper rank order relative to other services. **The RUC recommends a work RVU of 0.33 for CPT code 90785.**

#### Practice Expense

The RUC reviewed the direct practice expense inputs submitted by the specialty societies and recommends no modifications.

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
90839	Psychotherapy for crisis; first 60 minutes	XXX	3.13

90840	<p>each additional 30 minutes (List separately in addition to code for primary service)</p> <p>(Use 90840 in conjunction with 90839)</p> <p>(Do not report 90839, 90840 in conjunction with 90791, 90792, psychotherapy codes 90832- 90838 or other psychiatric services, or 90785- 90899 )</p>	ZZZ	1.50
90785	<p>Interactive complexity (List separately in addition to the code for primary procedure)</p> <p>(Use 90785 in conjunction with codes for diagnostic psychiatric evaluation [90791, 90792], psychotherapy [90832, 90834, 90837], psychotherapy when performed with an evaluation and management service [90833, 90836, 90838, 99201- 99255 , 99304- 99337 , 99341-99350 ], and group psychotherapy [90853])</p> <p>(Do not report 90785 in conjunction with 90839, 90840, or in conjunction with E/M services when no psychotherapy service is also reported)</p>	XXX	0.33

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 90839	Tracking Number	Original Specialty Recommended RVU: <b>3.27</b>
		Presented Recommended RVU: <b>3.13</b>
Global Period: XXX		RUC Recommended RVU: <b>3.13</b>

CPT Descriptor: Psychotherapy for crisis; first 60 minutes

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: Psychotherapy for crisis with young adult who has been seen in psychotherapy for depression and is now severely depressed and distraught. The patient expresses suicidal ideation with an imminent plan.

Percentage of Survey Respondents who found Vignette to be Typical: 85%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Triage crisis contact (phone, walk-in, etc.), either through direct qualified healthcare professional contact or through office staff as intermediary; adjust schedule to accommodate emergent visit; review patient records prior to visit.

Description of Intra-Service Work: Review with the patient interval history, including stressors, compliance with psychotherapy assignments, compliance with prescribed medications and assess use of substances. Discuss relevant risk factors for suicide/homicide. Conduct examination, assess current emotional state, assess current emotional risk factors for suicide/homicide (plan, means, safety plan, etc), as well as protective factors (religious prohibitions, supports available, etc.). Assess competence of individual's decision-making and ability to follow through with decisions. A standardized screening tool may be administered, if indicated. Consider safety and other determinants for psychotherapeutic intervention and safety planning as well as discussion and consideration of hospitalization and review rationale, risks, benefits and alternatives for plan. Offer recommendations, maintain patient safety during the session, discussion of follow-up services with family, including possible hospitalization or involuntary commitment petition. Involve significant others during intervention as necessary (could be at any or all of the above intervention points).

Description of Post-Service Work: Complete mandated paperwork as necessary. Document services and coordinate care with patient's other health care professionals, as appropriate, including phone calls and making arrangements for disposition.



**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Jeremy Musher, MD, Sherry Barron-Seabrook, MD, James Georgoulakis, PhD, Doris Tomer, LCSW				
<b>Specialty(s):</b>	American Psychiatric Association, American Academy of Child/Adolescent Psychiatry, American Psychological Association Practice Organization, National Association of Social Workers				
<b>CPT Code:</b>	90839				
<b>Sample Size:</b>	1768	<b>Resp N:</b>	60	<b>Response:</b> 3.3 %	
<b>Description of Sample:</b>	Random Sample - Each organization sent the 90839 and 90840 to approximately 500 randomly selected members				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	1.00	3.00	11.00	46.00
<b>Survey RVW:</b>	0.25	2.54	3.13	3.53	5.00
<b>Pre-Service Evaluation Time:</b>			10.00		
<b>Pre-Service Positioning Time:</b>			0.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.00		
<b>Intra-Service Time:</b>	0.00	40.00	60.00	60.00	120.00
<b>Immediate Post Service-Time:</b>	<b>20.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

<b>CPT Code:</b>	90839	<b>Recommended Physician Work RVU: 3.13</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		10.00	0.00	10.00
<b>Pre-Service Positioning Time:</b>		0.00	0.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	0.00	0.00
<b>Intra-Service Time:</b>		60.00		
<b>Immediate Post Service-Time:</b>	<b>20.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

<b>Sub Obs Care:</b>	<b>0.00</b>	99224x <b>0.00</b>	99225x <b>0.00</b>	99226x <b>0.00</b>
----------------------	-------------	--------------------	--------------------	--------------------

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? Yes

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99215	XXX	2.11	RUC Time

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Medicare Utilization</u>
99327	XXX	3.46	RUC Time	42,638

CPT Descriptor 1 Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Typically, 60 minutes are spent with the patient and/or family or caregiver.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Medicare Utilization</u>
99337	XXX	3.58	RUC Time	209,629

CPT Descriptor 2 Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent with the patient and/or family or caregiver.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99220	XXX	3.56	RUC Time

CPT Descriptor Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 19      % of respondents: 31.6 %**

<b><u>TIME ESTIMATES (Median)</u></b>	<b>CPT Code: 90839</b>	<b>Key Reference CPT Code: 99215</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	10.00	5.00	
Median Intra-Service Time	60.00	35.00	
Median Immediate Post-service Time	20.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
<b>Median Total Time</b>	<b>90.00</b>	<b>55.00</b>	
<b>Other time if appropriate</b>			

**INTENSITY/COMPLEXITY MEASURES (Mean)**      **(of those that selected Key Reference code)**

**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.79	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.58	3.61
Urgency of medical decision making	4.89	3.83

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.21	3.56
Physical effort required	2.53	2.17

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.68	3.61
Outcome depends on the skill and judgment of physician	4.47	3.83
Estimated risk of malpractice suit with poor outcome	4.05	3.00

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.74	2.41
Intra-Service intensity/complexity	4.58	4.06
Post-Service intensity/complexity	4.05	3.00

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background and CPT Definition**

90839 is a new CPT code, describing work that was not previously identified by a separate CPT code. Introductory language in CPT states:

*“Psychotherapy for crisis is an urgent assessment and history of a crisis state, a mental status exam, and a disposition. The treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma. The presenting problem is typically life threatening or complex and requires immediate attention to a patient in high distress.”*

The service is billed based on the total duration of the face-to-face time with the patient and/or family and the patient must be present for all or some of the service. The physician or other qualified Health care professional must devote his or her full attention to the patient during this visit and cannot provide services to any other patients during the same period of time.

**Survey process**

The American Psychiatric Association (APA), American Academy of Child and Adolescent Psychiatry (AACAP), American Psychological Association Practice Organization (APAPO), and National Association of Social Workers (NASW): conducted a random survey of 90839. Each society sent surveys to roughly five hundred of their member psychiatrists (APA and AACAP members), psychologists (APAPO members) and clinical social workers (NASW members).

At the suggestion of the Research Subcommittee, one reference service list was developed and approved for use with CPT 90839, 90840, and 90785. Modifications to the survey tool were also approved by the research committee, primarily consisting of changes related to the provider types for clarity to the different provider types taking the survey.

**Analysis and recommendations from the expert panel**

The specialty societies convened a joint society expert panel with broad representation from each group to review the survey data and make recommendations.

The expert panel reviewed the number of responses, the typicality of the vignette and the service performance rate. Of the 60 survey respondents, 85 percent found the vignette to be typical. The panel believes that the performance rate is reasonable in that this is a service that would not be reported frequently unless the focus of the practice was on crisis care. The expert panel believes that psychologists and clinical social workers will be reporting the large majority of these CPT codes. While psychiatrists will be using this on occasion (we project 6 percent of the time), the panel

believes that psychiatrists will be more likely to bill this encounter using an evaluation and management code along with a psychotherapy add-on code. There were a number of individuals who indicated they had not performed the service within the past year (entered 0 for performance rate of survey code). Attached with the typical RUC summary format we have provided the “perform” versus “did not perform” on the total data set. In general, those who reported they did not perform the service valued it lower than those who stated they did perform the service and therefore were familiar with it. Staff from NASW noted that a number of the randomly selected survey participants contacted them by email or phone to decline from participating in the survey process. The most frequently cited reasons for not completing the survey were: there were no codes on the RSL they were familiar with or billed; they had a financial conflict as owners of their practice; and they were not familiar enough with the new codes to adequately respond to the questions being asked, since it was a new CPT code. The expert panel agreed to keep the survey open a week longer than anticipated to allow NASW to send reminders in hopes to get the volumes from these providers more in line with the projected utilization by specialty. This extension yielded a few more responses from the clinical social workers, not, however, enough to satisfy the expert panel. Therefore, the expert panel requested another analysis be run using the weighted projections of 6 percent psychiatrists, 47 percent psychologists, and 47 percent clinical social workers. Those values are provided in the RUC summary format with this submission.

### Time

The expert panel reviewed the survey times and agreed the median survey times of 10 minutes pre-service, 60 minutes of intra-service, and 20 minutes of post-service time appropriately represent the time for the service. The pre-service time includes speaking to the patient and/or family, arranging for an emergency appointment, and reviewing the patient’s medical record. The intra-service time includes time spent evaluating the patient including assessing risk factors and competence, consider safety and risks, benefits and treatment options (including hospitalization when appropriate). Work includes maintaining the safety of the patient while making arrangements and involving others as necessary. Face-to-face time during the intra service period includes time with the patient and time with family member(s) and does not include time spent coordinating care when neither the patient nor the family are present. The post-service time of 20 minutes includes arranging for further services (e.g., hospitalization, contact with the police regarding an involuntary commitment), other necessary phone calls and documenting the encounter. This work is typically performed by the physician or other qualified health care professional due to a lack of clinical staff support.

### RVW

Thirty-one percent of the survey respondents chose 99215, *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family, (5, 35, 15; RVW 2.11)* with a total time of 55 minutes, as the key reference service (99205 was the second most chosen reference service with 23% selecting that code). In addition to a significantly longer total time, a review of the intensity and complexity measures shows that the respondents found the surveyed code to be greater in intensity/complexity for all of the areas of comparison except for one (amount/complexity of data for review). The differential was greatest for the measure tied to urgency of decision making and risk of complications, morbidity and mortality. Patients seen for crisis services are in acute distress requiring decision making at a high level. These patients are unstable and often require admission to a hospital (at times involuntarily) or the implementation of a safety plan that includes coordination with family or others. The expert panel agrees that the time and intensity of the work is greater for the 90839 than that of the 99215.

In looking at other services the expert panel compared the surveyed code to 99337, *Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically 60 minutes are spent with the patient and/or family or caregiver (15, 60, 20; RVW 3.58)*, which is similar in time and intensity. Additional comparisons were made to 99220, *Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of*

*the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of high severity. Typically 70 minutes are spent at the bedside and on the patient's hospital floor or unit (15, 45, 15; 3.56) and to 99327, Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Typically 60 minutes are spent with the patient and/or family or caregiver (15, 60, 25; RVW 3.46). The expert panel agreed both of these comparison services are similar in time and intensity to the surveyed code 90839, therefore supporting a value higher than the unweighted median value. All three of the comparison codes describe services provided to patients presenting with problems that are of high severity and require urgent attention.*

## Recommendation

**In summary, based on comparisons to the key reference code, MPC codes, and other reference codes, we recommend the median RVW of 3.13, and median times of 10 minutes pre-, 60 minutes intra-, and 20 minutes post-time for a total time of 90 minutes for the 90839.**

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. This code is a base code for the 90840 add-on code; there is insufficient experience to know how frequently the 90839 will be billed with the 90840. Both codes are being reviewed at this meeting. The following table provides information based on the specialty societies recommended values:

CPT code	Global	Rec RVW	Pre	Intra	Post
90839	XXX	3.27 10 min	60 min	20 min	
90840	ZZZ	1.97 0 min	30 min	0 min	
Combined service		5.24 10 min	90 min	20 min	

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) This was likely reported previously as a 90808, 90809 or a 99215

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Psychiatry                      How often? Sometimes

Specialty Psychology                      How often? Commonly

Specialty Social Work

How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 9588

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This was based on the previous utilization using the Medicare claims data and adjusting for the volume of non-Medicare services.

Specialty Psychiatry	Frequency 576	Percentage 6.00 %
Specialty Psychology	Frequency 4507	Percentage 47.00 %
Specialty Social Work	Frequency 4507	Percentage 47.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3,196

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This was based on the previous utilization using the Medicare claims data

Specialty Psychiatry	Frequency 192	Percentage 6.00 %
Specialty Psychology	Frequency 1503	Percentage 47.02 %
Specialty Social Work	Frequency 1503	Percentage 47.02 %

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 90837

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 90840	Tracking Number	Original Specialty Recommended RVU: <b>1.97</b>
		Presented Recommended RVU: <b>1.50</b>
Global Period: ZZZ		RUC Recommended RVU: <b>1.50</b>

CPT Descriptor: Psychotherapy for crisis, each additional 30 minutes (List separately in addition to code for primary service)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: Psychotherapy for crisis with young adult who has been seen in psychotherapy for depression and is now severely depressed and distraught. The patient expresses suicidal ideation with an imminent plan. Patient disclosed late in the session they had been sexually assaulted recently.

Percentage of Survey Respondents who found Vignette to be Typical: 82%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

**Description of Pre-Service Work: (captured in primary procedure)**

Description of Intra-Service Work: Continuation of 99239 intra-service work until resolution achieved. Review with the patient interval history, including stressors, compliance with psychotherapy assignments, compliance with prescribed medications and assess use of substances. Discuss relevant risk factors for suicide/homicide. Conduct examination, assess current emotional state, assess current emotional risk factors for suicide/homicide (plan, means, safety plan, etc), as well as protective factors (religious prohibitions, supports available, etc.). Assess competence of individual's decision-making and ability to follow through with decisions. A standardized screening tool may be administered, if indicated. Consider safety and other determinants for psychotherapeutic intervention and safety planning as well as discussion and consideration of hospitalization and review rationale, risks, benefits and alternatives for plan. Offer recommendations, maintain patient safety during the session, discussion of follow-up services with family, including possible hospitalization or involuntary commitment petition. Involve significant others during intervention as necessary (could be at any or all of the above intervention points).

**Description of Post-Service Work: (captured in primary procedure)**



**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Jeremy Musher, MD, Sherry Barron-Seabrook, MD, James Georgoulakis, PhD, Doris Tomer, LCSW				
<b>Specialty(s):</b>	American Psychiatric Association, American Academy of Child/Adolescent Psychiatry, American Psychological Association Practice Organization, National Association of Social Workers				
<b>CPT Code:</b>	90840				
<b>Sample Size:</b>	1768	<b>Resp N:</b>	60	<b>Response:</b> 3.3 %	
<b>Description of Sample:</b>	Random Sample - Each organization sent the 90839 and 90840 to 500 randomly selected members				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	0.00	2.00	6.00	180.00
<b>Survey RVW:</b>	0.00	1.50	1.95	2.21	4.00
<b>Pre-Service Evaluation Time:</b>			0.00		
<b>Pre-Service Positioning Time:</b>			0.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.00		
<b>Intra-Service Time:</b>	10.00	30.00	30.00	40.00	120.00
<b>Immediate Post Service-Time:</b>	<u>0.00</u>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

<b>CPT Code:</b>	90840	<b>Recommended Physician Work RVU: 1.50</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		0.00	0.00	0.00
<b>Pre-Service Positioning Time:</b>		0.00	0.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	0.00	0.00
<b>Intra-Service Time:</b>		30.00		
<b>Immediate Post Service-Time:</b>	<u>0.00</u>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00

<b>Sub Obs Care:</b>	<b>0.00</b>	99224x <b>0.00</b>	99225x <b>0.00</b>	99226x <b>0.00</b>
----------------------	-------------	--------------------	--------------------	--------------------

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? Yes

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99355	ZZZ	1.77	RUC Time

CPT Descriptor Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (List separately in addition to code for prolonged service)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99292	ZZZ	2.25	RUC Time	434,114

CPT Descriptor 1 Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
93464	XXX	1.80	RUC Time

CPT Descriptor Physiologic exercise study (eg, bicycle or arm ergometry) including assessing hemodynamic measurements before and after (List separately in addition to code for primary procedure)

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code:** 14      **% of respondents:** 23.3 %

**TIME ESTIMATES (Median)**

	<b>CPT Code:</b> <b>90840</b>	<b>Key Reference CPT Code:</b> <b>99355</b>	<b>Source of Time</b> <b>RUC Time</b>
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	30.00	30.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>30.00</b>	<b>30.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.93
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.57	3.71
--	------	------

Urgency of medical decision making	4.79	4.31
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.50	4.21
--------------------------	------	------

Physical effort required	2.93	2.93
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.57	4.14
---	------	------

Outcome depends on the skill and judgment of physician	4.64	4.29
--	------	------

Estimated risk of malpractice suit with poor outcome	4.46	4.08
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	0.00	0.00
----------------------------------	------	------

Intra-Service intensity/complexity	4.57	4.57
------------------------------------	------	------

Post-Service intensity/complexity	0.00	0.00
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

CPT 90840 is a new add-on code similar to the prolonged service code that captures additional time when providing extension services. This code is billed beginning at the 75<sup>th</sup> minute of the extended service. The 90839 and 90840 are billed on the total time of the face-to-face portion (with patient and/or family members) of the visit and the patient must be present for all or some of the service. The physician or other qualified health care professional must devote his or her full attention to the patient during this visit and cannot provide services to any other patients during the same period of time.

### **Survey process**

The American Psychiatric Association (APA), American Academy of Child and Adolescent Psychiatry (AACAP), American Psychological Association Practice Organization (APAPO), and National Association of Social Workers (NASW): conducted a random survey of 90840. All societies sent surveys to roughly five hundred each randomly selected psychiatrists (APA and AACAP members), psychologists (APAPO members) and clinical social workers (NASW members).

At the suggestion of the research subcommittee, one reference service list was developed and approved for use with CPT 90839, 90840 and 90785. Modifications to the survey tool were also approved by the research committee, primarily consisting of changes related to the provider types for clarity to the different provider types taking the survey.

### **Analysis and recommendations from the expert panel**

The specialty societies convened a joint society expert panel with broad representation from each group to review the survey data and make recommendations.

The expert panel reviewed the number of responses, the typicality of the vignette and the service performance rate. Of the 60 survey respondents, 82 percent found the vignette to be typical. The panel believes that the performance rate is reasonable in that the primary service is one that would not be reported frequently and this add-on even less so. The expert panel believes that psychologists and clinical social workers will be reporting the large majority of these CPT codes. While psychiatrists will be using this on occasion (we project 6 percent of the time), the panel believes that psychiatrists will be more likely to bill this encounter using an evaluation and management code along with a psychotherapy add-on code. There were a number of individuals who indicated they had not performed the service within the past year (entered 0 for performance rate of survey code). As with the 90839 service, attached with the typical RUC summary format we provided the “perform” versus “did not perform” on the total data set. In general, those who reported they did not perform the service valued it lower than those who stated they did perform the service and therefore were familiar with it. Therefore, the expert panel requested another analysis be run using the weighted projections of 6 percent psychiatrists, 47 percent psychologists, and 47 percent clinical social workers. Those values are provided in the RUC summary format with this submission.

### **Time**

The expert panel reviewed the survey times and agreed the median survey times of 0 minutes pre-service, 30 minutes of intra-service, and 0 minutes of post-service time appropriately represent the time for this extension service to 90839, when performed.

### **Recommendation**

**In summary, based on comparisons to the reference code and other services, we recommend the 25<sup>th</sup> percentile RVW of 1.50, and median times of 0 minutes pre, 30 minutes intra, and 0 minutes post time for a total time of 30 minutes for the 90840.**

## **SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. This code is an add-on code that is reported with 90839 to report time beyond the first hour (beginning on the 75<sup>th</sup> minute). There is insufficient experience to know how frequently the 90839 will be billed with the 90840. Both codes are being reviewed at this meeting. The following table provides information based on the specialty societies recommended values:

CPT code	Global	Rec RVW	Pre	Intra	Post
90839	XXX	3.27 10 min	60 min	20 min	
90840	ZZZ	1.97 0 min	30 min	0 min	
Combined service		5.24 10 min	90 min	20 min	

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) This was likely reported as a 90808, 90809 or a 99215

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Psychiatry                      How often? Sometimes

Specialty Psychology                      How often? Commonly

Specialty Social Work                      How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 3198

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This is based on the previous utilization using the Medicare claims data and adjusting for the volume of non-Medicare services.

Specialty Psychiatry	Frequency 192	Percentage 6.00 %
Specialty Psychology	Frequency 1503	Percentage 46.99 %
Specialty Social Work	Frequency 1503	Percentage 46.99 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,066

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is based on the previous utilization using the Medicare claims data.

Specialty Psychiatry	Frequency 64	Percentage 6.00 %
Specialty Psychology	Frequency 501	Percentage 46.99 %
Specialty Social Work	Frequency 501	Percentage 46.99 %

Do many physicians perform this service across the United States? Yes

---

**Professional Liability Insurance Information (PLI)**

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 90833

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 90785	Tracking Number	Original Specialty Recommended RVU: <b>0.33</b>
		Presented Recommended RVU: <b>0.33</b>
Global Period: ZZZ		RUC Recommended RVU: <b>0.33</b>

CPT Descriptor: Interactive complexity (List separately in addition to the code for primary procedure)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey:

1. Psychotherapy for an older elementary school-aged child accompanied by divorced parents, reporting declining grades, temper outbursts, and bedtime difficulties. Parents are extremely anxious and repeatedly ask questions about the treatment process. Each parent continually challenges the other's observations of the patient.
2. A widowed white male presents for an evaluation of depressed mood and new onset of memory and other cognitive disturbance which makes you question his decision making capacity. He comes to the office with two of his children, a daughter who lives close by and a son who lives at some distance and visits infrequently. He requests they both be present during the interview. Throughout the interview the son and daughter become angry and upset with each other, often providing contradictory history and disrupting the flow of the interview. Additional effort is required to obtain an accurate history and to control the emotional tone of the interview.
3. A widow who suffers from chronic mild to moderate depression and anxiety is being seen for psychotherapy. She struggles with her increasing physical limitations and is contemplating a move into an Assisted Living Facility. During the course of the current visit the patient discloses information that clearly indicates she has recently been the victim of elder abuse by a neighbor. You spend additional effort discussing your obligations under state statutes to report this as elder abuse and initiate this process.
4. Follow-up visit for 4 year old established patient with ADHD, severe oppositional and aggressive behaviors on stimulant. Mother reports mild improvement but oppositional and aggressive behaviors persist. Parents are more consistent with behavioral program. Psychotherapy using therapeutic games is provided to the child to teach cooperative behaviors.

Percentage of Survey Respondents who found Vignette to be Typical: 79%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

**Description of Pre-Service Work:**

Description of Intra-Service Work: Increased intensity of work is performed in order to manage the anxiety, maladaptive communications, emotional reactivity and conflict of the other participants present during the session with active and repeated redirection back to focus on the treatment of the patient's symptoms, strengths, deficits, and treatment needs. Engage the patient through therapeutic play which requires additional work and skills, when play therapy is provided

Description of Post-Service Work: Document the nature of the interactive work, communicate with participants and others between sessions to ensure treatment plan is implemented. Put away play materials, when play therapy is provided.



**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Jeremy Musher, MD, Sherry Barron-Seabrook, MD, James Georgoulakis, PhD, Doris Tomer, LCSW				
<b>Specialty(s):</b>	American Psychiatric Association, American Academy of Child/Adolescent Psychiatry, American Psychological Association Practice Organization, National Association of Social Workers				
<b>CPT Code:</b>	90785				
<b>Sample Size:</b>	389	<b>Resp N:</b>	116	<b>Response:</b> 29.8 %	
<b>Description of Sample:</b>	The Research Subcommittee approved a follow-up survey which was sent to all of the psychiatrists, psychologists and social workers who submitted RVU recommendations as part of a 2012 RUC survey of the primary services with which this code will be billed.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	0.00	<b>10.00</b>	35.00	3000.00
<b>Survey RVW:</b>	0.00	0.33	<b>0.52</b>	1.00	3.16
<b>Pre-Service Evaluation Time:</b>			<b>11.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>0.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>0.00</b>		
<b>Intra-Service Time:</b>			<b>0.00</b>		
<b>Immediate Post Service-Time:</b>	<b>16.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

ZZZ Global Code

<b>CPT Code:</b>	90785	<b>Recommended Physician Work RVU: 0.33</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		0.00	0.00	0.00
<b>Pre-Service Positioning Time:</b>		0.00	0.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	0.00	0.00
<b>Intra-Service Time:</b>		0.00		
<b>Immediate Post Service-Time:</b>	<b>11.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		

<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? Yes

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
NA		0.00	

CPT Descriptor See "Attachment B - RUC Summary of 2013 Data with Details" for info on Key Reference Service**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
95874	ZZZ	0.37	RUC Time	56,504
<u>CPT Descriptor 1</u> Needle electromyography for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
-----------------------	---------------	-----------------	--------------------	---

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
36400	XXX	0.38	RUC Time

CPT Descriptor Venipuncture, younger than age 3 years, necessitating the skill of a physician or other qualified health care professional, not to be used for routine venipuncture; femoral or jugular vein**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.****Number of respondents who choose Key Reference Code:** 47 **% of respondents:** 40.5 %**TIME ESTIMATES (Median)**

	<b>CPT Code:</b> <b>90785</b>	<b>Key Reference CPT Code:</b> <u>NA</u>	<b>Source of Time</b>
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	0.00	0.00	
Median Immediate Post-service Time	11.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>11.00</b>	<b>0.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered		
--	--	--

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed		
--	--	--

Urgency of medical decision making		
------------------------------------	--	--

**Technical Skill/Physical Effort (Mean)**

Technical skill required		
--------------------------	--	--

Physical effort required		
--------------------------	--	--

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality		
---	--	--

Outcome depends on the skill and judgment of physician		
--	--	--

Estimated risk of malpractice suit with poor outcome		
--	--	--

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity		
----------------------------------	--	--

Intra-Service intensity/complexity		
------------------------------------	--	--

Post-Service intensity/complexity		
-----------------------------------	--	--

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**See Attachments C and D for the 9 code comparisons of the intensity complexity measures. Attachment C is the 2013 survey data; attachment D is the 2012 survey data.**

### **CPT Background**

Interactive complexity (IC) is a new/revised service, which in some instances was previously reported using the following stand-alone codes: Interactive psychiatric diagnostic interview examination (90802); Individual psychotherapy, interactive in the office setting (90810, 90811, 90812, 90813, 90814, 90815); Individual psychotherapy, interactive in the inpatient setting (90823, 90824, 90826, 90827, 90828, 90829); and Interactive group psychotherapy (90857). The new IC add-on code can be used along with the following primary procedures: diagnostic evaluation codes (90791, 90792), the psychotherapy XXX and ZZZ codes (90832-90838) and the group psychotherapy code (90853). Its definition of work has been expanded from that of the previously reported stand-alone codes.

### ***From CPT 2013***

Interactive complexity refers to specific communication factors that complicate the delivery of a psychiatric procedure. Common factors include more difficult communication with discordant or emotional family members and engagement of young and verbally undeveloped or impaired patients. Typical patients are those who have third parties, such as parents, guardians, other family members, interpreters, language translators, agencies, court officers, or schools involved in their psychiatric care.

These factors are typically present with patients who:

- Have other individuals legally responsible for their care, such as minors or adults with guardians, or
- Request others to be involved in their care during the visit, such as adults accompanied by one or more participating family members or interpreter or language translator, or
- Require the involvement of other third parties, such as child welfare agencies, parole or probation officers, or schools.

Psychiatric procedures may be reported “with interactive complexity” when at least one of the following is present:

1. The need to manage maladaptive communication (related to, e.g., high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicates delivery of care.
2. Caregiver emotions or behavior that interferes with the caregiver’s understanding and ability to assist in the implementation of the treatment plan.
3. Evidence or disclosure of a sentinel event and mandated report to third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.
4. Use of play equipment, other physical devices, interpreter, or translator to communicate with the patient to overcome barriers to therapeutic or diagnostic interaction between the physician or other qualified health care professional and a patient who:
  - Is not fluent in the same language as the physician or other qualified health care professional, or
  - Has not developed, or has lost, either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the physician or other qualified health care professional if he/she were to use typical language for communication.

### **Survey process**

The RUC Research Subcommittee approved a follow-up modified survey tool to be sent to individuals who had previously participated in the 2012 RUC surveys on the diagnostic and psychotherapy (individual and group) CPT codes. The participants were provided with their 2012 responses to the work RVW estimates for each surveyed code and were asked to provide work RVW recommendation(s) for the same service(s) when IC was added to the primary procedure. From this point forward we will refer to this as the “combined” service. Additionally, participants were asked to select a reference service from the research approved Reference Service List (RSL) keeping in mind the “combined” service and then asked to compare the “combined” service to the RS code chosen.

In addition, the Research Subcommittee approved the inclusion of 4 vignettes: the vignette originally approved by the CPT Editorial panel and three additional vignettes, each one based on a unique instance of IC as described in the CPT introductory language. With Research's approval, an additional question was added asking participants to identify which of the four vignettes would be the most typical IC encounter. Given the recent expansion of what is included in the definition of IC, it was unclear if the typical service was going to continue to be play therapy. Responses to this additional question allowed us to better understand the use of the code.

Finally, the Research Subcommittee approved a revised PowerPoint, consistent with this modified survey tool and approved an AMA proctored webinar, which was recorded and available for participants as they completed the survey.

### Explanation of Data Included in RUC Packet

The table titled "**Attachment A - Psychiatry Family Summary of 2011-2013**" provides information regarding all of the values associated with the codes that have been reviewed and under discussion since 2010. It includes the RUC recommended values from the 2012 survey, the values recommended by the survey participants for each service when it included IC (both the 25<sup>th</sup> percentile and the median) from the 2013 survey, and the interim values assigned by CMS in an effort to maintain budget neutrality for CY 2013. Finally, the table provides information on the RUC approved and CMS interim and final times.

In addition, we have supplied the typical RUC summary, titled "**Attachment B - RUC Summary of 2013 Data with Details**," which includes the total summary information (derived as described below, see note), the total breakdown of responses by physicians/psychologists/clinical social workers, as well as by those who indicated they had performed versus not performed the service in the past year. The tables in attachment B also contain code-by-code details of the 9 primary procedures when performed with IC, and the key reference service code chosen for each code with IC. NOTE: To determine the RVW for add-on code 90785 we took the survey data for the "combined" service (the primary procedure when performed with IC) and then subtracted the 2012 values for the primary procedure to determine the value of the IC for each code. We used the IC values from all 9 primary procedures to determine the median and 25<sup>th</sup> percentile for 90785 noted in Attachment A.

Finally, we have provided summary information on the responses to the intensity and complexity measures for the Key Reference Service chosen for each individual code. We provide the intensity and complexity responses for the 2013 data in **Attachment C** and for the 2012 data in **Attachment D** for comparison. We did not provide intensity and complexity measures for the key reference service selected (99215) since this would blend responses for more than one procedure (psychiatric diagnostic evaluation and psychotherapy services).

### Analysis and recommendations from the expert panel

The societies involved in this survey convened a joint society expert panel with broad representation from each group to review the survey data and make recommendations. A number of tables in addition to the RUC summary table have been developed in an effort to present the information collected through this survey in a clear and concise way. References to specific tables will be made throughout this discussion. To differentiate between survey responses, the years (i.e., 2012, 2013) have been added to the table headers. We will mirror that in the discussion that follows. We have also included CMS's interim values since they have not yet finalized any of the work values and some of the physician time inputs.

The expert panel reviewed the level of participation and responses to the questions about the typical patient and typical type of IC. There were a total of 116 individual respondents. Seventy-nine percent of the respondents found at least one of the vignettes typical. Responses to the follow-up question as to which vignette was typical are displayed in the chart below. Thirty percent of the respondents identified vignette number 2 "caregiver emotions or behavior that interferes with care and the need to manage maladaptive communication" – as typical.

Typical Patient Choice	Response	Percentage
<b>Patient 1:</b> The need to manage maladaptive communication (related to, eg, high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicates delivery of care.	27	23%
<b>Patient 2:</b> Caregiver emotions or behavior that interferes with the caregiver's understanding and ability to assist in the implementation of the treatment plan.	35	30%
<b>Patient 3:</b> Evidence or disclosure of a sentinel event and mandated report to third	19	16%

party (eg, abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.		
<b>Patient 4:</b> Use of play equipment, other physical devices, interpreter, or translator to communicate with the patient to overcome barriers to therapeutic or diagnostic interaction between the physician or other qualified health care professional and a patient who: <ul style="list-style-type: none"> <li>Is not fluent in the same language as the physician or other qualified health care professional, or</li> <li>Has not developed, or has lost, either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive</li> </ul>	10	9%
<b>Total Completed</b>	<b>116</b>	<b>100%</b>

The panel noted that of those respondents who said the vignettes were not typical several did so because the age range differed from their typical patient or they find that more than one IC condition is met during the typical session.

### Time

We included questions regarding pre- and post-service time for this service to better understand the time of the work involved. This add-on code has no separate intra-service time; it describes the increased intensity of the work during the delivery of the primary procedure, not additional intra-service time.

The median pre-service time for all codes (when totaled together, see discussion of the data noted earlier) is 11 minutes and the median post-service time for all codes is 16 minutes. The expert panel agrees with the respondents who said there is additional work beyond that captured in the pre- and post-service work of the primary service. The panel believes that while there may be some pre-service work occurring on occasion (typically with play therapy and the set-up of the materials), it would be typical in each instance of IC to have additional post-service time. This would include additional documentation, and the need for telephone calls between visits with family or others (i.e., schools, police, etc.). **The expert panel therefore supports the median survey post-service time of 16 minutes**, which would account for the additional time necessary to prepare and clean up any play therapy materials as well as the time spent documenting and providing appropriate follow-up care.

### RVW

The expert panel reviewed the survey data from both the 2012 survey data and the 2013 survey data for the “combined” services. They believe the “combined” data from the 2013 survey compared to the previous RUC approved values supports the 2012 RUC recommendations. The expert panel believes the median RVW (2013 survey) value for IC alone of 0.52 is overstated; based on the panel’s expert opinion the 25<sup>th</sup> percentile at 0.33 is more representative of the service. The panel believes that the interim value assigned by CMS of 0.11, which is not based on any survey, understates the work involved.

The panel then reviewed the RUC recommendations for each of the individual codes, comparing the RUC approved value to the 25<sup>th</sup> and median values from the 2013 “combined” survey results. In general, they found either the 25<sup>th</sup> or between the 25<sup>th</sup> and the median supported the RUC recommended values from the 2012 survey. For example, the “combined” results for the 90791 show a service with IC at 3.34 RVWs which is 0.34 more than the RUC approved value of 3.00 RVWs for a service without IC, supporting a value for IC in the 25<sup>th</sup> percentile level. As with averaging of any service there will be some that appear somewhat high and others that are somewhat low, but in general the 0.33 RVW maintains rank order.

The expert panel searched the CPT book to identify services that were the same, yet for another reason, such as age of the patient, the services had separate codes that share the same intra-time and were valued differently. Unfortunately our searches led us to widely different work values for services that did not seem to relate well to the IC service. We remain open to consideration of these types of services as comparisons, however at this point we have none to offer the RUC.

There are no codes in the RUC database with RUC approved values that do not have any intra-service time. There are no codes that have 0 pre, 0 intra, and 16 minutes of post-service time. A review of services with a global ZZZ was too limiting in that most ZZZ services have only intra time or mostly intra time. Therefore, the expert panel expanded our search to global ZZZ, XXX and 000 services that had a similar total time in an effort to assess relativity. For comparison, we offer MPC and ZZZ code 95874, *Needle electromyography for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)* with an RVW of 0.37 and a total time of 20 minutes and 36400, *Venipuncture, younger than age 3 years, necessitating the skill of a physician or other qualified health care professional, not to be used for routine venipuncture; femoral or jugular vein*; with an RVW of 0.38 and a total time of 20 minutes and 36405, *Venipuncture, younger than age 3 years, necessitating the skill of a physician or other qualified health care professional, not to be used for routine venipuncture; scalp vein* with an RVW of 0.31 and a total time of 18 minutes

### Recommendation

**In summary, based on the comparisons noted, our expert panel, recommends the 25<sup>th</sup> percentile RVW of 0.33 and times of 0 minutes pre, 0 minutes intra, and 16 minutes post time, for a total time of 16 minutes for 90785.**

### SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. SEE TABLE TITLED "SERVICES REPORTED WITH MULTIPLE CPT CODES" BELOW THE PLI INFO

### FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 90802, 90810, 90811, 90812, 90813, 90814, 90815, 90823, 90824, 90826, 90827, 90828, 90829, and 90857

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Psychiatry	How often? Sometimes
Specialty Psychology	How often? Sometimes
Specialty Social Work	How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 235047

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This is based on the previous utilization using the Medicare claims data and adjusting for the volume of non-Medicare services.

Specialty Psychiatry	Frequency 61113	Percentage 26.00 %
Specialty Psychology	Frequency 56412	Percentage 24.00 %
Specialty Social Work	Frequency 117524	Percentage 50.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

78,349 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This was based on the previous utilization using the Medicare claims data

Specialty Psychiatry	Frequency 20371	Percentage 26.00 %
Specialty Psychology	Frequency 18804	Percentage 24.00 %
Specialty Social Work	Frequency 39175	Percentage 50.00 %

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 90836



**SERVICES REPORTED WITH MULTIPLE CPT CODES: Attachment for ques 2**

Primary service						IC add-on							total			
cpt code	long descriptor	work rvu	pre	intraservice time	post	cpt code	work rvu	pre	intraservice time	post		total work rvu	pre	intraservice time	post	
90791	Psych diag eval	2.8	10	60	20	90785	0.33	0	0	16		3.13	10	60	36	
90792	Psych diag eval w/ med serv	2.96	10	60	20	90785	0.33	0	0	16		3.29	10	60	36	
90832	Psychotherapy, 30 min	1.25	5	30	10	90785	0.33	0	0	16		1.58	5	30	26	
90833	Psychotherapy, 30 min w E/M	0.98		30	3	90785	0.33	0	0	16		1.31	0	30	19	
90834	Psychotherapy, 45 min	1.89	5	45	10	90785	0.33	0	0	16		2.22	5	45	26	
90836	Psychotherapy, 45 min w E/M	1.6		45	3	90785	0.33	0	0	16		1.93	0	45	19	
90837	Psychotherapy, 60 min	2.83	5	60	10	90785	0.33	0	0	16		3.16	5	60	26	
90838	Psychotherapy, 60 min w/ E/M	2.56		60	3	90785	0.33	0	0	16		2.89	0	60	19	
90853	Group psychotherapy	0.59	2	14	8	90785	0.33	0	0	16		0.92	2	14	24	

**ISSUE: Psychotherapy for Crisis 60 Min. & 30 Min Add-On REVISED 4/25/2013****TAB: 35**

Source	CPT	Short DESC	Resp	IWPUT	RVW					Total Time	PRE EVAL	INTRA					IMMD POST	SURVEY EXPERIENCE				
					MIN	25th	MED	75th	MAX			MIN	25th	MED	75th	MAX		MIN	25th	MED	75th	MAX
Key REF	99215	Office visit for the E/M of an established patient... Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.	19	0.0475			2.11			55	5			35			15					
REF 2	99205	Office visit for the E/M of a new patient.. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.	14	0.0595			3.17			67	7			45			15					
Other	99235	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date. Usually the presenting problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.		0.0498			3.24				14			50			19.5					
SVY-T	90839	Psychotherapy for crisis; first 60 minutes	60	0.0410	0.25	2.54	3.13	3.53	5.00	90	10	0	40	60	60	120	20	0	1	3	11	250
REC	90839	Psychotherapy for crisis; first 60 minutes		0.041	3.13					90	10			60			20					

Source	CPT	Short DESC	Resp	IWPUT	RVW					Total Time	PRE EVAL	INTRA					IMMD POST	SURVEY EXPERIENCE				
					MIN	25th	MED	75th	MAX			MIN	25th	MED	75th	MAX		MIN	25th	MED	75th	MAX
Key REF	99355	Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes	14	0.0590			1.77			30				30								
SVY-T	90840	Psychotherapy for crisis; each additional 30 minutes	60	0.0650	0.00	1.50	1.95	2.21	4.00	30		10	30	30	40	120		0	0	2	6	180
REC	90840	Psychotherapy for crisis; each additional 30 minutes		0.0500	1.50					30				30								

		Society REC RVW			CMS 2013 Interim RVW (based on 2012 values)			Society REC Time						CMS 2013 Interim Time						Society REC IWPUT			CMS IWPUT		
Description	2013 Code	REC w/o IC	Total Values w/ IC CMS Interim	Total Values w/ IC REC	Interim CMS Values w/o IC 2012	Total Values w/ IC CMS Interim	Total Values w/ IC REC	Pre w/o IC	Intra w/o IC	Post w/o IC	Total Time w/o IC	Total Post Time w/ IC REC	Total Time w/ IC REC	Pre w/o	Intra w/o	Post w/o	Total Time w/o	Total Post Time w/ IC REC	Total Time w/ IC REC	IWPUT RUC REC Values w/o IC	IWPUT w/ IC CMS Interim	IWPUT w/ IC REC	IWPUT Interim CMS Values w/o IC 2012	IWPUT w/ IC CMS Interim	IWPUT w/ IC REC
Add-on Interactive Complexity	●+90785	0.33	0.11	0.33	0.11	0.11	0.33	0	0	11		11	11							NA	NA	NA			
Psychtxy for Crisis	90839	3.13			Carrier Priced			10	60	20	90			Carrier Priced					0.0410						
Add-on Psychtxy each add 30 min	●+90840	1.50			Carrier Priced			0	30	0	30			Carrier Priced					0.0500						
Diagnostic Interview		RUC Approved Values			CMS 2013 Interim RVW (based on 2012 values)			RUC Approved Time with out and with IC						CMS 2013 Interim Time with out and with IC						RUC Approved IWPUT			CMS IWPUT		
Psych diag interview	●90791	3.00	3.11	3.33	2.80	2.91	3.13	10	60	20	90	31	101	10	60	20	90	31	101	0.0388	0.0365	0.0529	0.0355	0.0332	0.0369
Psych diag interview w/ med services	●90792	3.25	3.36	3.58	2.96	3.07	3.29	10	60	20	90	31	101	10	60	20	90	31	101	0.0430	0.0407	0.0571	0.0381	0.0359	0.0395
Psychotherapy XXX																									
Psychotherapy, 30 minutes	●90832	1.50	1.61	1.83	1.25	1.36	1.58	5	30	10	45	21	56	5	30	10	45	21	56	0.0388	0.0343	0.0592	0.0305	0.0259	0.0333
Psychotherapy, 45 minutes	●90834	2.00	2.11	2.33	1.89	2.00	2.22	5	45	10	60	21	71	5	45	10	60	21	71	0.0370	0.0339	0.0506	0.0345	0.0315	0.0364
Psychotherapy, 60 minutes	●90837	3.00	3.11	3.33	2.83	2.94	3.16	5	60	10	75	21	86	5	60	10	75	21	86	0.0444	0.0421	0.0546	0.0416	0.0393	0.0430
Psychotherapy ZZZ																									
✚Psychotherapy, 30 minutes	●+90833	1.50	1.61	1.83	0.98	1.09	1.31	0	30	3	33	14	44	0	30	3	33	14	44	0.0478	0.0432	0.0610	0.0304	0.0259	0.0332
Outpt E/M, Psychtx 30 min	99212	1.98	2.09	2.31	1.46	1.57	1.79	2	40	7	49	18	60	2	40	7	49	18	60	0.0445	0.0411	0.0573	0.0315	0.0281	0.0336
✚Psychotherapy, 45 minutes	●+90836	1.90	2.01	2.23	1.60	1.71	1.93	0	45	3	48	14	59	0	45	3	48	14	59	0.0407	0.0377	0.0496	0.0341	0.0310	0.0359
Outpt E/M, Psychtx 45 min	99212	2.38	2.49	2.71	2.08	2.19	2.41	2	55	7	64	18	75	2	55	7	64	18	75	0.0396	0.0371	0.0489	0.0342	0.0317	0.0357
✚Psychotherapy, 60 minutes	●+90838	2.50	2.61	2.83	2.56	2.67	2.89	0	60	3	63	14	74	0	60	3	63	14	74	0.0405	0.0383	0.0472	0.0415	0.0393	0.0429
Outpt E/M, Psychtx 60 min	99212	2.98	3.09	3.31	3.04	3.15	3.37	2	70	7	79	18	90	2	70	7	79	18	90	0.0397	0.0377	0.0470	0.0405	0.0386	0.0417
October 2011 RUC meeting																									
Psychoanalysis	90845	2.10			1.79			5	50	5	60			5	45	11	61			0.0375			0.0318		
Family & Group Psychotherapy																									
Family Psychotherapy w/o pt	90846	2.40			1.83			5	50	10	65			0	50	0	50			0.0413			0.0366		
Family Psychotherapy conjoint	90847	2.50			2.21			5	55	10	70			5	50	21	76			0.0393			0.0326		
Group Psychotherapy	90853	0.59	0.70	0.92	0.59	0.70	0.92	3	10	3	16	14	27	2	14	8	24	19	35	0.0456	0.0319	0.0899	0.0261	0.0164	0.0321
Outpt E/M	99212	0.48			0.48			2	10	4	16			2	10	4	16								

**Attachment B**  
**RUC Summary 2013 Survey Data with Details**

**ISSUE:** Diagnostic Evaluation with Interactive Complexity

**TAB:** 35

Source	CPT	Short DESC	Resp	IWPUT	RVW					Total Time	PRE EVAL	INTRA					IMMD POST	SURVEY EXPERIENCE				
					MIN	25th	MED	75th	MAX			MIN	25th	MED	75th	MAX		MIN	25th	MED	75th	MAX
CMS Interim	90791	Psychiatric diagnostic evaluation		0.035			2.80			90	10			60			20					
RUC 2012	90791	Psychiatric diagnostic evaluation		0.039			3.00			90	10			60			20					
Key REF	99205	Office visit for the E/M of a new patient... Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.	12	0.059			3.17			67	7			45			15					
SVY	Combo 7	Surveyed Code 7: 90791 plus 90785	35		1.35	3.34	4.00	4.43	5.50									0	0	7	38	200
SVY	90785	Surveyed Code 7: 90785	35		0.00	0.53	0.80	1.31	2.60	32	11						21	0	0	7	38	200

CMS Interim	90792	Psychiatric diagnostic evaluation with medical services		0.038			2.96			90	10			60			20					
RUC 2012	90792	Psychiatric diagnostic evaluation with medical services		0.043			3.25			90	10			60			20					
Key REF	99205	Office visit for the E/M of a new patient... Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.	7	0.059			3.17			67	7			45			15					
SVY	Combo 8	Surveyed Code 8: 90792 plus 90785	18		3.17	3.93	4.15	4.83	8.00									0	3	8	20	150
SVY	90785	Surveyed Code 8: 90785	18		0.00	0.50	0.75	1.19	2.93	0	0						0	0	3	8	20	150

**Attachment B**  
**RUC Summary 2013 Survey Data with Details**

**ISSUE:** Group with Interactive Complexity

**TAB:** 35

Source	CPT	Short DESC	Resp	IWPUT	RVW					Total	PRE	INTRA					IMMD	SURVEY EXPERIENCE				
					MIN	25th	MED	75th	MAX	Time	EVAL	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
CMS Interim	90853	Group psychotherapy (other than of a multiple-family group)		0.046			0.59			16	3			10			3					
RUC 2012	90853	Group psychotherapy (other than of a multiple-family group)		0.046			0.59			16	3			10			3					
Key REF	99205	Office visit for the E/M of a new patient... Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.	7	0.059			3.17			67	7			45			15					
SVY	Combo 9	Surveyed Code 9: 90853 plus 90785	13		3.10	3.42	3.95	4.80	5.50									0	0	1	45	95
SVY	90785	Surveyed Code 9: 90785	13		0.35	0.52	0.86	1.10	2.25	29	13						16	0	0	1	45	95
SVY	2013	Typical Number In group session with IC	13		3	4	6	8	9													
SVY	2012	Typical Number In group session w/o IC	82		3	6	7	8	25													

**Attachment B**  
**RUC Summary 2013 Survey Data with Details**

**ISSUE:** Interactive Complexity (IC): All 9 CPT Codes with IC

**TAB:** 35

Source	CPT	Short DESC	Resp	IWPUT	RVW					Total Time	PRE	PRE	INTRA					POST	Post	SURVEY EXPERIENCE				
					MIN	25th	MED	75th	MAX		25%	Med	MIN	25th	MED	75th	MAX	Med	25%	MIN	25th	MED	75th	MAX
Key REF	99205	Office visit for the E/M of a new patient... Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.	47	0.059			3.17			67		7			45			15						
CURRENT	90785	Interactive Complexity	0	#DIV/0!			0.11			0														
SVY	Combined	All 9 CPT Codes reported with IC			0.97	2.30	3.00	3.92	8.00															
SVY	90785	Interactive Complexity	216		0.00	0.33	0.52	1.00	3.16	27	6.00	11						16	11.00	0	0	10	35	3000
SVY	Physician	Interactive Complexity	95		0.00	0.35	0.50	0.90	3.00	24	5.00	8						16	11.00	0	0	36	35	940
SVY	Psychologist	Interactive Complexity	106		0.00	0.46	0.69	1.15	3.16	32	6.00	11						21	16.00	0	0	10	26	3000
SVY	Clinical Social Worker	Interactive Complexity	15		0.00	0.31	0.70	0.99	2.11	27	6.00	11						16	11.00	0	0	7	50	100
SVY Perform	Combined	All 9 CPT Codes reported with IC			0.97	2.30	3.00	4.00	8.00															
SVY Perform	90785	Interactive Complexity	151		0.00	0.35	0.50	0.97	3.16	26	6.00	10						16	11.00	1	5	20	50	3000
SVY Do NOT Perform	Combined	All 9 CPT Codes reported with IC			1.15	2.28	3.10	3.86	6.10															
SVY Do NOT Perform	90785	Interactive Complexity	65		0.00	0.25	0.62	1.01	3.00	32	6.00	11						21	13.50	0	0	0	0	0
REC	90785	Interactive Complexity			0.33					11		0			0			11						

**Attachment B**  
**RUC Summary 2013 Survey Data with Details**

**ISSUE:** Psychotherapy XXX 30, 45, 60 with Interactive Complexity

**TAB:** 35

Source	CPT	Short DESC	Resp	IWPUT	RVW					Total Time	PRE EVAL	INTRA					IMMD POST	SURVEY EXPERIENCE				
					MIN	25th	MED	75th	MAX			MIN	25th	MED	75th	MAX		MIN	25th	MED	75th	MAX
CMS Interim	90832	Psychotherapy XXX 30 minutes		0.030			1.25			45	5			30			10					
RUC 2012	90832	Psychotherapy XXX 30 minutes		0.039			1.50			45	5			30			10					
Key REF	99355	Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes	7	0.059			1.77			30				30								
SVY	Combo 1	Surveyed Code 1: 90832 plus 90785	33		1.15	1.85	2.11	2.50	4.00									0	0	2	15	400
SVY	90785	Surveyed Code 1: 90785	33		0.05	0.29	0.50	0.97	1.77	22	6						16	0	0	2	15	400

CMS Interim	90834	Psychotherapy XXX 45 minutes		0.035			1.89			60	5			45			10					
RUC 2012	90834	Psychotherapy XXX 45 minutes		0.037			2.00			60	5			45			10					
Key REF	99215	Office visit E/M of an established patient... Typically, 40 minutes are spent face-to-face with the patient and/or family.	10	0.047			2.11			55	5			35			15					
SVY	Combo 2	Surveyed Code 2: 90834 plus 90785	33		1.45	2.25	2.75	3.00	4.59									0	0	15	40	2000
SVY	90785	Surveyed Code 2: 90785	33		0.15	0.31	0.60	1.00	2.37	32	11						21	0	0	15	40	2000

CMS Interim	90837	Psychotherapy XXX 60 minutes		0.042			2.83			75	5			60			10					
RUC 2012	90837	Psychotherapy XXX 60 minutes		0.044			3.00			75	5			60			10					
KEY REF	99205	Office visit for the E/M of a new patient...Typically, 60 minutes are spent face-to-face with the patient and/or family.	12	0.059			3.17			67	7			45			15					
SVY	Combo 3	Surveyed Code 3: 90837 plus 90785	33		1.85	2.61	3.20	3.70	5.00									0	0	8	25	3000
SVY	90785	Surveyed Code 3: 90785	33		0.05	0.29	0.50	0.97	1.77	37	11						26	0	0	8	25	3000

**Attachment B**  
**RUC Summary 2013 Survey Data with Details**

**ISSUE:** Psychotherapy ZZZ 30, 45, 60 with Interactive Complexity

**TAB:** 35

Source	CPT	Short DESC	Resp	IWP/UT	RVW					Total Time	PRE EVAL	INTRA					IMMD POST	SURVEY EXPERIENCE				
					MIN	25th	MED	75th	MAX			MIN	25th	MED	75th	MAX		MIN	25th	MED	75th	MAX
CMS Interim	90833	Psychotherapy ZZZ 30 minutes		0.030			0.98			33	0			30			3					
RUC 2012	90833	Psychotherapy ZZZ 30 minutes		0.048			1.50			33	0			30			3					
Key REF	99214	Office visit for the E/M of an established patient... Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.	6	0.047			1.50			40	5			25			10					
SVY	Combo 4	Surveyed Code 4: 90833 plus 90785	17		0.97	1.85	2.00	2.25	3.50									0	6	33	210	940
SVY	90785	Surveyed Code 4: 90785	17		0.15	0.27	0.50	0.85	1.77	17	6						11	0	6	33	210	940
CMS Interim	90836	Psychotherapy ZZZ 45 minutes		0.034			1.60			48	0			45			3					
RUC 2012	90836	Psychotherapy ZZZ 45 minutes		0.041			1.90			48	0			45			3					
Key REF	99215	Office visit E/M of an established patient... Typically, 40 minutes are spent face-to-face with the patient and/or family.	8	0.047			2.11			55	5			35			15					
SVY	Combo 5	Surveyed Code 5: 90836 plus 90785	17		1.90	2.25	2.50	3.10	4.00									0	5	16	70	400
SVY	90785	Surveyed Code 5: 90785	17		0.14	0.40	0.50	0.75	2.11	6	6						0	0	5	16	70	400
CMS Interim	90838	Psychotherapy ZZZ 60 minutes		0.042			2.56			63	0			60			3					
RUC 2012	90838	Psychotherapy ZZZ 60 minutes		0.041			2.50			63	0			60			3					
KEY REF	99215	Office visit E/M of an established patient... Typically, 40 minutes are spent face-to-face with the patient and/or family.	9	0.047			2.11			55	5			35			15					
SVY	Combo 6	Surveyed Code 6: 90838 plus 90785	17		2.20	2.75	3.00	3.75	5.00									0	2	15	30	125
SVY	90785	Surveyed Code 6: 90785	17		0.15	0.27	0.50	0.85	1.77	22	6						16	0	2	15	30	125



April 1, 2013

To: Scott Manaker, MD, Chair, AMA Practice Expense Subcommittee and Sherry Smith

From: American Psychiatric Association (APA), American Academy of Child and Adolescent Psychiatry (AACAP), American Psychological Association Practice Organization (APAPO) and National Association of Social Workers (NASW)

The American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, the American Psychological Association Practice Organization and the National Association of Social Workers have submitted practice expense (PE) recommendations for CPT codes +90785 (Interactive complexity), 90839 (Psychotherapy for crisis, 60 minutes) and +90840 (Psychotherapy for crisis, each 30 minutes) for the subcommittee's review. These codes are currently carrier priced and are three of the four codes approved by CPT in 2012 that had not yet been valued by the RUC.

The recommendations were developed by an expert panel that consisted of psychiatrists, psychologists and licensed clinical social workers. The recommendations are based on the PE values for psychiatric services that were presented and approved by the RUC in April 2012 as well as the previous PE values for interactive diagnostic and psychotherapeutic services. The recommendations include medical supplies and equipment; there is no clinical labor. We have asked for an increase in the number of tissues on the basis of the nature of the encounter when providing psychotherapy for crisis. Other than that, all other values mirror what had been approved previously.

Contact Becky Yowell ([byowell@psych.org](mailto:byowell@psych.org)) if you have questions or need additional information.

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor:

**90839, Psychotherapy for crisis; first 60 minutes**

**(Use 90840 in conjunction with 90839)**

**(Do not report 90839, 90840 in conjunction with 90791, 90792, psychotherapy codes 90832-90838 or other psychiatric services, or 90785-90899)**

Global Period: XXX Meeting Date: **April 2013**

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

**An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expenses for this code submission. The group included participants familiar with the services described by this code.**

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

**This is a new code describing work not previously reported separately. The panel selected CPT code 90837 Psychotherapy, 60 minutes with patient and/or family member, as the reference code because that code is similar in work and time to the 90839, Psychotherapy for crisis; first 60 minutes.**

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time: **We are not requesting any clinical labor time.**

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence: **NA**

5. Please describe in detail the clinical activities of your staff: **NA**

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor:

**90839, Psychotherapy for crisis; first 60 minutes**

**(Use 90840 in conjunction with 90839)**

**(Do not report 90839, 90840 in conjunction with 90791, 90792, psychotherapy codes 90832-90838 or other psychiatric services, or 90785-90899)**

Global Period: XXX Meeting Date: **April 2013**

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: **An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expenses for this code submission. The group included participants familiar with the services described by this code.**
2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale: **This is a new code describing work not previously reported separately. The panel selected CPT code 90837 Psychotherapy, 60 minutes with patient and/or family member, as the reference code because that code is similar in work and time to the 90839, Psychotherapy for crisis; first 60 minutes.**
3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time: **We are not requesting any clinical labor time.**
4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence: **Our request reflects the supplies and equipment for similar services that were approved by the PE subcommittee and the RUC in April 2012 with the exception of the percentage of tissue usage. The panel believes that usage will increase due to the fact that the patient is in crisis (i.e., unstable) during the encounter.**
5. Please describe in detail the clinical activities of your staff: **NA**

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor:

**90785, Interactive complexity (List separately in addition to the code for primary procedure)**

**(Use 90785 in conjunction with codes for diagnostic psychiatric evaluation [90791, 90792], psychotherapy [90832, 90834, 90837], psychotherapy when performed with an evaluation and management service [90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350], and group psychotherapy [90853])**

**(Do not report 90785 in conjunction with 90839, 90840, or in conjunction with E/M services when no psychotherapy service is also reported)**

Global Period: **ZZZ** Meeting Date: **April 2013**

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: **An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expenses for this code submission. The group included participants familiar with the services described by this add-on code.**

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale: **This code is an add-on code to 90791, 90792, 90832-90838 and 90853. The panel chose 90834, Psychotherapy 45 minute with patient present and/or family member, one of the base codes to which this add-on service can be used, as a reference service for this code. This add-on code replaces a series of stand-alone codes that described interactive diagnostic and psychotherapy services (90802, 90810-90815, 90823-90829, 90857). Our expert panel believes that the add-on code will be most frequently billed with this particular base code. The base code reflects the April 2012 RUC-approved PE inputs for the psychotherapy codes.**

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time: **We are not requesting any clinical labor time.**

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence: **We are not requesting an increase over the current inputs. Our request includes the supplies and equipment for the interactive services previously described by CPT codes 90802, 90810-90815, 90823-90829, 90857. These services were originally valued in 2001.**

5. Please describe in detail the clinical activities of your staff: **NA**

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor:

**90785, Interactive complexity (List separately in addition to the code for primary procedure)**

**(Use 90785 in conjunction with codes for diagnostic psychiatric evaluation [90791, 90792], psychotherapy [90832, 90834, 90837], psychotherapy when performed with an evaluation and management service [90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350], and group psychotherapy [90853])**

**(Do not report 90785 in conjunction with 90839, 90840, or in conjunction with E/M services when no psychotherapy service is also reported)**

Global Period: **ZZZ** Meeting Date: **April 2013**

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

**An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expenses for this code submission. The group included participants familiar with the services described by this add-on code.**

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

**This code is an add-on code to 90791, 90792, 90832-90838 and 90853. The panel chose 90834, Psychotherapy 45 minute with patient present and/or family member, one of the base codes to which this add-on service can be used, as a reference service for this code. This add-on code replaces a series of stand-alone codes that described interactive diagnostic and psychotherapy services (90802, 90810-90815, 90823-90829, 90857). Our expert panel believes that the add-on code will be most frequently billed with this particular base code. The base code reflects the April 2012 RUC-approved PE inputs for the psychotherapy codes.**

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time: **We are not requesting any clinical labor time.**

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence: **NA**

5. Please describe in detail the clinical activities of your staff: **NA**

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor:

**90840, Psychotherapy for crisis, each additional 30 minutes (List separately in addition to code for primary service)**

**(Use 90840 in conjunction with 90839)**

**(Do not report 90839, 90840 in conjunction with 90791, 90792, psychotherapy codes 90832-90838 or other psychiatric services, or 90785-90899)**

Global Period: **ZZZ** Meeting Date: **April 2013**

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: **An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expenses for this code submission. The group included participants familiar with the services described by this code.**

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale: **This is a new code describing work not previously reported separately. The panel selected CPT code 90837 Psychotherapy, 60 minutes with patient and/or family member, as the reference code because that code is similar in work and time to the 90839, Psychotherapy for crisis; first 60 minutes. The 90840 is an add-on code used to designate that the service went and additional 31 minutes or more.**

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time: **We are not requesting any clinical labor time.**

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence: **Our request includes the supplies and equipment for similar services that were approved by the PE subcommittee and the RUC in April 2012.**

5. Please describe in detail the clinical activities of your staff: **NA**

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor:

**90840, Psychotherapy for crisis, each additional 30 minutes (List separately in addition to code for primary service)**

**(Use 90840 in conjunction with 90839)**

**(Do not report 90839, 90840 in conjunction with 90791, 90792, psychotherapy codes 90832-90838 or other psychiatric services, or 90785-90899)**

Global Period: **ZZZ** Meeting Date: **April 2013**

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

**An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expenses for this code submission. The group included participants familiar with the services described by this code.**

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

**This is a new code describing work not previously reported separately. The panel selected CPT code 90837 Psychotherapy, 60 minutes with patient and/or family member, as the reference code because that code is similar in work and time to the 90839, Psychotherapy for crisis; first 60 minutes. The 90840 is an add-on code used to designate that the service went and additional 31 minutes or more.**

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time: **We are not requesting any clinical labor time.**

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence: **NA**

5. Please describe in detail the clinical activities of your staff: **NA**

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:

	A	B	C	D	E	H	I	J	K	L	M	N	O
1				REFERENCE CODE				REFERENCE CODE					
2	<p><b>*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.</b></p> <p><b>**Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.</b></p>			90834		90875		90837		90839		90840	
3	<p><b>Meeting Date: April 2013</b></p> <p><b>Tab: 35</b></p> <p><b>Specialty: APA, AACAP, APAPO, NASW</b></p>	CMS Code	Staff Type	Psychotherapy, 45 minutes with patient and/or family member		Interactive complexity (List separately in addition to the code for primary procedure)		Psychotherapy, 60 minutes with patient and/or family member		Psychotherapy for crisis; first 60 minutes		Psychotherapy for crisis; each additional 30 minutes	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			XXX	XXX	ZZZ	ZZZ	XXX	XXX	XXX	XXX	ZZZ	ZZZ
6	TOTAL CLINICAL LABOR TIME			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
10	PRE-SERVICE												
11	Start: Following visit when decision for surgery or procedure made												
12	Complete pre-service diagnostic & referral forms												
15	Provide pre-service education/obtain consent												
16	Follow-up phone calls & prescriptions												
17	*Other Clinical Activity - specify:												
18	End: When patient enters office/facility for surgery/procedure												
19	SERVICE PERIOD												
20	Start: When patient enters office/facility for surgery/procedure:												
21	Greet patient, provide gowning, ensure appropriate medical records are available												
22	Obtain vital signs												
23	Provide pre-service education/obtain consent												
24	Prepare room, equipment, supplies												
28	*Other Clinical Activity - specify:												
29	Intra-service												
30	Assist physician in performing procedure												
31	Post-Service												
36	Complete diagnostic forms, lab & X-ray requisitions												
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions												
39	*Other Clinical Activity - specify:												
43	End: Patient leaves office												
44	POST-SERVICE Period												
45	Start: Patient leaves office/facility												
46	Conduct phone calls/call in prescriptions												
53	Total Office Visit Time			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
55	End: with last office visit before end of global period												



AMA Specialty Society Recommendation

	A	B	C	D	E	H	I	J	K	L	M	N	O
1				REFERENCE CODE				REFERENCE CODE					
2	<p><b>*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.</b></p> <p><b>**Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.</b></p>			90834	90875			90837		90839		90840	
3	<p><b>Meeting Date: April 2013</b></p> <p><b>Tab: 35</b></p> <p><b>Specialty: APA, AACAP, APAPO, NASW</b></p>	CMS Code	Staff Type	Psychotherapy, 45 minutes with patient and/or family member	Interactive complexity (List separately in addition to the code for primary procedure)			Psychotherapy, 60 minutes with patient and/or family member		Psychotherapy for crisis; first 60 minutes		Psychotherapy for crisis; each additional 30 minutes	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			XXX	XXX	ZZZ	ZZZ	XXX	XXX	XXX	XXX	ZZZ	ZZZ
56	MEDICAL SUPPLIES**												
		CODE	UNIT										
57	pack, minimum multi-specialty visit	SA048	pack										
58	Tissues	SK114	box	0.05				0.05		0.10		0.05	
59	Patient education booklet	SK062	item										
60	assessment monitoring instruments	SK005	item	0.25				0.25		0.25			
61	Reproduced patient worksheet	SK115	each	0.50				0.50		0.50			
62	kit, therapeutic toys-games	SA033	kit			0.20							
63	kit, activity-crafts	SA001	kit			0.04							
64	EQUIPMENT												
		CODE											
65	One Couch/ Two Chairs	EF042		45				60		60		30	
66													
67													
68													
69													

## **AMA/Specialty Society RVS Update Committee Summary of Recommendations**

### *Fourth Five-Year Review*

### *CMS High Expenditure Procedural Codes screen*

April 2012

### **Psychotherapy**

In the 4<sup>th</sup> Five-Year Review of the RBRVS, CMS received comment letters from the providers of psychotherapy, CPT codes 90801-90880 as potentially misvalued. CMS forwarded these services to the RUC to be included in the fourth Five-Year Review process. CPT code 90849 was withdrawn by the original commenter as the specialties indicated that very few of their members provide this service. This specialty recommendation was supported by the Medicare utilization data for this service which was very low in 2008, 343 claims. In April and May 2010, the Research Subcommittee met to review vignettes and reference service lists. The Subcommittee recommended that 90801 and 90802 be removed from the list of codes to be reviewed and be referred to the CPT Editorial Panel so that modifications could be made to the descriptors to reflect the different work performed by the physician and non-physician providers. In June 2010, a RUC Facilitation Committee met with the sponsoring specialty societies. The Pre-Facilitation Committee agreed with the Research Subcommittee's recommendations to refer 90801 and 90802 to the CPT Editorial Panel. The Pre-Facilitation Committee recommended that all of the psychotherapy codes with Evaluation and Management components (90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827, 90829, and 90862) be referred to the CPT Editorial Panel to potentially create a new coding structure based on the varying levels of evaluation and management within each code. The remainder of the CPT codes identified were surveyed for the October 2010 RUC Meeting.

At the October 2010 RUC Meeting, the specialties presented compelling evidence arguments to change the current value of the remaining psychotherapy services. The specialties indicated that the patient population receiving these services has dramatically changed since the codes were previously reviewed. Currently, according to a National Comorbidity Survey, 56% of patients receiving psychotherapy have multiple comorbid conditions, meaning having more than one mental or physical disorder, including substance abuse. Due to the prevalence of comorbid patients, the work of the provider has changed as most research treatment protocols were originally designed for patients with single disorders. Further, the specialties indicated that the site of service for patients receiving many of these services has changed. Patients, who were once treated in the hospital setting, are now more frequently being treated in the office setting as the number of psychiatric beds has dropped by more than 60% between 1970 and 2000. The RUC accepted these compelling evidence arguments to potentially modify the current value of these services.

However, the RUC review of survey data presented at the October 2010 meeting, concluded that the entire section of psychotherapy services would benefit from a restructuring within CPT. A CPT Workgroup was created to address these concerns and a coding proposal was issued from the Workgroup to the CPT Editorial Panel for review. In February 2012, after a year of analysis and participation by all providers of the services, the CPT

Editorial Panel replaced the current psychotherapy section with a new structure allowing separate reporting of E/M codes, eliminating site of service differential and creation of series of add-on codes to psychotherapy to describe interactive complexity and medication management.

The new coding framework, allows all codes to be used in all settings instead of describing site specific services. There are four groupings of services. First, code 90801 *Psychiatric diagnostic interview examination* will be deleted and replaced by two new codes 90791 *Psychiatric diagnostic evaluation* and 90792 *Psychiatric diagnostic evaluation with medical service*. CPT code 90791 is a service without medical work and describes comprehensive psychiatric diagnostic evaluation of psychological and psychosocial conditions often in collaboration with referring primary care physicians. CPT code 90792 is to be reported when a complete comprehensive diagnostic evaluation involves medical work, capturing the work and teasing out medical causes of psychiatric symptoms such as those caused by thyroid disease or metabolic infectious conditions. The next family has two groupings, psychotherapy stand alone codes without medical services (CPT codes 90832, 90834 and 90837) and the psychotherapy add-on codes, which are used only in conjunction with Evaluation and Management services (90833, 90836 and 90838). The current psychotherapy with E/M inpatient or outpatient codes contain one fixed low level E/M service combined with three levels of time-based psychotherapy services. These fixed E/M components were inadequate for today's patient and are replaced by the psychotherapy add-on codes. Thereby, using the existing E/M structure and a choice of one add-on psychotherapy time-based code, 30, 45 or 60 minutes. The selection of the time increment is based both on patient characteristics and the work to be accomplished in certain types of psychotherapy. Some patients are more resistant to open-up in a session and may require longer sessions. Additionally, some forms of psychotherapy are more geared toward 45 minute sessions (psychodynamic or cognitive behavioral therapy), whereas others are more geared towards 30 minute sessions (brief focused supportive therapy). The add-on codes will be new to many professionals and the American Psychiatric Association will offer extensive education on the use of these codes and to ensure that physicians understand that the time on E/M services is not used to determine the time of the psychotherapy service. The third grouping, psychotherapy inpatient and outpatient services that do not include E/M services (90832, 90834 and 90837) are likely to be reported by psychologists and clinical social workers in all clinical settings. The last grouping are family psychotherapy codes, with and without the patient and in a group setting, remain essentially unchanged (90845, 90846, 90847 and 90853).

### **90791 Psychiatric diagnostic evaluation**

The RUC reviewed the survey results from 202 adult and child psychiatrists, psychologists and social workers for CPT code 90791 and determined that the median work RVU of 3.00 appropriately accounts for the physician work required to perform this service. The RUC agreed with the survey times of 10 minutes pre-service, 60 minutes intra-service and 20 minutes post-service. The RUC compared the surveyed service to key reference service 99205 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 3.17 and 45 minutes intra-service time) and agreed with the survey respondents that 90791 requires more physician time to perform but is less intense and complex than 99205. The RUC also compared the surveyed service to similar services 95974 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour* (work RVU = 3.00 and 60 minutes intra-service time) and 75559 *Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging* (work RVU = 2.95 and 50 minutes intra-service time) and

determined that the recommended physician work and time place this service in the proper rank order relative to other services on the physician payment schedule. **The RUC recommends a work RVU of 3.00 for CPT code 90791.**

#### **90792 Psychiatric diagnostic evaluation with medical services**

The RUC reviewed the survey results from 82 adult and child psychiatrists for CPT code 90792 and determined that the median work RVU of 3.25 appropriately accounts for the physician work required to perform this service. The RUC agreed with the survey times of 10 minutes pre-service, 60 minutes intra-service and 20 minutes post-service. The RUC compared code 90792 to 90791, which does not include medical services, and determined that the survey respondents appropriately valued the additional work required to perform this service. The RUC compared the surveyed service to key reference service 99205 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 3.17 and 45 minutes intra-service time) and agreed with the survey respondents that 90792 requires more physician time and is more intense and complex to perform than 99205. For additional support, the RUC also compared the surveyed service to similar services 99350 *Home visit for the evaluation and management of an established patient* (work RVU = 3.28 and 75 minutes intra-service time) and 99235 *Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date* (work RVU = 3.24 and 50 minutes intra-service time) and determined that the recommended physician work and time place this service in the proper rank order relative to other services on the physician payment schedule. **The RUC recommends a work RVU of 3.25 for CPT code 90792.**

#### **90832 Psychotherapy, 30 minutes with patient and/or family member**

The RUC reviewed the survey results from 185 adult and child psychiatrists, psychologists and social workers for CPT code 90832 and determined that the median work RVU of 1.50 appropriately accounts for the work required to perform this service. The RUC determined 5 minutes pre-service, 30 minutes intra-service and 10 minutes post-service is appropriate to perform this service. Pre-time activities include completing checklists in anticipation of the service depending on the type of therapy and post-service activities include documenting the visit, documentation of therapy notes and treatment plans, follow-up with the primary care physician or therapists and setting up the next visit. The RUC compared the surveyed service to key reference service 96152 *Health and behavior intervention, each 15 minutes, face-to-face; individual* (work RVU = 0.46 and 15 minutes intra-service time) and agreed with the survey respondents that 90832 requires more time and is more intense and complex to perform than 96152. For additional support, the RUC also compared the surveyed service to similar services 99214 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 1.50 and 25 minutes intra-service time) and 94005 *Home ventilator management care plan oversight of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living) requiring review of status, review of laboratories and other studies and revision of orders and respiratory care plan (as appropriate), within a calendar month, 30 minutes or more* (work RVU = 1.50 and 25 minutes intra-service time) and determined that the recommended work and time place this service in the proper rank order relative to other services on the physician payment schedule. **The RUC recommends a work RVU of 1.50 for CPT code 90832.**

**90833 Psychotherapy, 30 minutes with patient and/or family member when performed with an Evaluation and Management service**

The specialty societies reiterated that there are specific guidelines that indicate the Evaluation and Management service is to be billed separately with this service. The RUC reviewed the survey results from 114 adult and child psychiatrists for CPT code 90833 and determined that the median work RVU of 1.50 appropriately accounts for the physician work required to perform this service. The RUC determined 0 minutes pre-service, 30 minutes intra-service and 3 minutes post-service is appropriate to perform this service. The specialty indicated and the RUC agreed that any pre-time work will be captured in the separately reported Evaluation and Management service and the 3 minutes of post-service include activities specific to documentation of the symptoms and behaviors that are the focus of the treatment as well as documentation of the specific psychotherapeutic intervention performed. The RUC compared the surveyed service to key reference service 99214 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 1.50 and 25 minutes intra-service time) and agreed with the survey respondents that 90833 requires the same physician work, slightly more physician time and similar intensity and complexity to perform compared to 99214. For additional support, the RUC also compared the surveyed service to similar service 94005 *Home ventilator management care plan oversight of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living) requiring review of status, review of laboratories and other studies and revision of orders and respiratory care plan (as appropriate), within a calendar month, 30 minutes or more* (work RVU = 1.50 and 25 minutes intra-service time) and determined that the recommended work and time place this service in the proper rank order relative to other services on the physician payment schedule. **The RUC recommends a work RVU of 1.50 for CPT code 90833.**

**90834 Psychotherapy, 45 minutes with patient and/or family member**

The RUC reviewed the survey results from 183 adult and child psychiatrists, psychologists and social workers for CPT code 90834 and determined that the median work RVU of 2.00 appropriately accounts for the work required to perform this service. The RUC determined 5 minutes pre-service, 45 minutes intra-service and 10 minutes post-service is appropriate to perform this service. Pre-time activities include completing checklists in anticipation of the service depending on the type of therapy and post-service activities include documenting the visit, documentation of therapy notes and treatment plans, follow-up with the primary care physician or therapists and setting up the next visit. The RUC compared the surveyed service to similar services 99215 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 2.11 and 35 minutes intra-service time) and 94002 *Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day* (work RVU = 1.99 and 30 minutes intra-service time) and determined that the recommended physician work and time place this service in the proper rank order relative to other services on the physician payment schedule. **The RUC recommends a work RVU of 2.00 for CPT code 90834.**

**90836 Psychotherapy, 45 minutes with patient and/or family member when performed with an Evaluation and Management service**

The specialty societies reiterated that there are specific guidelines that indicate the Evaluation and Management service is to be billed separately with this service. The RUC reviewed the survey results from 114 adult and child psychiatrists for CPT code 90836 and determined that the median work RVU of 1.90 appropriately accounts for the physician work required to perform this service. The RUC determined 0 minutes pre-service, 45 minutes intra-service and 3 minutes post-service is appropriate to perform this service. The specialty indicated and the RUC agreed that any pre-time work will be captured in the separately reported Evaluation and Management service and the 3 minutes of post-service include activities specific to

documentation of the symptoms and behaviors that are the focus of the treatment as well as documentation of the specific psychotherapeutic intervention performed. The RUC compared the surveyed service to key reference service 99214 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 1.50 and 25 minutes intra-service time) and agreed with the survey respondents that 90836 requires more physician work and time and is more intense and complex to perform compared to 99214. For additional support, the RUC also compared the surveyed service to similar service 99221 *Initial hospital care, per day, for the evaluation and management of a patient* (work RVU = 1.92 and 30 minutes intra-service time) and determined that the recommended physician work and time place this service in the proper rank order relative to other services on the physician payment schedule. **The RUC recommends a work RVU of 1.90 for CPT code 90836.**

#### **90837 Psychotherapy, 60 minutes with patient and/or family member**

The RUC reviewed the survey results from 185 adult and child psychiatrists, psychologists and social workers for CPT code 90837 and determined that the survey 75<sup>th</sup> percentile work RVU of 3.00 appropriately accounts for the work required to perform this service. The RUC determined that the survey median work RVU of 2.25 would be too low in relation to 90834 and 0.25 difference in work RVU would not appropriately account for an additional 15 minutes of intra-service time and additional intensity and complexity required to perform 90837. The RUC determined 5 minutes pre-service, 60 minutes intra-service and 10 minutes post-service is appropriate to perform this service. Pre-time activities include completing checklists in anticipation of the service depending on the type of therapy and post-service activities include documenting the visit, documentation of therapy notes and treatment plans, follow-up with the primary care physician or therapists and setting up the next visit. The RUC compared the surveyed service to similar services 99205 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 3.17 and 45 minutes intra-service time), 96111 *Developmental testing, (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report* (work RVU = 2.60 and 60 minutes intra-service time) and 99222 *Initial hospital care, per day, for the evaluation and management of a patient* (work RVU = 2.61 and 40 minutes intra-service time) and determined that the recommended physician work and time place this service in the proper rank order relative to other services on the physician payment schedule. **The RUC recommends a work RVU of 3.00 for CPT code 90837.**

#### **90838 Psychotherapy, 60 minutes with patient and/or family member when performed with an Evaluation and Management service**

The specialty societies reiterated that there are specific guidelines that indicate the Evaluation and Management service is to be billed separately with this service. The RUC reviewed the survey results from 114 adult and child psychiatrists for CPT code 90838 and determined that the survey 75<sup>th</sup> percentile work RVU of 2.50 appropriately accounts for the physician work required to perform this service. The RUC determined that the survey median work RVU of 2.10 would be too low in relation to 90836 and 0.20 difference in work RVU would not appropriately account for an additional 15 minutes of intra-service time and additional intensity and complexity required to perform 90838. The RUC determined 0 minutes pre-service, 60 minutes intra-service and 3 minutes post-service is appropriate to perform this service. The specialty indicated and the RUC agreed that any pre-time work will be captured in the separately reported Evaluation and Management service and the 3 minutes of post-service include activities specific to documentation of the symptoms and behaviors that are the focus of the treatment as well as documentation of the specific psychotherapeutic intervention performed. The RUC compared the surveyed service to key reference service 99354 *Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour* (work RVU = 1.77 and 60 minutes intra-service time) and agreed with the

survey respondents that 90838 requires more physician work and is more intense and complex to perform compared to 99354. For additional support, the RUC also compared the surveyed service to similar service 96111 *Developmental testing, (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report* (work RVU = 2.60 and 60 minutes intra-service time) and determined that the recommended physician work and time place this service in the proper rank order relative to other services on the physician payment schedule. **The RUC recommends a work RVU of 2.50 for CPT code 90838.**

**90785 Interactive Complexity (List separately in addition to the code for primary procedure)**

**90839 Psychotherapy for crisis, first 60 minutes;**

**90840 Psychotherapy for crisis, first 60 minutes; each additional 30 minutes**

The specialty societies indicated and the RUC agreed that codes 90785, 90839 and 90840 be carrier priced to allow for education and experience with a significantly different coding structure. This will allow providers to gain experience with the codes prior to conducting a RUC survey. After a year of experience with the new coding structure the specialties will conduct RUC surveys for these services.

**90845 Psychoanalysis**

*October 2011 RUC recommendation*

Multiple specialty societies submitted public comment to CMS to review code 90845 *Psychoanalysis* as part of the 4<sup>th</sup> Five-Year Review. In September 2010, recommendations regarding code 90845 were submitted along with 16 additional codes. During that presentation the specialties requested that the entire tab be referred to the CPT Editorial Panel to revised the code descriptors to more accurately describe these services. During the CPT review process, CPT recommended to remove psychoanalysis, as revisions to the descriptor were unnecessary because the work inherent in providing this service was the same regardless of the provider.

In September 2011, the RUC reviewed 90845 and agreed with the specialty society that there is compelling evidence that the patient population has changed and that the technique employed in psychoanalytic practice has changed. Psychoanalysis traditionally treated a wide variety of conditions which included a considerable number of high functioning patients who were treated for relatively minor psychological problems by current standards. Patients with these conditions are now often treated in a variety of newer treatment modalities rather than psychoanalysis. Given this, patients now receiving psychoanalysis are more complex and typically require a more active approach on part of the psychoanalyst due to the increased number of co-morbidities. In addition, in the past psychoanalysts tended to be silent during the treatment, intervening infrequently. Current practice emphasizes the importance of interaction between the psychoanalyst and the patient. As a result of this technical change the psychoanalyst is required to be much more intently focused on the minute to minute interaction during the session and considerably more active during the session. This substantially increases the psychoanalyst's intensity and complexity effort during the session, when compared with the earlier model.

The RUC reviewed CPT code 90845 and agreed with the specialty societies that the typical service is one hour, 5 minute pre-service, 50 minutes intra-service and 5 minutes immediate post-service time. The RUC reviewed the survey results and agreed that the median survey work RVU of 2.10

accurately values the typical physician work involved in the procedure. To justify this value, the RUC compared CPT code 90845 to key reference service 99404 *Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes* (work RVU = 1.95, total time = 60 minutes). Although the reference code has greater intra service time compared to the surveyed code, the survey respondents indicated and the RUC agreed that intensity and complexity to perform 90845 is greater in every measure compared to reference service 99404. The RUC also compared 90845 to reference code 99215 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 2.11, total time = 55 minutes). The respondents indicated 90845 was more intense and complex than 99215, specifically the technical skill required to perform 90845 indicated the greatest difference. Finally, the RUC compared 90845 to MPC code 99233 *Subsequent hospital care, per day, for the evaluation and management of a patient* (work RVU = 2.00, total time = 55 minutes). The RUC determined that these comparison codes coupled with the median survey results support a recommendation of 2.10 work RVUs for CPT code 90845. **The RUC recommends a work RVU of 2.10 for CPT code 90845.**

#### **90846 Family psychotherapy (without the patient present)**

The RUC reviewed the survey results from 123 adult and child psychiatrists, psychologists and social workers for CPT code 90846 and determined that the survey median work RVU of 2.40 appropriately accounts for the work required to perform this service. The RUC determined 5 minutes pre-service, 50 minutes intra-service and 10 minutes post-service is appropriate to perform this service. Pre-time activities include completing checklists in anticipation of the service depending on the type of therapy and post-service activities include documenting the visit, documentation of therapy notes and treatment plans, follow-up with the primary care physician or therapists and setting up the next visit. The RUC compared the surveyed service to key reference service 99215 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 2.11 and 35 minutes intra-service time) and agreed with the survey respondents that 90846 requires more work and time and to perform than 99215. For additional support, the RUC also compared the surveyed service to similar services 99204 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 2.43 and 30 minutes intra-service time) and 99349 *Home visit for the evaluation and management of an established patient* (work RVU = 2.33 and 40 minutes intra-service time) and determined that the recommended physician work and time place this service in the proper rank order relative to other services on the physician payment schedule. **The RUC recommends a work RVU of 2.40 for CPT code 90846.**

#### **90847 Family psychotherapy (conjoint psychotherapy) (with patient present)**

The RUC reviewed the survey results from 123 adult and child psychiatrists, psychologists and social workers for CPT code 90847 and determined that the survey median work RVU of 2.50 appropriately accounts for the work required to perform this service. The RUC determined 5 minutes pre-service, 55 minutes intra-service and 10 minutes post-service is appropriate to perform this service. Pre-time activities include completing checklists in anticipation of the service depending on the type of therapy and post-service activities include documenting the visit, documentation of therapy notes and treatment plans, follow-up with the primary care physician or therapists and setting up the next visit. The RUC compared the surveyed service to key reference service 99205 *Office or other outpatient visit for the evaluation and management of a new patient*, (work RVU = 3.17 and 45 minutes intra-service time) and agreed with the survey respondents that although 90847 requires 10 more minutes of intra-service time, it requires slightly less work to perform than 99205. For additional support, the RUC also compared the surveyed service to similar services 99222 *Initial*



hospital care, per day, for the evaluation and management of a patient (work RVU = 2.61 and 40 minutes intra-service time) and 99336 *Domiciliary or rest home visit for the evaluation and management of an established patient* (work RVU = 2.46 and 40 minutes intra-service time) and determined that the recommended physician work and time place this service in the proper rank order relative to other services on the physician payment schedule. **The RUC recommends a work RVU of 2.50 for CPT code 90847.**

#### **90853 Group psychotherapy (other than of a multiple-family group)**

The RUC reviewed the survey results from 82 adult and child psychiatrists, psychologists and social workers for CPT code 90853 and determined that the current work RVU of 0.59 be maintained. The survey median work RVU of 3.00, for the entire group session divided by 5 the typical number of patients in a group equals 0.60 and maintaining the value appropriately accounts for the work required to perform this service. The RUC agreed with the survey times divided by the typical number of patients resulting in 3 minutes pre-service, 10 minutes intra-service and 3 minutes post-service is appropriate to perform this service. The RUC compared the surveyed service to key reference service 96153 *Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)* (work RVU = 0.10 and 5 minutes total time) and agreed with the survey respondents that 90853 requires more work, time, intensity and complexity to perform than 96153. For additional support, the RUC also compared the surveyed service to MPC code 97002 *Physical therapy re-evaluation* (work RVU = 0.60 and 18 minutes intra-service time) and 76881 *Ultrasound, extremity, nonvascular, real-time with image documentation; complete* (work RVU = 0.63 and 15 minutes intra-service time) and determined that the recommended physician work and time place this service in the proper rank order relative to other services on the physician payment schedule. **The RUC recommends a work RVU of 0.59 for CPT code 90853.**

#### **Practice Expense**

The RUC reviewed the direct practice expense inputs submitted by the specialty societies and recommends no modifications.

<b>CPT Code (•New)</b>	<b>Tracking Number</b>	<b>CPT Descriptor</b>	<b>Global Period</b>	<b>Work RVU Recommendation</b>
<b>Psychiatry</b> <u>Psychiatry services include diagnostic services, psychotherapy, and other services to an individual, family, or group. Patient condition, characteristics, or situational factors may require services described as being with interactive complexity. Services may be provided to a patient in crisis. Services are provided in all settings of care and psychiatry services codes are reported without regard to setting. Services may be provided by a physician or other qualified health care professional. Some psychiatry services may be reported with <b>Evaluation and Management Services</b> (99201-99255, 99281-99285, 99304-99337, 99341-99350) or other services when performed. <b>Evaluation and Management Services</b> (99201-99285, 99304-99337, 99341-99350) may be reported for treatment of psychiatric conditions, rather than using <b>Psychiatry Services</b> codes, when appropriate.</u>				

Hospital care by the attending physician in treating a psychiatric inpatient or partial hospitalization may be initial or subsequent in nature (see 99221-99233) and may include exchanges with nursing and ancillary personnel. Hospital care services involve a variety of responsibilities unique to the medical management of inpatients, such as physician hospital orders, interpretation of laboratory or other medical diagnostic studies and observations.

Some patients receive hospital evaluation and management services only and others receive hospital evaluation and management services and other procedures. If other procedures such as electroconvulsive therapy or psychotherapy are rendered in addition to hospital evaluation and management services, these ~~should~~may be listed separately (~~ieeg~~, hospital care services (99221-99223, 99231-99233) plus electroconvulsive therapy (90870), or when psychotherapy is done, ~~an~~with appropriate code(s) defining psychotherapy with medical evaluation and management services). Modifier 22 may be used to indicate a more extensive service. Modifier 52 may be used to signify a service that is reduced or less extensive than the usual procedure.

Other evaluation and management services, such as office medical service or other patient encounters, may be described as listed in the section on **Evaluation and Management**, if appropriate.

The evaluation and management services should not be reported separately, when reporting codes 90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827, 90829.

Consultation for psychiatric evaluation of a patient includes examination of a patient and exchange of information with the primary physician and other informants such as nurses or family members, and preparation of a report. These ~~consultation~~ services (99241-99255) are limited to initial evaluation and do not involve psychiatric treatment. Follow-up visits in the consultant's office or other outpatient facility that are initiated by the physician consultant or patient ~~are~~may be reported using the appropriate codes for established patients, office visits (99211-99215), domiciliary, rest home (99334-99337), or home (99347-99350). If an additional request for an opinion or advice regarding the same or a new problem is received from another physician or other appropriate source and documented in the medical record, the office consultation codes may be used again. Services that constitute transfer of care (ie, are provided for the management of the patient's entire care or for the care of a specific condition or problem~~see~~ **Consultations**) are reported with the appropriate new or established patient codes for office or other outpatient visits, domiciliary, rest home services, or home services.

### **Interactive Complexity**

Code 90785 is an add-on code for interactive complexity to be reported in conjunction with codes for diagnostic psychiatric evaluation (90791, 90792), psychotherapy (90832, 90834, 90837), psychotherapy when performed with an Evaluation and Management service (90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350), and group psychotherapy (90853).

Interactive complexity refers to specific communication factors that complicate the delivery of a psychiatric procedure. Common factors include more difficult communication with discordant or emotional family members and engagement of young and verbally undeveloped or impaired patients. Typical patients are those who have third parties, such as parents, guardians, other family members, interpreters, language translators, agencies, court officers, or schools involved in their psychiatric care.

These factors are typically present with patients who:

- Have other individuals legally responsible for their care, such as minors or adults with guardians, or
- Request others to be involved in their care during the visit, such as adults accompanied by one or more participating family members or interpreter or language translator, or
- Require the involvement of other third parties, such as child welfare agencies, parole or probation officers, or schools.

Psychiatric procedures may be reported “with interactive complexity” when at least one of the following is present:

1. The need to manage maladaptive communication (related to, eg, high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicates delivery of care.
2. Caregiver emotions or behavior that interferes with the caregiver’s understanding and ability to assist in the implementation of the treatment plan.

3. Evidence or disclosure of a sentinel event and mandated report to third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.
4. Use of play equipment, other physical devices, interpreter or translator to communicate with the patient to overcome barriers to therapeutic or diagnostic interaction between the physician or other qualified health care professional and a patient who:
  - Is not fluent in the same language as the physician or other qualified health care professional, or
  - Has not developed, or has lost, either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the physician or other qualified health care professional if he/she were to use typical language for communication.

When provided in conjunction with the psychotherapy codes 90832-90838, the amount of time spent by a physician or other qualified health care professional providing interactive complexity services should be reflected in the timed service code for psychotherapy (90832, 90834, 90837) or the psychotherapy add-on code performed with an Evaluation and Management service (90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350) and must relate to the psychotherapy service only. Interactive complexity is not a factor for Evaluation and Management Services selection (99201-99255, 99281-99285, 99304-99337, 99341-99350), except as it directly affects key components as defined in Evaluation and Management Services Guidelines (ie, history, examination and medical decision making).

+●90785	LL1	<p>Interactive Complexity (List separately in addition to the code for primary procedure)</p> <p><u>(Use 90785 in conjunction with codes for diagnostic psychiatric evaluation (90791, 90792), psychotherapy (90832, 90834, 90837), psychotherapy when performed with an Evaluation and Management service (90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350), and group psychotherapy (90853))</u></p> <p><u>(Do not use 90785 in conjunction with 90839, 90840 or in conjunction with E/M services when no psychotherapy service is also reported)</u></p>	ZZZ	Carrier Price
---------	-----	--	-----	---------------

### Psychiatric Diagnostic or Evaluative Interview Procedures

Psychiatric diagnostic interview examination includes a evaluation is an integrated biopsychosocial assessment, including history, mental status, and a disposition, and recommendations. The evaluation may include communication with family or other sources, ordering and review and medical interpretation ordering of laboratory or other medical diagnostic studies. In certain circumstances other informants will be seen in lieu of the patient.

Psychiatric diagnostic evaluation with medical services is an integrated biopsychosocial and medical assessment, including history, mental status, other physical examination elements as indicated, and recommendations. The evaluation may include communication with family or other sources, prescription of medications, and review and ordering of laboratory or other diagnostic studies.

In certain circumstances one or more other informants (family members, guardians, or significant others) may be seen in lieu of the patient. Codes 90791, 90792 may be reported more than once for the patient when separate diagnostic evaluations are conducted with the patient and other informants. Report services as being provided to the patient and not the informant or other party in such circumstances. Codes 90791, 90792 may be reported once per day and not on the same day as an Evaluation and Management service performed by the same individual for the same patient.

Interactive psychiatric diagnostic interview examination is typically furnished to children. It involves the use of physical aids and non-verbal communication to overcome barriers to therapeutic interaction between the clinician and a patient who has not yet developed, or has lost, either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the clinician if he/she were to use ordinary adult language for communication.

The psychiatric diagnostic evaluation may include interactive complexity services when factors exist that complicate the delivery of the psychiatric procedure. These services should be reported with add-on code 90785 used in conjunction with the diagnostic psychiatric evaluation codes 90791, 90792.

Codes 90791, 90792 are used for the diagnostic assessment(s) or reassessment(s), if required, and do not include psychotherapeutic services. Psychotherapy services, including for crisis, may not be reported on the same day.

D90801		Psychiatric diagnostic interview examination	XXX	N/A
--------	--	--	-----	-----

D90802		<del>Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication</del>  (90801 and 90802 have been deleted. To report diagnostic evaluations, see 90791, 90792)	XXX	N/A
●90791	LL2	Psychiatric diagnostic evaluation	XXX	3.00
●90792	LL3	Psychiatric diagnostic evaluation with medical services  (Do not report 90791 or 90792 in conjunction with 99201-99337, 99341-99350, 99366-99368, 99401-99444)  (Use 90785 in conjunction with 90791, 90792 when the diagnostic evaluation includes interactive complexity services)	XXX	3.25

### **Psychiatric Therapeutic Procedures**

Psychotherapy is the treatment for mental illness and behavioral disturbances in which the clinician establishes a professional contract with the patient and, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. The codes for reporting psychotherapy are divided into two broad categories: Interactive Psychotherapy; and Insight Oriented, Behavior Modifying and/or Supportive Psychotherapy.

Interactive psychotherapy is typically furnished to children. It involves the use of physical aids and nonverbal communication to overcome barriers to therapeutic interaction between the clinician and a patient who has not yet developed, or has lost, either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the clinician if he/she were to use ordinary adult language for communication.

Insight oriented, behavior modifying and/or supportive psychotherapy refers to the development of insight or affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination of the above to provide therapeutic change.

Some patients receive psychotherapy only and others receive psychotherapy and medical evaluation and management services. These evaluation and management services involve a variety of responsibilities unique to the medical management of psychiatric patients, such as medical diagnostic evaluation (eg, evaluation of comorbid medical conditions, drug interactions, and physical examinations), drug management when indicated, physician orders, interpretation of laboratory or other medical diagnostic studies and observations.

In reporting psychotherapy, the appropriate code is chosen on the basis of the type of psychotherapy (interactive using non verbal techniques versus insight oriented, behavior modifying and/or supportive using verbal techniques), the place of service (office versus inpatient), the face-to-face time spent with the patient during psychotherapy, and whether evaluation and management services are furnished on the same date of service as psychotherapy. Face-to-face time when providing psychotherapy with medical evaluation and management services includes time spent providing both psychotherapy and evaluation and management services (ie, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827, 90829).

To report medical evaluation and management services furnished on a day when psychotherapy is not provided, select the appropriate code from the **Evaluation and Management Services Guidelines**.

Office or Other Outpatient Facility  
Insight Oriented, Behavior Modifying  
and/or Supportive Psychotherapy

D90804		<del>Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face to face with the patient;</del>	XXX	N/A
D90805		<del>with medical evaluation and management services</del>	XXX	N/A
D90806		<del>Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face to face with the patient;</del>	XXX	N/A
D90807		<del>with medical evaluation and management services</del>	XXX	N/A
D90808		<del>Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face to face with the patient;</del>	XXX	N/A
D90809		<del>with medical evaluation and management services</del>  (90804, 90805, 90806, 90807, 90808, 90809 have been deleted. To report, see 90832, 90833, 90834, 90836, 90837, 90838 and 99201-99215, 99217-99220, 99224-99226, 99234-99236 as appropriate)	XXX	N/A
D90810		<del>Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face to face with the patient;</del>	XXX	N/A



D90811		<del>with medical evaluation and management services</del>	XXX	N/A
D90812		<del>Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;</del>	XXX	N/A
D90813		<del>with medical evaluation and management services</del>	XXX	N/A
D90814		<del>Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;</del>	XXX	N/A
D90815		<del>with medical evaluation and management services</del>  <u>(90810, 90811, 90812, 90813, 90814, 90815 have been deleted. To report, use 90785 in conjunction with 90832, 90833, 90834, 90836, 90837, 90838 and 99201-99215, 99217-99220, 99224-99226, 99234-99236 as appropriate)</u>	XXX	N/A
D90816		<del>Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient;</del>	XXX	N/A
D90817		<del>with medical evaluation and management services</del>	XXX	N/A

D90818		<del>Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face to face with the patient;</del>	XXX	N/A
D90819		<del>with medical evaluation and management services</del>	XXX	N/A
D90821		<del>Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face to face with the patient;</del>	XXX	N/A
D90822		<del>with medical evaluation and management services</del>  <u>(90816, 90817, 90818, 90819, 90821, 90822 have been deleted. To report, see 90832, 90833, 90834, 90836, 90837, 90838 and 99221-99223, 99231-99233, 99304-99316, 99324-99337 as appropriate)</u>	XXX	N/A
D90823		<del>Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face to face with the patient;</del>	XXX	N/A
D90824		<del>with medical evaluation and management services</del>	XXX	N/A
D90826		<del>Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face to face with the patient;</del>	XXX	N/A

D90827		<del>with medical evaluation and management services</del>	XXX	N/A
D90828		<del>Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face to face with the patient;</del>	XXX	N/A
D90829		<del>with medical evaluation and management services</del>  <u>(90823, 90824, 90826, 90827, 90828, 90829 have been deleted. To report, use 90785 in conjunction with 90832, 90833, 90834, 90836, 90837, 90838 and 99221-99223, 99231-99233, 99304-99316, 99324-99337 as appropriate)</u>	XXX	N/A

## **Psychotherapy**

Psychotherapy is the treatment of mental illness and behavioral disturbances in which the physician or other qualified health care professional, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

The psychotherapy service codes 90832–90838 include ongoing assessment and adjustment of psychotherapeutic interventions, and may include involvement of family member(s) or others in the treatment process.

Psychotherapy times are for face-to-face services with patient and/or family member. The patient must be present for all or some of the service. For family psychotherapy without the patient present, use 90846. In reporting, choose the code closest to the actual time (ie, 16-37 minutes for 90832 and 90833, 38-52 minutes for 90834 and 90836, and 53 or more minutes for 90837 and 90838). Do not report psychotherapy of less than 16 minutes duration. (See instructions for the usage of Time in the Introduction of the CPT code set).

Psychotherapy provided to a patient in a crisis state is reported with codes 90839 and 90840 and cannot be reported in addition to the psychotherapy codes 90832-90838. For psychotherapy for crisis, see “Other Psychotherapy”.

Code 90785 is an add-on code to report interactive complexity services when provided in conjunction with the psychotherapy codes 90832-90838. The amount of time spent by a physician or other qualified health care professional providing interactive complexity services should be reflected in the timed service code for psychotherapy (90832, 90834, 90837) or the psychotherapy add-on code performed with an Evaluation and Management service (90833, 90836, 90838).

Some psychiatric patients receive a medical evaluation and management (E/M) service on the same day as a psychotherapy service by the same physician or other qualified health care professional. To report both E/M and psychotherapy, the two services must be significant and separately identifiable. These services are reported by using codes specific for psychotherapy when performed with Evaluation and Management services (90833, 90836, and 90838) as add-on codes to the Evaluation and Management service.

Medical symptoms and disorders inform treatment choices of psychotherapeutic interventions, and data from therapeutic communication are used to evaluate the presence, type, and severity of medical symptoms and disorders. For the purposes of reporting, the medical and psychotherapeutic components of the service may be separately identified as follows:

1. The type and level of E/M service is selected first based upon the key components of history, examination, and medical decision-making.

<p>2. <u>Time associated with activities used to meet criteria for the E/M service is not included in the time used for reporting the psychotherapy service (ie, time spent on history, examination and medical decision making <b>when used for the E/M service</b> is not psychotherapy time). Time may not be used as the basis of E/M code selection and Prolonged Services may not be reported when psychotherapy with E/M (90833, 90836, 90838) are reported.</u></p> <p>3. <u>A separate diagnosis is not required for the reporting of E/M and psychotherapy on the same date of service.</u></p>				
●90832	LL4	Psychotherapy, 30 minutes with patient and/or family member	XXX	1.50
●+90833	LL5	Psychotherapy, 30 minutes with patient and/or family member when performed with an Evaluation and Management service (List separately in addition to the code for primary procedure)  (Use 90833 in conjunction with 99201-99255, 99304-99337, 99341-99350)	ZZZ	1.50
●90834	LL6	Psychotherapy, <b>45</b> minutes with patient and/or family member	XXX	2.00
●+90836	LL7	Psychotherapy, <b>45</b> minutes with patient and/or family member when performed with an Evaluation and Management service (List separately in addition to the code for primary procedure)  (Use 90836 in conjunction with 99201-99255, 99304-99337, 99341-99350)	ZZZ	1.90
●90837	LL8	Psychotherapy, <b>60</b> minutes with patient and/or family member	XXX	3.00

●+90838	LL9	<p>Psychotherapy, <b>60</b> minutes with patient and/or family member when performed with an Evaluation and Management service (List separately in addition to the code for primary procedure)</p> <p>(Use 90838 in conjunction with 99201-99255, 99304-99337, 99341-99350)</p> <p>(Use the appropriate prolonged services code (99354-99357) for psychotherapy services 68 minutes or longer)</p> <p>(Use 90785 in conjunction with 90832, 90833, 90834, 90836, 90837, 90838 when psychotherapy includes interactive complexity services)</p>	ZZZ	2.50
<p><b>Other Psychotherapy</b>  <b><u>Psychotherapy for Crisis</u></b></p> <p><u>Psychotherapy for crisis is an urgent assessment and history of a crisis state, a mental status exam, and a disposition. The treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma. The presenting problem is typically life threatening or complex and requires immediate attention to a patient in high distress.</u></p> <p><u>Codes 90839, 90840 are used to report the total duration of time face-to-face with the patient and/or family spent by the physician or other qualified health care professional providing psychotherapy for crisis, even if the time spent on that date is not continuous. For any given period of time spent providing psychotherapy for crisis state, the physician or other qualified health care professional must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same time period. The patient must be present for all or some of the service. Do not report with 90791 or 90792.</u></p> <p><u>Code 90839 is used to report the first 30-74 minutes of psychotherapy for crisis on a given date. It should be used only once per date even if the time spent by the physician or other health care professional is not continuous on that date. Psychotherapy for crisis of less than 30 minutes total duration on a given date should be reported with 90832 or 90833 (when provided with Evaluation and Management services).</u></p> <p><u>(90840 is used to report additional block(s) of time, of up to 30 minutes each beyond the first 74 minutes)</u></p>				
●90839	LL10	Psychotherapy for crisis, first 60 minutes;	XXX	Carrier Price

+●90840	LL11	each additional 30 minutes (List separately in addition to code for primary service)  (Use 9080CP2 in conjunction with 9080CP1)  (Do not report 90839, 90840 in conjunction with 90791, 90792, psychotherapy codes 90832-90838 or other psychiatric services, or 90785-90899)	ZZZ	Carrier Price
90845	LL12	Psychoanalysis	XXX	2.10 (RUC Recommendation October 2011)
90846	LL13	Family psychotherapy (without the patient present)	XXX	2.40
90847	LL14	Family psychotherapy (conjoint psychotherapy) (with patient present)	XXX	2.50
90849		Multiple-family group psychotherapy	XXX	0.59 (No Change)
90853	LL15	Group psychotherapy (other than of a multiple-family group)  (Use 90785 in conjunction with 90853 for the specified patient when group psychotherapy includes interactive complexity)	XXX	0.59 (No Change)
D90857		<del>Interactive group psychotherapy</del>  (90857 has been deleted. To report, use 90785 in conjunction with 90853)	XXX	N/A

<b>Other Psychiatric Services or Procedures</b> (For repetitive transcranial magnetic stimulation for treatment of clinical depression, see Category III codes 0160T, 0161T) (For analysis/programming of neurostimulators used for vagus nerve stimulation therapy, see 95970, 95974, 95975)				
D90862		<del>Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy</del>  <u>(90862 has been deleted. To report see evaluation and management codes 99201-99255, 99304-99337, 99341-99350 or 90863)</u>	XXX	N/A
●+90863	LL16	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)  <u>(Use 90863 in conjunction with 90832, 90834, 90837)</u>  <u>(For pharmacologic management with psychotherapy services performed by a physician or other qualified health care professional, who may report Evaluation and Management codes, use the appropriate Evaluation and Management codes 99201-99255, 99281-99285, 99304-99337, 99341-99350 and the appropriate Psychotherapy with Evaluation and Management service 90833, 90836, 90838)</u>  <u>(Do not count time spent on providing pharmacologic management services in the time used for selection of the psychotherapy service)</u>	ZZZ	Carrier Price (HCPAC Recommendation)
90875	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the Patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); approximately 20-30 minutes			
90876	approximately 45-50 minutes			





# American Psychiatric Association

1000 Wilson Boulevard  
Suite 1825  
Arlington, VA 22209  
Telephone 703.907.7300  
Fax 703.907.1085  
E-mail [apa@psych.org](mailto:apa@psych.org)  
Internet [www.psych.org](http://www.psych.org)

April 3, 2012

Barbara Levy, MD, AMA RUC Chair  
Sherry L. Smith, MS, CPA, Director, AMA Physician Payment Policy and Systems  
American Medical Association  
515 North State Street  
Chicago, Illinois 60654

Re: Tab 26, Psychotherapy

Dear Dr. Levy and Ms. Smith,

The American Psychiatric Association (APA), American Academy of Child and Adolescent Psychiatry (AACAP), American Psychological Association (APA-HCPAC), and National Association of Social Workers are submitting recommendations on 16\* new or revised codes within the Psychiatry section of CPT.

As you know, the above organizations originally put forward 36 codes as part of the fourth Five Year Review process in 2010. These codes comprised the bulk of the codes within the Psychiatry section of CPT. A pre-facilitation committee was assigned early in the process to assist the societies in their efforts. In June 2010 the pre-facilitation committee concurred with the recommendation of the RUC Research Subcommittee that the codes describing the psychiatric diagnostic examinations and psychotherapy with evaluation and management services be referred to the CPT Editorial Panel for review and revision to address changes in work.

Seventeen of the remaining codes were surveyed by the above named organizations, as well as by the American Psychiatric Nurses Association, and recommendations were presented for review by the RUC in October 2010. The RUC accepted the compelling evidence arguments put forward by the specialties as to a change in the work for these codes (see minutes of the October 2010 RUC meeting tab 52 page 87, Attachment 1). The specialties then requested that the 17 psychotherapy services that were to be reviewed at the October 2010 RUC meeting instead be referred to the CPT Editorial Panel for review and possible revision to address differences in work. This request was granted, and these codes were added to the work of a CPT Editorial Panel workgroup that was formed to address the earlier referral for revision of the CPT codes describing the psychiatric diagnostic exams and the codes describing the work when psychotherapy is performed in conjunction with an evaluation and management service.

The CPT Editorial Panel Workgroup on Psychological and Psychiatric Services (PPS), chaired by Patrick Cafferty, PA-C, and Boyd Buser, DO, met over the course of several months to develop a series of CPT codes that would more accurately describe the work performed. During that time, the workgroup determined that the description of work for Psychoanalysis (CPT code 90845) did not require changes and could move forward to the RUC. Recommendations based on the survey data from 2010 were submitted to

\*15 codes with 2012 survey data and 1 code, 90845, Psychoanalysis for reaffirmation



the RUC for review at its September 2011 meeting. The RUC accepted the societies' recommended values for 90845, (5 pre-service, 50 intra-service, 5 post-service time; 2.10 RVW) and forwarded that recommendation to CMS. In the 2012 Final Rule, published November XX, 2011, CMS elected not to finalize the RUC's recommended values until the remaining codes in the family were reviewed by the RUC. We are asking that the RUC reaffirm the previously approved values for 90845 at this meeting.

In February 2012, the CPT Editorial Panel approved a revised version of the workgroup's proposal that included 15 new or revised codes. We have submitted RUC recommendations on the following codes:

- 9080D1, Psychiatric diagnostic interview examination
- 9080D2, Psychiatric diagnostic evaluation with medical services
- 908P10 – 908P30 (30, 45, 60 minutes respectively) (XXX code), Psychotherapy with the patient and/or family member
- 908P10X-908P30X (30, 45, 60 minutes respectively) (ZZZ code), Psychotherapy with the patient and/or family member when performed with an evaluation and management service
- 90846, Family Therapy without the patient present
- 90847, Family Therapy with the patient present
- 90853, Group Therapy (other than multiple family group therapy)

As mentioned earlier we are requesting the RUC reaffirm the 2011 recommendation for the following code:

- 90845, Psychoanalysis – Reaffirmation of the RUC's 2011 recommendation

In addition to the recommendations for the codes listed above, we are requesting that the following codes be carrier priced. This will allow for education and experience with a significantly different coding structure than that in place for 2012. This will afford the RUC time to assess options for a survey and it will give providers experience with the codes prior to moving to an AMA RUC survey:

- 9080XE (ZZZ code), Interactive Complexity
- 908CP1, Psychotherapy for Crisis, first 60 minutes
- 908CP2 (ZZZ code), Psychotherapy for crisis, each additional 30 minutes
- 90862X (ZZZ code), Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services

### **Current RUC Recommendations**

The societies sought the approval of the RUC's Research Subcommittee prior to fielding their surveys. The subcommittee granted approval for the following items;

- Modification of the survey tools, including:
  - Adding the term "healthcare professional" to reflect varying educational backgrounds.
  - Adding a link to a PDF of the revised introductory language to the Psychiatry section
  - Modifying the XXX tool (XXX Group) used to survey the group psychotherapy code, 90853, for clarity
    - Adding a question asking for survey participants to indicate the typical number of patients they see in a group session.
    - Asking survey participants to base the time estimates and RVU estimates on the entire session rather than calculating them on a per patient basis.
  - Eliminating the moderate sedation section on the ZZZ tool (ZZZ) used to survey the add-on codes.
- Use of a common Reference Service list for all survey respondents, and approval to include a select number of reference service codes where the RVU calculation was done for the participant per the recommendation made by HCPAC at their September 2011 meeting.



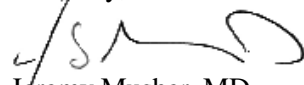
- Approval of a revised vignette for group psychotherapy (the current vignette in the RUC database was found to be typical by only 39% of survey respondents in the last survey process.)
- Modifications to the RUC educational tool, consistent with our requests regarding the healthcare professional and survey changes.
- Approval of a request by the American Psychological Association to conduct both a random survey and a proctored convenience sample of participants attending their March leadership conference.

As a result of the change noted above, the SOR for the group psychotherapy code, 90853, reflects a calculated RVW and times based on responses to the additional questions. The survey participants were asked to calculate the RVW and times based on the full length of the session rather than on a per patient basis. Those RVWs were then divided by the typical number of patients in a group therapy session as determined by respondents' answers to that additional survey question and those values were used in completing the SOR.

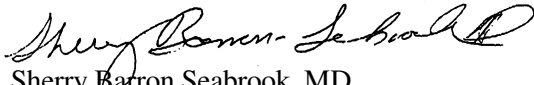
As we did in the 2011 presentation, we have included a breakdown of the survey results by physicians and non-physicians in those surveys where both groups jointly surveyed to facilitate RUC review of the data.

Thank you for your assistance throughout this process. We look forward to presenting our recommendations at the April RUC meeting in Chicago. We are available before then should you have any questions.

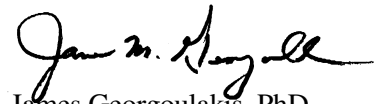
Sincerely,



Jeremy Musher, MD  
American Psychiatric Association, RUC Advisor



Sherry Barron Seabrook, MD  
American Academy of Child and Adolescent Psychiatry, RUC Advisor



James Georgoulakis, PhD  
American Psychological Association, HCPAC Advisor



Doris Tomer, LCSW  
National Association of Social Workers, HCPAC Advisor



**I. AMA/Specialty RVS Update Committee  
Meeting Minutes  
September 29 – October 3, 2010**

**II. Welcome and Call to Order**

Doctor Barbara Levy called the meeting to order on Thursday, September 30, 2010, at 8:00 am.  
The following RUC Members were in attendance:

Barbara Levy, MD (Chair)	Arthur Traugott, MD
Michael D. Bishop, MD	James Waldorf, MD
James Blankenship, MD	George Williams, MD
R. Dale Blasier, MD	Allan Anderson, MD*
Joel Bradley, MD	Gregory Barkley, MD*
Ronald Burd, MD	Dennis M. Beck., MD*
John Gage, MD	Bruce Deitchman, MD*
William Gee, MD	Gregory DeMeo, DO*
David Hitzeman, DO	Jane Dillon, MD*
Peter Hollmann, MD	Verdi DiSesa, MD*
Charles F. Koopmann, Jr., MD	Jeffrey Paul Edelstein, MD*
Robert Kossmann, MD	Emily Hill, PA-C*
Walt Larimore, MD	Robert Jansen, MD*
Brenda Lewis, DO	M. Douglas Leahy, MD*
J. Leonard Lichtenfeld, MD	William J. Mangold, Jr., MD*
Scott Manaker, MD, PhD	Daniel McQuillen, MD*
Geraldine McGinty, MD	Terry Mills, MD*
Bill Moran, Jr., MD	Scott D. Oates, MD*
Guy Orangio, MD	Julia Pillsbury, DO*
Gregory Przybylski, MD	Chad Rubin, MD*
Marc Raphaelson, MD	Steven Schlossberg, MD*
Sandra Reed, MD	Stanley Stead, MD*
Daniel Mark Siegel, MD	J. Allan Tucker, MD*
Lloyd Smith, DPM	Robert Stomel, DO*
Peter Smith, MD	
Susan Spires, MD	

\*Alternate

**III. Chair's Report**

- Doctor Levy welcomed the CMS staff and representatives attending the meeting, including:
  - Edith Hambrick, MD, CMS Medical Officer
  - Ken Simon, MD, CMS Medical Officer
  - Ryan Howe
  - Ferhat Kassamali
- Doctor Levy welcomed Jeffrey Cozzens, MD of the CPT Editorial Panel who is observing this meeting.

**Gastric Emptying Study (Tab 51)**

**Kevin Donohoe, MD, SNM; Kenneth McKusick, MD, SNM; Zeke Silva, MD, ACR**

In the 4<sup>th</sup> Five-Year Review of the RBRVS, CMS identified CPT code 78264 *Gastric emptying study* as potentially misvalued through the Harvard-Valued – Utilization Over 30,000 screen.

***78264 Gastric emptying study***

The specialty society provided compelling evidence there has been a change in technology as the protocol to perform CPT code 78264 has been standardized, the procedure is different than it was 20 years ago and the Harvard methodology was flawed as it used extrapolation to determine physician time and the work RVU. The performance and interpretation of radionuclide solid phase gastric emptying was standardized in 2009. The new guideline standardized the radiolabeled meal, the preparation of the patient, the acquisition and processing of the imaging data and the interpretation criteria. The preparation of the patient requires a standard patient questionnaire, assessment of the patient's glucose level, assessment of patient's current medications to avoid an adverse reaction and determining women's menstrual cycle. The standardized procedure now requires that the interpreting physician be certain that there was or was not >90% gastric emptying of the radiolabeled meal by four hours. Additionally, the interpretation is more complex requiring both greater knowledge of the clinical conditions leading to the procedures as well as the limitations and causes of errors in the results. The RUC determined that there is compelling evidence that the physician work and time required to perform this service has changed.

The RUC review the survey results from 168 radiologists and nuclear medicine physicians for code 78264 and determined that the median work RVU of 0.95 appropriately maintains the relativity among similar services. The RUC compared 78264 to key reference service CPT code 78707 *Kidney imaging morphology; with vascular flow and function, single study without pharmacological intervention* (work RVU = 0.96 and total time = 22 minutes) and determined that this service is a code comparison because the total physician time is the same, 22 minutes. For further support, the RUC compared this service to CPT code 78453 *Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)* (work RVU = 1.00 and total time = 20 minutes) and determined that the total physician time is similar to the surveyed service,.22 and 20 minutes, respectively, and that the survey median work RVU of 0.95 is appropriate in relation to this service. **The RUC recommends a work RVU of 0.95 for CPT code 78264.**

**Psychotherapy (Tab 52)**

**Naakesh Dewan, MD, APA; Chester Schmidt, MD, APA; Sherry Barron-Seabrook, MD, AACAP; Mary Moller, DNP, ARNP, ANA; Eileen Carlson, RN, JD, ANA; James Georgoulakis, PhD, APA; Doris Tomer, LCSW, NASW**  
***Facilitation Committee #1***

In the 4<sup>th</sup> Five-Year Review of the RBRVS, CMS received comment letters from the providers of psychotherapy, CPT codes 90801-90880 as potentially misvalued. CMS forwarded these services to the RUC to be included in the fourth Five-Year Review process. CPT code 90849 was withdrawn by the original commenter as the specialties

indicated that very few of their members provide this service. This specialty recommendation was supported by the Medicare utilization data for this service which was very low in 2008, 343 claims. In April 2010 and May 2010, the Research Subcommittee met to review vignettes and reference service lists. The Subcommittee recommended that 90801 and 90802 be removed from the list of codes to be reviewed and be referred to the CPT Editorial Panel so that modifications could be made to the descriptors to reflect the different work performed by the physician and non-physician providers. In June 2010, the Pre-Facilitation Committee met with the sponsoring specialty societies. The Pre-Facilitation Committee agreed with the Research Subcommittee's recommendations to refer 90801 and 90802 to the CPT Editorial Panel. The Pre-Facilitation Committee recommended that all of the psychotherapy codes with Evaluation and Management components (90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827, 90829, and 90862) be referred to the CPT Editorial Panel to potentially create a new coding structure based on the varying levels of evaluation and management within each code. The remainder of the CPT codes identified were surveyed for the October 2010 RUC Meeting.

At the October 2010 RUC Meeting, the specialties presented compelling evidence arguments to change the current value of the remaining psychotherapy services. The specialties indicated that the patient population receiving these services has dramatically changed since the codes were previously reviewed. Currently, according to a National Comorbidity Survey, 56% of patients receiving psychotherapy have comorbid conditions, meaning having more than one mental or physical disorder, including substance abuse. Due to the prevalence of co-morbid patients, the work of the provider has changed as most research treatment protocols were originally designed for patients with single disorders. Further, the specialties indicated that the site of service for patients receiving many of these services has changed. Patients, who were once treated in the hospital setting, are now more frequently being treated in the office setting as the number of psychiatric beds has dropped by more than 60% between 1970 and 2000. The RUC accepted these compelling evidence arguments to change the current value of these services.

The specialties requested that the remaining psychotherapy codes be referred to the CPT Editorial Panel along with the other psychotherapy codes for revision to address the differences in work performed by the physician and the non-physician providers. The RUC understands that a CPT Workgroup has been created to address all of these concerns with the psychotherapy codes and that a coding proposal will be issued from this Workgroup upon completion of their work to the CPT Editorial Panel for review. **The RUC recommends the psychotherapy codes be referred to the CPT Editorial Panel for revision.**

**Nasopharyngoscopy (Tab 53)**  
**Wayne Koch, MD, AAO-HNS**

In the 4<sup>th</sup> Five-Year Review of the RBRVS, CMS identified CPT code 92511 as potentially misvalued through the Harvard-Valued – Utilization over 30,000 screen.

***92511 Nasopharyngoscopy with endoscope (separate procedure)***

The RUC reviewed the survey results 30 otolaryngologists for CPT code 92511. The RUC noted that there is typically an Evaluation and Management services provided on the same day as this service. The specialties' explained that pre-service time of 11

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 90791      Tracking Number LL2

Original Specialty Recommended RVU: **3.00**Presented Recommended RVU: **3.00**

Global Period: XXX

RUC Recommended RVU: **3.00**

CPT Descriptor: Psychiatric diagnostic evaluation code

(Do not report 90791 or 90792 in conjunction with 99201-99337, 99341-99350, 99366-99368, 99401-99444)

(Use 90785 in conjunction with 90791, 90792 when the diagnostic evaluation includes interactive complexity services)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: Diagnostic evaluation of an adult with co-morbid medical conditions who reports increasing anxiety, irritability, and trouble sleeping. Although on antidepressant medication, the patient has been feeling increasingly depressed and helpless and is unable to go to work. The patient was referred by the primary care provider for psychotherapy services.

Percentage of Survey Respondents who found Vignette to be Typical: 82%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Review reason for referral, usually involves discussion with person who initiated referral, e.g. physician, family, law enforcement, employer, or an initial phone conversation when self-referred. When possible, involves review of records from referral source and lab or consultation reports.

Description of Intra-Service Work: Explain and obtain informed consent, obtain a psychiatric history, including present illness, past history, family history, complete mental status examination; referrals for other tests and evaluations as needed; review and ordering of diagnostic studies; establishing a definitive diagnosis or at least a narrow enough differential to warrant a treatment plan; decision making concerning need for degree of supervision (e.g. hospitalization); counseling with patient concerning diagnosis and options for treatment and proposed options, including explaining the need for and process of psychotherapy. May also include communication with family or other informants in addition to or in lieu of the patient.

Description of Post-Service Work: Arrange for further studies and further care; report to or discussion with referral source; arrange getting additional information; write or dictate results of examination; and frequently involves additional communication with patient and/or family after results of studies are known or additional health care records reviewed. May include report and consultation with third party utilization manager to arrange for payment and funding for proposed treatment.



**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2012				
<b>Presenter(s):</b>	Jeremy Musher, MD, Sherry Barron-Seabrook, MD; James Georgoulakis, PhD; Doris Tomer, LCSW				
<b>Specialty(s):</b>	American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, American Psychological Association, National Association of Social Workers				
<b>CPT Code:</b>	90791				
<b>Sample Size:</b>	1731	<b>Resp N:</b>	202	<b>Response:</b> 11.6 %	
<b>Description of Sample:</b> Random and Convenience					
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	30.00	<b>52.00</b>	126.00	2000.00
<b>Survey RVW:</b>	0.75	2.25	<b>3.00</b>	3.20	6.00
<b>Pre-Service Evaluation Time:</b>			<b>15.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>0.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>0.00</b>		
<b>Intra-Service Time:</b>	15.00	50.00	<b>60.00</b>	60.00	180.00
<b>Immediate Post Service-Time:</b>	<b>20.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

<b>CPT Code:</b>	90791	<b>Recommended Physician Work RVU: 3.00</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>10.00</b>	<b>0.00</b>	<b>10.00</b>
<b>Pre-Service Positioning Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>60.00</b>		
<b>Immediate Post Service-Time:</b>	<b>20.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00		

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99205	XXX	3.17	RUC Time

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Medicare Utilization</u>
99222	XXX	2.61	RUC Time	Most Recent 7,451,227

CPT Descriptor 1 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Medicare Utilization</u>
99223	XXX	3.86	RUC Time	Most Recent 11,496,707

CPT Descriptor 2 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99244	XXX	3.02	RUC Time

CPT Descriptor Office consultation for a new or established patient, which required these 3 key components: A comprehensive history; a comprehensive examination, and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code:** 86      **% of respondents:** 42.5 %

**TIME ESTIMATES (Median)**

	CPT Code: 90791	Key Reference CPT Code: 99205
Median Pre-Service Time	10.00	7.00
Median Intra-Service Time	60.00	45.00
Median Immediate Post-service Time	20.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>90.00</b>	<b>67.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)**

(of those that selected Key  
Reference code)

**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.11	4.19
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.40	3.61
Urgency of medical decision making	3.53	3.70

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.44	4.51
--------------------------	------	------

Physical effort required	2.02	2.15
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.60	3.71
Outcome depends on the skill and judgment of physician	4.23	4.20
Estimated risk of malpractice suit with poor outcome	3.17	3.26

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**

**Reference  
Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	2.21	2.21
Intra-Service intensity/complexity	4.24	4.19

---

## Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

### Background

We have provided a detailed cover letter regarding the background of this RUC submission which includes this code and the 10 others from the Psychiatry section that were surveyed in March 2012.

The physician specialty societies (the *MDs*) include the American Psychiatric Association (Psychiatry) and the American Academy of Child and Adolescent Psychiatry (Child Psychiatry). The psychologist and clinical social worker specialty societies (the *Non-MDs*) include the American Psychological Association (Psychology) and the National Association of Social Workers (Social Work).

90791, Psychiatric diagnostic evaluation, is a new code for a service that was previously reported using 90801, Psychiatric diagnostic interview examination. Psychologists and clinical social workers will typically use this code, while physicians and other medical professionals are expected to use 90792, although they may also use 90791 if medical services are not provided. These procedures can be reported in all settings (i.e., outpatient, inpatient, residential care, nursing facility) so the RVW recommended reflects the range of work necessary in order to appropriately provide the service in all settings.

As noted in our cover letter, the RUC accepted the compelling evidence arguments presented by the societies at the RUC's October 2010 meeting.

### Survey process

The survey was sent randomly to members of Psychiatry, Child Psychiatry, Psychology, and Social Work. In addition to the random sample, Psychology conducted a convenience sample of 100 psychologists attending a conference in Washington, DC. This in-person survey was monitored by AMA RUC staff and the chair of the RUC HCPAC. The reference service list was the same list used in all of the other XXX surveys for this family of codes that was reviewed and approved by the RUC Research Subcommittee. The societies worked jointly to develop a typical vignette.

As noted in our submission to the Practice Expense Subcommittee, there has been a shift in practice over the years, and while approximately half of the practicing psychiatrists employ administrative staff, a lesser number employ clinical staff. These numbers are even lower for psychologists, clinical social workers and other qualified healthcare providers. As a result, our PE submission did not include any clinical staff time. This is another argument for the RVW recommendation since this increased work is done entirely by the treating provider.

### Analysis and recommendations from the expert panel

The associations convened a joint society expert panel with broad representation from each group to review the survey data and make recommendations.

The review of the survey data by the expert panel showed that 82 percent of the survey respondents indicated that the vignette described the typical patient. The expert panel concluded the service performance rate was reasonable.

The expert panel supported the median survey time of 15 minutes pre-, 60 minutes intra-, and 20 minutes post-service work. The pre-service work includes locating and reviewing information from multiple sources, including notes from other professionals, correspondence from the patient or family members, symptom check lists, etc.

As noted earlier in the SOR, the intra-service work includes a variety clinical tasks and decision making functions. Given the nature and complexity of the patients and the need to generate comprehensive diagnostic reports, integrate information from multiple sources, follow up with referral sources when necessary, develop formal written treatment plans (typically required by insurers), and arrange appropriate disposition for the patient, and in light of the fact that the provider has no clinical staff to assist with these tasks, the expert panel agrees that 20 minutes accurately reflects the post-service time. **Therefore the expert panel recommends 15 minutes of pre-, 60 minutes intra-, and 20 minutes post-service for a total time of 95 minutes.**

The expert panel reviewed the survey median and 25<sup>th</sup> percentile data. The panel concluded that the median survey RVW of 3.00 was supported by the key reference service code, 99205, *Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family* (7, 45, 15; RVW 3.17), which was chosen by 42% of the survey respondents. An analysis of the data on intensity and complexity measures shows that in most instances the survey respondents found the work of the surveyed code was slightly less intense/complex than that of the higher valued reference code. This held true for most of the measures, with the key exceptions being the measure addressing the outcome (dependent on the skill and judgment of the physician) and the intensity and complexity of the intra-service period. Overall, the panel concluded this provided support for the median value.

The expert panel also compared the work of the surveyed code to 99222, *Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit* (15, 40, 20; RVW 2.61), with a total time of 75 minutes, which has a lower RVW and lower intra and total time, and to 99223, *Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit* (15, 55, 20; RVW 3.86) with a total time of 90 minutes. The surveyed code fell between the two MPC codes, which both have intra times and total times less than the surveyed code.

In addition, the expert panel compared the work of the surveyed code to 99244, *Office consultation for a new or established patient, which required these 3 key components: A comprehensive history; a comprehensive examination, and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family* (10, 40, 15; RVW 3.02), with a total time of 65 minutes and medical decision making of moderate complexity.

Based on the review and comparisons above, the expert panel believes the median RVW of 3.00 correctly reflects the appropriate rank order of this procedure. They also compared it to the current value of 2.80, and believe that the survey median reflects the appropriate value based on the increased complexity of the patients and the increased intensity of the work as compared to when the current values were established.

### **Recommendation**

In summary, based on comparisons of the reference code, and MPCs, **we recommend a median RVW of 3.00 and median times of 10 minutes pre-, 60 minutes intra-, 20 minutes post-time for a total time of 95 minutes for code 90791.**

---

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 90801

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Psychiatry                      How often? Rarely

Specialty Psychology                      How often? Commonly

Specialty Social Work                      How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 2532026

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This estimate is based on the fact that Medicare accounts for approximately 25% of all physician and clinician payments in the US; and that psychiatrists will only provide this service 1% of the time

Specialty Psychiatry	Frequency 27470	Percentage 1.08 %
Specialty Psychology	Frequency 1796554	Percentage 70.95 %
Specialty Social Work	Frequency 708002	Percentage 27.96 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

753,593 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on the most recent RUC database and the assumption that psychiatrists will only provide this service approximately 1% of the time

Specialty Psychiatry	Frequency 7530	Percentage 0.99 %
Specialty Psychology	Frequency 527515	Percentage 69.99 %
Specialty Social Work	Frequency 211006	Percentage 27.99 %

Do many physicians perform this service across the United States? Yes

---

**Professional Liability Insurance Information (PLI)**

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 90846

## AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 90792      Tracking Number   LL3

Original Specialty Recommended RVU: **3.25**Presented Recommended RVU: **3.25**

Global Period: XXX

RUC Recommended RVU: **3.25**

CPT Descriptor: Psychiatric diagnostic evaluation with medical services

(Do not report 90791 or 90792 in conjunction with 99201-99337, 99341-99350, 99366-99368, 99401-99444)

(Use 90785 in conjunction with 90791, 90792 when the diagnostic evaluation includes interactive complexity services)

### CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Diagnostic evaluation of an adult with co-morbid medical conditions who reports worsening depression and agitation. The patient has been feeling hopeless and sleeping poorly, and reports deteriorating work performance and marital problems. The patient was referred by the primary care provider after a six-week trial of an antidepressant medication with little improvement.

Percentage of Survey Respondents who found Vignette to be Typical: 71%

#### Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

#### Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Review available information including records, reason for referral, outside information and other gathered information such as rating scales and intake data forms including medical review of systems.

Description of Intra-Service Work: Introduce self to patient and obtain informed consent, including discussion of mandatory reporting. The purposes of the evaluation may include assessing competence, assessing safety, establishing a presumptive diagnosis(es) and formulating a treatment plan, including consideration of additional medical evaluation, medication, psychotherapy, or both and the appropriate site of service based on acuity and level of risk for potentially harmful behaviors, among other criteria (in-patient, day treatment or outpatient).

In order to accomplish the above, an extensive history is obtained, including present illness, past psychiatric history, chemical dependency history, family history, social history, and treatments, as well as a medical history, review of systems, and focused questions related to safety, lethality, aggression, and/or competence, as indicated. A specialty specific examination is completed as well. A working therapeutic relationship is established.

The findings are integrated into a diagnostic formulation, including specific medical psychiatric diagnoses, personality considerations, contributing general medical factors, psychosocial stressors and current level of functioning.

Based on these multi-faceted diagnoses, a treatment plan is formulated including consideration of medications, psychotherapy, general medical laboratory or other tests as well as level of care (inpatient, day hospital, intensive outpatient



or outpatient). This plan is discussed with the patient (and other parties as indicated/appropriate), treatment options are reviewed and informed consent is obtained to begin treatment. Prescriptions are provided for medication and additional medical diagnostic tests, when indicated.

Description of Post-Service Work: Arrangements are made for further studies and care including psychotherapy and other scheduled follow-up appointments. Requests may be made for other outside records. Documentation of the visit is completed. Referral sources may be contacted, and records forwarded to them. Follow-up as needed to address questions regarding medications, titration of dosage, and side-effects and results of additional testing. Questions or issues related to the psychiatric reasons for the visit are addressed, including addressing general psychiatric status as well as dealing with subsequent crises.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2012				
<b>Presenter(s):</b>	Jeremy Musher, MD, Sherry Barron-Seabrook, MD				
<b>Specialty(s):</b>	American Psychiatric Association, American Academy of Child and Adolescent Psychiatry				
<b>CPT Code:</b>	90792				
<b>Sample Size:</b>	1722	<b>Resp N:</b>	82	<b>Response:</b> 4.7 %	
<b>Description of Sample:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	37.50	100.00	150.00	1500.00
<b>Survey RVW:</b>	1.00	3.00	3.25	3.80	15.00
<b>Pre-Service Evaluation Time:</b>			10.00		
<b>Pre-Service Positioning Time:</b>			0.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.00		
<b>Intra-Service Time:</b>	30.00	50.00	60.00	75.00	180.00
<b>Immediate Post Service-Time:</b>	<b>20.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

XXX Global Code

<b>CPT Code:</b>	90792	<b>Recommended Physician Work RVU: 3.25</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		10.00	0.00	10.00
<b>Pre-Service Positioning Time:</b>		0.00	0.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	0.00	0.00
<b>Intra-Service Time:</b>		60.00		
<b>Immediate Post Service-Time:</b>	<b>20.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00		

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status?

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99205	XXX	3.17	RUC Time

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99223	XXX	3.86	RUC Time	11,496,707

CPT Descriptor 1 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99222	XXX	2.61	RUC Time	7,451,227

CPT Descriptor 2 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99244	XXX	3.02	RUC Time

CPT Descriptor Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code:** 35      **% of respondents:** 42.6 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 90792</b>	<b>Key Reference CPT Code: 99205</b>
Median Pre-Service Time	10.00	7.00
Median Intra-Service Time	60.00	45.00
Median Immediate Post-service Time	20.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>90.00</b>	<b>67.00</b>
<b>Other time if appropriate</b>		

Source of Time  
RUC Time**INTENSITY/COMPLEXITY MEASURES (Mean)**(of those that selected Key  
Reference code)**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.49	4.38
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.94	3.88
Urgency of medical decision making	3.71	3.69

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.66	4.47
--------------------------	------	------

Physical effort required	2.51	2.53
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.14	4.00
Outcome depends on the skill and judgment of physician	4.54	4.44
Estimated risk of malpractice suit with poor outcome	3.57	3.47

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.40	2.45
Intra-Service intensity/complexity	4.51	4.45

---

### Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

#### Background

We have provided a detailed cover letter regarding the background of this RUC submission which includes this code and the 10 others from the Psychiatry section that were surveyed in March 2012.

The physician specialty societies (the MDs) include the American Psychiatric Association (Psychiatry) and the American Academy of Child and Adolescent Psychiatry (Child Psychiatry).

90792, *Psychiatric diagnostic evaluation with medical services*, is a new code for a physician service that was previously reported by medical and nonmedical professionals using 90801. This new code, *Psychiatric diagnostic interview examination with medical services*, will be used by physicians and other qualified medical professionals. This procedure can be reported in all settings (i.e., outpatient, inpatient, residential care, nursing facility) so the RVW recommended reflects the range of work necessary in order to appropriately provide the service in all settings.

As noted in our cover letter, the RUC accepted the compelling evidence arguments presented by the societies at the RUC's October 2010 meeting.

#### Survey process

The survey was sent randomly to members of the American Psychiatric Association (APA) and the American Academy of Child and Adolescent Psychiatry (AACAP).

The reference service list was the same list used in all of the other XXX surveys for this family of codes that was reviewed and approved by the RUC Research Subcommittee. This new code 90792 will be used in all settings (i.e., outpatient, inpatient, residential care, nursing facility).

A typical vignette was developed with assistance of experts from APA and AACAP. It was agreed that while there are a considerable number of children and adolescents evaluated, the typical patient is an adult.

As noted in our submission to the Practice Expense Subcommittee, there has been a shift in practice over the years, and while approximately half of the practicing psychiatrists employ administrative staff, a lesser number employ clinical staff. As a result, our PE submission did not include any clinical staff time. This is another argument for the RVW recommendation since this increased work is done entirely by the treating provider.

#### Analysis and recommendations from the expert panel

The associations convened a joint society expert panel with broad representation from each group to review the survey data and make recommendations.

The expert panel concluded that 82 survey responses and the service performance rate of 100 per year are reasonable. They noted that while only 71 percent of those responding found the vignette to be typical, the majority of those who indicated the vignette was not typical stated that they worked with children and adolescents so their typical patient was simply not an adult.

The expert panel supported the median survey times of 10 minutes pre, 60 minutes intra, and 20 minutes post. As noted in the work descriptor, the 10 minutes of pre-service time is spent arranging for the appointment and collecting and reviewing medical records and other data, including correspondence from other professionals, the

patient and patient's family, symptom check lists, etc. prior to the first face-to-face visit. The 20 minutes of post-service time is spent scheduling the next appointment, developing a written treatment plan and documenting the visit, following up with others (providers/agencies/family members) to get collateral information and confirm any necessary information, providing verbal or written findings to referring providers, and seeking treatment authorizations. The pre- and post-service times are slightly higher than a higher level E/M office visit for a new patient, but equal to or slightly lower than the higher level initial hospital care code. Based on this comparison, **we recommend 10 minutes pre-, 60 minutes intra-, and 20 minutes post-service time for a total time of 90 minutes.**

We believe the median RVW result of 3.25 appropriately represents the current physician work for this code. This value is supported by an analysis of the intensity and complexity measures comparing the 90792 with the key reference service, 99205, *Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family, with an RVW of 3.17 and a total time of 67 minutes (7, 45, 15 pre, intra, and post respectively), which was chosen by 42% of the survey respondents. In reviewing those figures, the survey respondents indicated that the intensity and complexity of the work of the 90792 was greater than the 99205 in every measure with the exception of physical effort and the pre-service time segment, where the differences between the two were 0.02 and 0.05 respectively.*

An additional comparison can be made to 99223, *Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit. (15, 55, 20; RVW of 3.86) for a total time of 90 minutes. In comparing the two services, the expert panel noted that the total time was the same and the variation of the RVW could be accounted for by the increased intensity for inpatient care. They noted that the survey median RVW of 3.25 falls between the codes for the initial day inpatient service and a new patient outpatient visit.*

The expert panel also compared the typical work to the inpatient and outpatient consultation codes: 99254, *Inpatient consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes at the bedside and on the patient's hospital floor or unit (15, 45, 20; RVW 3.29), with a total time of 80 minutes and medical decision making of moderate complexity; and 99244, *Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family, (10, 40, 15; RVW 3.02) with a total time of 65 minutes and medical decision making of moderate complexity.**

The 99254 and the 99244 codes are similar in work and level of medical decision making to the surveyed code and represent work performed in inpatient and outpatient settings. The survey median of 3.25 is greater than the shorter timed service of the 99244 and closer to the 80 minute service of the 99254. For 90792, in addition to completing an evaluation, the physician is also constructing a detailed treatment plan and discussing ongoing treatment options with the patient rather than writing a report back to the referring provider. We believe this comparison supports the median value.

### Recommendation

In summary, based on comparisons to the reference code, MPCs, and other codes, **we recommend the median RVW of 3.25, and median times of 10 minutes pre-, 60 minutes intra-, and 20 minutes post-time for a total time of 90 minutes for code 90792.**

---

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 90801, 90802

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Psychiatry                      How often? Commonly

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 2719532

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on Medicare accounting for approximately 25% of all physician and clinical expenses, and the number of 90801 and 90802s done by psychiatrists in the latest RUC database, and assuming only 1% of them will do an initial evaluation without medical services (908D1).

Specialty Psychiatry                      Frequency 2719532                      Percentage 100.00 %

Specialty                      Frequency                      Percentage                      %

Specialty                      Frequency                      Percentage                      %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

753,593 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on most recent RUC database, with the assumption that 99% of psychiatrists will use this new code for evaluation with medical services.

Specialty Psychiatry                      Frequency 753593                      Percentage 100.00 %

Specialty                      Frequency                      Percentage                      %

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States?

---

**Professional Liability Insurance Information (PLI)**

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 90846



**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:90832      Tracking Number LL4

Original Specialty Recommended RVU: **1.50**Presented Recommended RVU: **1.50**

Global Period: XXX

RUC Recommended RVU: **1.50**

CPT Descriptor: Psychotherapy, 30 minutes with patient and/or family member

(Use the 90785 in conjunction with (90832, 90833, 90834, 90836, 90837, 90838 when psychotherapy includes interactive complexity services)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: Psychotherapy for a young adult with the diagnoses of depression, anxiety, and attention deficit disorder who has relationship problems and recently moved away from family. Patient is taking stimulant and antidepressant medications.

Percentage of Survey Respondents who found Vignette to be Typical: 69%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&amp;M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Prepare to see patient and/or family member. Review record. Communicate with other professionals and significant others such as guardians, caretakers, and family members.

Description of Intra-Service Work: Face-to-face therapeutic communication with patient and/or family member. Obtain objective information and interval history. Examine mental state. Evaluate and explore intensity and complexity of symptoms, feelings, thoughts, and behaviors in the context of psychosocial and health stressors and coping styles. Use a range of psychotherapy approaches to reduce distress, morbidity, and address ongoing behavioral and mental status changes in the patient.

Description of Post-Service Work: Arrange for further services. Coordinate care in writing or by telephone with patient, family, and other professionals such as a primary care provider. Document intra-service and post-service work activities. Provide written or telephone reports to third-party payers.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2012				
<b>Presenter(s):</b>	Jeremy Musher, MD, Sherry Barron-Seabrook, MD; James Georgoulakis, PhD; Doris Tomer, LCSW				
<b>Specialty(s):</b>	American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, American Psychological Association, National Association of Social Workers				
<b>CPT Code:</b>	90832				
<b>Sample Size:</b>	1873	<b>Resp N:</b>	185	<b>Response:</b> 9.8 %	
<b>Description of Sample:</b>	Random and Convenience				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	2.00	15.00	60.00	1600.00
<b>Survey RVW:</b>	0.45	1.00	1.50	1.75	4.00
<b>Pre-Service Evaluation Time:</b>			10.00		
<b>Pre-Service Positioning Time:</b>			0.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.00		
<b>Intra-Service Time:</b>	1.00	30.00	30.00	30.00	75.00
<b>Immediate Post Service-Time:</b>	<u>10.00</u>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

<b>CPT Code:</b>	90832	<b>Recommended Physician Work RVU: 1.50</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		5.00	0.00	5.00
<b>Pre-Service Positioning Time:</b>		0.00	0.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	0.00	0.00
<b>Intra-Service Time:</b>		30.00		
<b>Immediate Post Service-Time:</b>	<u>10.00</u>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00		

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
96152	XXX	0.46	RUC Time

CPT Descriptor Health and behavior intervention, each 15 minutes, face-to-face; individual**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99214	XXX	1.50	RUC Time	78,471,610

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99232	XXX	1.39	RUC Time	50,265,346

CPT Descriptor 2 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99382	XXX	1.60	RUC Time

CPT Descriptor Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years)**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 58      % of respondents: 31.6 %

**TIME ESTIMATES (Median)**

	CPT Code: 90832	Key Reference CPT Code: 96152	Source of Time RUC Time
Median Pre-Service Time	5.00	4.00	
Median Intra-Service Time	30.00	15.00	

Median Immediate Post-service Time	10.00	5.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>45.00</b>	<b>24.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.09	2.89
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.82	2.82
--	------	------

Urgency of medical decision making	2.68	2.63
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.60	3.45
--------------------------	------	------

Physical effort required	1.67	1.68
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.54	2.47
---	------	------

Outcome depends on the skill and judgment of physician	3.65	3.40
--	------	------

Estimated risk of malpractice suit with poor outcome	2.47	2.33
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.11	2.04
----------------------------------	------	------

Intra-Service intensity/complexity	3.44	3.30
------------------------------------	------	------

Post-Service intensity/complexity	2.42	2.32
-----------------------------------	------	------

## Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

### Background

We have provided a detailed cover letter regarding the background of this RUC submission which includes this code and the 10 others from the Psychiatry section that were surveyed in March 2012.

The physician specialty societies (the *MDs*) include the American Psychiatric Association (Psychiatry) and the American Academy of Child and Adolescent Psychiatry (Child Psychiatry). The psychologist and clinical social worker specialty societies (the *Non-MDs*) include the American Psychological Association (Psychology) and the National Association of Social Workers (Social Work).

The 90832, Psychotherapy, 30 minutes with patient and/or family member had previously been reported as 90804 (Psychotherapy 20-30 minutes, outpatient) and 90816 (Psychotherapy, 20-30 minutes, facility). The 90832 will be used in all settings (i.e., outpatient, inpatient, residential care, nursing facility).

### Survey process

The survey was sent randomly to members of Psychiatry, Child Psychiatry, Psychology, and Social Work. In addition to a random sample, Psychology conducted a convenience sample of 100 psychologists attending a conference in Washington, DC. The in-person survey was monitored by AMA RUC staff and the chair of the RUC HCPAC. The reference service list was the same list used in all of the other XXX surveys for this family of codes and was reviewed and approved by the RUC Research Subcommittee. The societies worked jointly to develop a typical vignette. The typical patient for this service is an adult patient.

As noted in our submission to the Practice Expense Subcommittee, there has been a shift in practice over the years, and while approximately half of the practicing psychiatrists employ administrative staff, a lesser number employ clinical staff. These numbers are even lower for psychologists, clinical social workers and other qualified healthcare providers. As a result, our PE submission did not include any clinical staff time. This is another argument for the RVW recommendation since this increased work is done entirely by the treating provider.

### Analysis and recommendations from the expert panel

The associations involved in this survey convened a joint society expert panel with broad representation from each group to review the survey data and make recommendations.

The review of the survey by the expert panel determined there were 185 survey responses. Sixty-nine percent of the survey respondents found the vignette typical. The panel noted that a variety of reasons were listed by those who did not find the vignette typical. The most frequent response was that they simply did not treat adult patients, some others noted they did not typically see patients for 30 minutes but rather for 45 minutes or that the vignette described a more complex patient than they would see for 30 minutes.

The median survey results regarding time are 10 minutes pre-service, 30 minutes intra-service, and 10 minutes post-service. The expert panel supports the survey results for the median time of 30 minutes for the intra-service. The panel also agreed that the survey result of 10 minutes of pre-service time is representative of what would typically occur with 90832. The panel noted that the post-service times from the survey varied across the three timed psychotherapy codes (90832, 90834, 90837). They believe the post-service time is typically consistent across the three services. They believe that the survey respondents likely underestimated the post-service time for the 90832. The panel believes 12 minutes is typical due to the range of services provided during the post-service period which include arranging for further service, coordinating care with the patient, family, and other professionals such as primary care providers, documenting intra-service and post-service work activities, and providing reports to third-party payers. These activities are typically performed directly by the psychotherapist without assistance of clinical staff. There is also increased documentation time because providers of psychotherapy services typically maintain a separate record from the medical record for psychotherapy process notes as allowed under HIPAA to protect patient privacy. **Therefore, the panel**

**recommends 10 minutes pre-service, 30 minutes intra-service, and 12 minutes post-service times for a total of 52 minutes.**

An analysis of the intensity and complexity measures of the surveyed code as compared to the key reference service, 96152, *Health and behavior intervention, each 15 minutes, face-to-face; individual* (4, 15, 5; RVW 0.46) shows that the surveyed code is greater in intensity and complexity in nine of the identified areas and the same for the tenth of the eleven measures. The panel agreed that 90832 and 96152 are different services. The skills and expertise required to provide a psychotherapy service exceed those for a health and behavior service. This increased intensity/complexity accounts for a higher RVW of 1.50 for the surveyed code.

Additional support for this is provided by the comparison of the surveyed code to 99214, *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family* (5, 25, 10; RVW 1.50), which is similar in work with less total time.

The panel also compared the surveyed code with 99382, *Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years)* (5, 25, 5; RVW 1.60), with a total time of 35 minutes, which they believe supports the median RVW of 1.50 on the basis of increased time, and increased intensity of work of the surveyed code when compared with a preventive medicine visit with a higher RVW.

The panel further compared the 90833 to 99232, *Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit* (10, 20, 10; RVW 1.39), with a total time of 40 minutes. The panel believes the median survey value is supported by the increased time of the 90832 and the range of settings in which the service is delivered.

Finally, the expert panel reviewed the median RVW in the context of survey values for the range of timed psychotherapy codes and found that the relativity of the values of the codes across the family of codes was consistent.

### **Recommendation**

In summary, based on the comparisons to the MPCs and other codes, **the expert panel recommends an RVW of 1.50 and median values of 10 minutes pre-, 30 minutes intra-, 12 minutes post-time for a total time of 52 minutes for 90832.**

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 90804, 90816

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Psychiatry                      How often? Sometimes

Specialty Psychology                      How often? Commonly

Specialty Social Work                      How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 8,822,536

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare payments are approximately 25% of total physician and clinical services expenses in US.

Specialty Psychiatry	Frequency 711249	Percentage 8.06 %
Specialty Psychology	Frequency 5071281	Percentage 57.48 %
Specialty Social Work	Frequency 2759059	Percentage 31.27 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,214,469 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on most recent RUC database

Specialty Psychiatry	Frequency 177157	Percentage 7.99 %
Specialty Psychology	Frequency 1273319	Percentage 57.49 %
Specialty Social Work	Frequency 686485	Percentage 30.99 %

Do many physicians perform this service across the United States? Yes

---

**Professional Liability Insurance Information (PLI)**

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 90846



**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 90833      Tracking Number   LL5

Original Specialty Recommended RVU: **1.50**Presented Recommended RVU: **1.50**

Global Period: ZZZ

RUC Recommended RVU: **1.50**

CPT Descriptor: Psychotherapy, 30 minutes with patient and/or family member when performed with an Evaluation and Management service

(List separately in addition to the code for primary procedure)

(Use 90833 in conjunction with 99201-99255, 99304-99337, 99341-99350)

(Use the 90785 in conjunction with (90832, 90833, 90834, 90836, 90837, 90838 when psychotherapy includes interactive complexity services)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: Psychotherapy for a young adult with the diagnoses of depression, anxiety, and attention deficit disorder who has relationship problems and recently moved away from family. Patient is taking stimulant and antidepressant medications.

Percentage of Survey Respondents who found Vignette to be Typical: 70%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

**Description of Pre-Service Work:**

Description of Intra-Service Work: Data from various sources, including past interactions with the patient, current history and mental status findings, information which may have come to light from other historians or outside records, and the patient's behavior, descriptions, and responses to intra-session interventions, are all reviewed or considered and a working therapeutic interpretation, behavioral treatment plan or supportive intervention strategy is formulated and enacted. Examples of the focus of this intervention could include a current acute situation, suicidal thought/ safety plan, or a pattern of dysfunctional behavior. Evidence of behavioral change, demonstration of insight, or reduction in symptoms (anxiety, depression, irritability, etc.) is sought based on the psychotherapeutic interventions.

Description of Post-Service Work: Documentation of the symptoms and behaviors that are the focus of the treatment, as well as the specific psychotherapeutic intervention and work done in the session.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2012				
<b>Presenter(s):</b>	Jeremy Musher, MD, Sherry Barron-Seabrook, MD				
<b>Specialty(s):</b>	American Psychiatric Association, American Academy of Child and Adolescent Psychiatry				
<b>CPT Code:</b>	90833				
<b>Sample Size:</b>	1797	<b>Resp N:</b>	114	<b>Response:</b> 6.3 %	
<b>Description of Sample:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	20.00	100.00	500.00	9000.00
<b>Survey RVW:</b>	0.48	1.25	1.50	1.60	3.50
<b>Pre-Service Evaluation Time:</b>			0.00		
<b>Pre-Service Positioning Time:</b>			0.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.00		
<b>Intra-Service Time:</b>	5.00	25.00	30.00	35.00	75.00
<b>Immediate Post Service-Time:</b>	<b>0.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

ZZZ Global Code

<b>CPT Code:</b>	90833	<b>Recommended Physician Work RVU: 1.50</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		0.00	0.00	0.00
<b>Pre-Service Positioning Time:</b>		0.00	0.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	0.00	0.00
<b>Intra-Service Time:</b>		30.00		
<b>Immediate Post Service-Time:</b>	<b>3.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00		

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99214	XXX	1.50	RUC Time

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99232	XXX	1.39	RUC Time	50,265,346

CPT Descriptor 1 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99243	XXX	1.88	RUC Time	1

CPT Descriptor 2 Office consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99252	XXX	1.50	RUC Time

CPT Descriptor Inpatient consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 40 minutes at the bedside and on the patient's hospital floor or unit.

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code:** 64      **% of respondents:** 56.1 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 90833</b>	<b>Key Reference CPT Code: 99214</b>
Median Pre-Service Time	0.00	5.00
Median Intra-Service Time	30.00	25.00
Median Immediate Post-service Time	3.00	10.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>33.00</b>	<b>40.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.76	2.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.71	2.83
Urgency of medical decision making	2.79	2.69

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.43	3.20
--------------------------	------	------

Physical effort required	2.02	2.06
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.79	2.82
Outcome depends on the skill and judgment of physician	3.59	3.55
Estimated risk of malpractice suit with poor outcome	2.93	2.91

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	1.81	1.92
Intra-Service intensity/complexity	3.26	3.24

---

## Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

### Background

We have provided a detailed cover letter regarding the background of this RUC submission which includes this code and the 10 others from the Psychiatry section that were surveyed in March 2012.

The physician specialty societies (the MDs) include the American Psychiatric Association (Psychiatry) and the American Academy of Child and Adolescent Psychiatry (Child Psychiatry).

The 90833, *psychotherapy, 30 minutes with patient and/or family member (list separately in addition to the code for primary service)* had previously been reported as a bundled service (90805, *Psychotherapy 20-30 minutes, office, with medical evaluation and management services*; and 90817, *Psychotherapy 20-30 minutes, facility, with medical evaluation and management services*) that captured the work of the psychotherapy and the E/M services in one code. The psychotherapy with medical evaluation and management codes varied only by time with the level of E/M work remaining constant. The newly approved framework describes the work more accurately, allowing for the differentiation of the E/M work based on the actual level of service provided. Psychiatrists will select the appropriate evaluation and management code based on the key elements, adding on the psychotherapy add-on code based only on the time spent providing psychotherapy. There is minimal overlap between the E/M service and the psychotherapy procedure. The information collected during the E/M portion of the service informs the psychotherapy process and the time spent collecting that data during the E/M portion is not counted in the time spent providing psychotherapy.

### Survey process

The survey for the 90833 was sent to a random sample of psychiatrist members of the American Psychiatric Association (APA) and the American Academy of Child and Adolescent Psychiatry (AACAP). This code can be used in all settings (i.e., outpatient, inpatient, residential care, nursing facility).

The reference service list was the same list used in all of the other ZZZ surveys for this family of codes and was reviewed and approved by the RUC Research Subcommittee. A typical vignette was developed with assistance of experts from APA and AACAP.

As noted in our submission to the Practice Expense Subcommittee, there has been a shift in practice over the years, and while approximately half of the practicing psychiatrists employ administrative staff, a lesser number employ clinical staff. As a result, our PE submission did not include any clinical staff time. This is another argument for the RVW recommendation since this increased work is done entirely by the treating provider.

### Analysis and recommendations from the expert panel

The associations convened a joint society expert panel with broad representation from each group to review the survey data and make recommendations.

The expert panel reviewed the number of responses and the service performance rate. Although there were a number of respondents who indicated they had never performed the service, the expert panel believes these individuals were unfamiliar with the survey process and did not recognize a current service being described in a different way. Of the 114 survey respondents, 70 percent found the vignette to be typical. As with the 9080D2, a significant number of those who said the patient described was not typical indicated that they specialized in child and adolescent or geriatric psychiatry, noting simply that their typical patient was not an adult.

The expert panel supports the median survey times of 30 minutes of intra service time. This code is an add-on code and as such typically has no pre or post time. The expert panel believes that additional documentation requirements for psychotherapy services adds additional time that is not captured in the evaluation and management codes billed with these services. It is typical for payers to require separate documentation of the psychotherapy session including a description of the modality used, the psychotherapeutic intervention, the focus of the session and the patient's response to treatment. The expert panel supports adding an additional 3 minutes post service time to account for that work, particularly in light of the fact that there is no clinical staff to assist in this work. Based on the above, **we recommend 0 minutes pre, 30 minutes intra, and 3 minutes post service time.**

We believe that the median survey RVW of 1.50 appropriately represents the typical work of this service. This is supported by a comparison of the intensity and complexity measures of the surveyed code with the key reference service. 56% of the survey respondents chose 99214, *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family, (5, 25, 10; RVW 1.50)* with a total time of 40 minutes, as the key reference service. A comparison of the measures shows that the respondents found the surveyed code to be greater in intensity/complexity to the reference code a majority of the time including during the intra-service period.

In looking at other services, the expert panel compared the 90833 with 99242, *Office consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family. (5, 25, 10; RVW 1.34).* In addition to a slightly longer intra-service time, the expert panel believes that the typical presenting problems addressed in the 90833 are of greater severity than those typically addressed by the low level consultation code, thus supporting a higher RVW.

Additional comparisons were made between the surveyed code and CPT codes 99232, *Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. (10, 20, 10; RVW 1.39)* and 99252, *Inpatient consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 40 minutes at the bedside and on the patient's hospital floor or unit. (5, 25, 10; RVW 1.50).* The panel concluded that the intensity of the work of the surveyed code surpassed or equaled the work of these code which have slightly lower intra-service times, thus providing further support for the median RVW.

The expert panel also reviewed the survey data for the entire family of psychotherapy codes and found relativity across the survey results, including the results for 90845, psychoanalysis, which was reviewed by the RUC in September 2011 with reaffirmation requested at this meeting. The panel found that the median RVWs of the 90833, 90836, 90838 codes (psychotherapy when done in conjunction with an E/M service) were equal to or just below that of the 90832, 90834, 90837 codes (psychotherapy only) There is also relativity when compared with other forms of psychotherapy ( 90845, 90846 and 90847).

### **Recommendation**

In summary, based on comparisons to the reference code, MPC codes, and other codes, **we recommend the median RVW of 1.50, and median times of 0 minutes pre, 30 minutes intra, and 3 minutes post time for a total time of 33 minutes for the 90833.**

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.  
☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.  
☐ Multiple codes allow flexibility to describe exactly what components the procedure included.  
☐ Multiple codes are used to maintain consistency with similar codes.  
☐ Historical precedents.  
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 90805, 90817

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Psychiatry                      How often? Commonly

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 7636948

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare payments are approximately 25% of total physician and clinical services expenses in US.

Specialty Psychiatry                      Frequency 6862470                      Percentage 89.85 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,439,350 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is the 2010 Medicare Data from the RUC database. We do not anticipate a change.

Specialty Psychiatry                      Frequency 1295415                      Percentage 90.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency                      Percentage                      %

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 90846

### Services Reported with Multiple CPT Codes – Psychotherapy when performed with an E/M Service

CPT Code	Global Day	Work RVU	Pre-Service	Intra-Service	Post-Service	Total Time
99212	XXX	0.48	2	10	4	16
99213	XXX	0.97	3	15	5	23
99214	XXX	1.5	5	25	10	40
99215	XXX	2.11	5	35	15	55
99224	XXX	0.76	5	10	5	20
99225	XXX	1.39	10	20	10	40
99226	XXX	2	10	30	15	55
99231	XXX	0.76	5	10	5	20
99232	XXX	1.39	10	20	10	40
99233	XXX	2	10	30	15	55
99307	XXX	0.76	5	10	5	20
99308	XXX	1.16	7	15	9	31
99309	XXX	1.55	10	25	10	45
90833	ZZZ	1.5		30	3	33
90836	ZZZ	1.9		45	3	48
90838	ZZZ	2.1		60	3	63



**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 90834      Tracking Number   LL6

Original Specialty Recommended RVU: **2.00**Presented Recommended RVU: **2.00**

Global Period: XXX

RUC Recommended RVU: **2.00**

CPT Descriptor: Psychotherapy, 45 minutes with patient and/or family member

(Use the 90785 in conjunction with (90832, 90833, 90834, 90836, 90837, 90838 when psychotherapy includes interactive complexity services)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: Psychotherapy for an adult suffering from co-morbid medical conditions, depression, and agitation of two months duration which resulted in loss of job after several emotional outbursts at work. Patient is anxious about loss of income and inability to find another job.

Percentage of Survey Respondents who found Vignette to be Typical: 82%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&amp;M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Prepare to see patient and/or family member. Review record. Communicate with other professionals and significant others such as guardians, caretakers, and family members.

Description of Intra-Service Work: Face-to-face therapeutic communication with patient and/or family member. Obtain objective information and interval history. Examine mental state. Evaluate and explore intensity and complexity of symptoms, feelings, thoughts, and behaviors in the context of psychosocial and health stressors and coping styles. Use a range of psychotherapy approaches to reduce distress, morbidity, and address ongoing behavioral and mental status changes in the patient.

Description of Post-Service Work: Arrange for further services. Coordinate care in writing or by telephone with patient, family, and other professionals such as a primary care provider. Document intra-service and post-service work activities. Provide written or telephone reports to third-party payers.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2012				
<b>Presenter(s):</b>	Jeremy Musher, MD, Sherry Barron-Seabrook, MD; James Georgoulakis, PhD; Doris Tomer, LCSW				
<b>Specialty(s):</b>	American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, American Psychological Association, National Association of Social Workers				
<b>CPT Code:</b>	90834				
<b>Sample Size:</b>	1873	<b>Resp N:</b>	183	<b>Response:</b> 9.7 %	
<b>Description of Sample:</b>	Random and Convenience				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	30.00	<b>240.00</b>	700.00	2500.00
<b>Survey RVW:</b>	0.98	1.50	<b>2.00</b>	2.35	4.00
<b>Pre-Service Evaluation Time:</b>			<b>0.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>0.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>0.00</b>		
<b>Intra-Service Time:</b>	10.00	45.00	<b>45.00</b>	45.00	95.00
<b>Immediate Post Service-Time:</b>	<b>12.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

<b>CPT Code:</b>	90834	<b>Recommended Physician Work RVU: 2.00</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		5.00	0.00	5.00
<b>Pre-Service Positioning Time:</b>		0.00	0.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	0.00	0.00
<b>Intra-Service Time:</b>		45.00		
<b>Immediate Post Service-Time:</b>	<b>10.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
96152	XXX	0.46	RUC Time

CPT Descriptor Health and behavior intervention, each 15 minutes, face-to-face; individual**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99233	XXX	2.00	RUC Time	21,650,554

CPT Descriptor 1 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99215	XXX	2.11	RUC Time	9,976,351

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99214	XXX	1.50	RUC Time

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 52      % of respondents: 28.4 %

**TIME ESTIMATES (Median)**

	<u>CPT Code:</u> 90834	<u>Key Reference CPT Code:</u> 96152	<u>Source of Time</u> RUC Time
Median Pre-Service Time	5.00	4.00	

Median Intra-Service Time	45.00	15.00
Median Immediate Post-service Time	10.00	5.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>60.00</b>	<b>0.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.56	3.35
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.31	3.25
Urgency of medical decision making	3.21	3.04

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.04	3.75
Physical effort required	1.77	1.80

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.08	3.02
Outcome depends on the skill and judgment of physician	3.98	3.76
Estimated risk of malpractice suit with poor outcome	2.82	2.73

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.24	2.25
Intra-Service intensity/complexity	3.90	3.71
Post-Service intensity/complexity	2.84	2.79

## **Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

### **Background**

We have provided a detailed cover letter regarding the background of this RUC submission which includes this code and the 10 others from the Psychiatry section that were surveyed in March 2012.

The physician specialty societies (the *MDs*) include the American Psychiatric Association (Psychiatry) and the American Academy of Child and Adolescent Psychiatry (Child Psychiatry). The psychologist and clinical social worker specialty societies (the *Non-MDs*) include the American Psychological Association (Psychology) and the National Association of Social Workers (Social Work).

The 90834, Psychotherapy, 45 minutes with patient and/or family member had previously been reported as 90806 (Psychotherapy 45-50 minutes, outpatient) and 90816 (Psychotherapy, 45-50 minutes, facility). The 90834 will be used in all settings (i.e., outpatient, inpatient, residential, nursing facility).

### **Survey process**

The survey was sent randomly to members of Psychiatry, Child Psychiatry, Psychology, and Social Work. In addition to a random sample, Psychology conducted a convenience sample of 100 psychologists attending a conference in Washington, DC. The in-person survey was monitored by AMA RUC staff and the chair of the RUC HCPAC.

The reference service list was the same list used in all of the other XXX surveys for this family of codes and was reviewed and approved by the RUC Research Subcommittee. The societies worked jointly to develop a typical vignette. The typical patient for this service is an adult patient.

As noted in our submission to the Practice Expense Subcommittee, there has been a shift in practice over the years, and while approximately half of the practicing psychiatrists employ administrative staff, a lesser number employ clinical staff. These numbers are even lower for psychologists, clinical social workers and other qualified healthcare providers. As a result, our PE submission did not include any clinical staff time. This is another argument for the RVW recommendation since this increased work is done entirely by the treating provider.

### **Analysis and recommendations from the expert panel**

The associations convened a joint society expert panel with broad representation from each group to review the survey data and make recommendations.

The expert panel reviewed the survey results citing that 82 percent of the 183 survey respondents found the vignette typical and the median service performance rate was 240, which is a reasonable number for this service.

The survey results regarding time are 10 minutes pre-service, 45 minutes intra-service, and 12 minutes post-service. The panel supported the survey results for the median time of 45 minutes for the intra-service. As with the 90832, there is typically increased documentation time as a result of maintaining a separate record from the medical record for psychotherapy process notes as allowed under HIPAA to protect patient privacy.

Support for the median RVW of 2.00 can be found in the comparison of the surveyed code with the key reference service. Twenty-eight percent of the survey respondents chose 96152, *Health and behavior intervention, each 15 minutes, face-to-face; individual*, as the key reference service. An analysis of the intensity and complexity measures shows that the respondents rated the surveyed code higher in every measure except two (physical effort and the pre-service time segment). The increased intensity and complexity in addition to the total time of the service supports the median value.

In addition, the panel compared the surveyed code to 99215, *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family* (5, 35, 15; RVW 2.11) with a total time of 55 minutes. The panel believes that increased time of the 90834 more than accounts for any variation in the intensity of the two services. The value is further supported by the fact that the surveyed code can be used in any setting (outpatient, inpatient, residential care, nursing facility) and the intensity of the patient encounter can vary greatly within each setting.

Additional support comes from the comparison of the surveyed code to 99233, *Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit* (10, 30, 15; RVW 2.00) which has a similar time and RVW. The panel believes the increased time of 90834 more than accounts for any variation in the RVW of the two services. The value is further supported by the fact that the surveyed code can be used in any setting (inpatient, outpatient, residential care, nursing facility) where the intensity of the patient encounter can vary greatly.

Finally, the expert panel also compared the median survey results of the 90834 to the other median survey results and found that the median value maintains relativity within the family. Psychoanalysis, which has a slightly longer intra-service time, is valued at 2.10 based on the RUC's review of that code at the September 2011 RUC meeting. The expert panel believes the work of the two services is similar and thus supportive of the median RVW. The 90834 also maintains relativity with the other timed-psychotherapy codes.

### Recommendations

In summary, based on the comparisons to the key reference service and MPC codes **we recommend the median RVW of 2.00 with 10 minutes pre-, 45 minutes intra-, and 12 minutes post-time for a total time of 67 minutes for 90834.**

### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

### FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 90806, 90818

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Psychiatry                      How often? Sometimes

Specialty Psychology                      How often? Commonly

Specialty Social Work                      How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 30873016

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare payments are approximately 25% of total physician and clinical services expenses in US.

Specialty Psychiatry	Frequency 1887479	Percentage 6.11 %
Specialty Psychology	Frequency 15058230	Percentage 48.77 %
Specialty Social Work	Frequency 13143397	Percentage 42.57 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 7,736,176 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on most recent RUC database

Specialty Psychiatry	Frequency 472680	Percentage 6.10 %
Specialty Psychology	Frequency 3790726	Percentage 48.99 %
Specialty Social Work	Frequency 3293290	Percentage 42.56 %

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 90846

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 90836      Tracking Number LL7

Original Specialty Recommended RVU: **1.90**Presented Recommended RVU: **1.90**

Global Period: ZZZ

RUC Recommended RVU: **1.90**

CPT Descriptor: Psychotherapy, 45 minutes with patient and/or family member when performed with an Evaluation and Management service

(List separately in addition to the code for primary procedure)

(Use 90836 in conjunction with 99201-99255, 99304-99337, 99341-99350)

(Use the 90785 in conjunction with (90832, 90833, 90834, 90836, 90837, 90838 when psychotherapy includes interactive complexity services)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: Psychotherapy for an adult suffering from co-morbid medical conditions, depression, and agitation of two months duration which resulted in loss of job after several emotional outbursts at work. Patient is anxious about loss of income and inability to find another job.

Percentage of Survey Respondents who found Vignette to be Typical: 75%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

**Description of Pre-Service Work:**

Description of Intra-Service Work: Data from various sources, including past interactions with the patient, current history and mental status findings, information which may have come to light from other historians or outside records, and the patient's behavior, descriptions, and responses to intra-session interventions, are all reviewed or considered and a working therapeutic interpretation, behavioral treatment plan or supportive intervention strategy is formulated and enacted. Examples of the focus of this intervention could include a current acute situation, suicidal thought/ safety plan, or a pattern of dysfunctional behavior. Evidence of behavioral change, demonstration of insight, or reduction in symptoms (anxiety, depression, irritability, etc.) is sought based on the psychotherapeutic interventions.

Description of Post-Service Work: Documentation of the symptoms and behaviors that are the focus of the treatment, as well as the specific psychotherapeutic intervention and work done in the session.



**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2012				
<b>Presenter(s):</b>	Jeremy Musher, MD, Sherry Barron-Seabrook, MD				
<b>Specialty(s):</b>	American Psychiatric Association, American Academy of Child and Adolescent Psychiatry				
<b>CPT Code:</b>	90836				
<b>Sample Size:</b>	1797	<b>Resp N:</b>	114	<b>Response:</b> 6.3 %	
<b>Description of Sample:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	20.00	<b>75.00</b>	200.00	1000.00
<b>Survey RVW:</b>	0.65	1.70	<b>1.90</b>	2.00	4.00
<b>Pre-Service Evaluation Time:</b>			<b>0.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>0.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>0.00</b>		
<b>Intra-Service Time:</b>	10.00	40.00	<b>45.00</b>	50.00	90.00
<b>Immediate Post Service-Time:</b>	<b>0.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x <b>0.00</b> 99292x <b>0.00</b>			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x <b>0.00</b> 99232x <b>0.00</b> 99233x <b>0.00</b>			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x <b>0.00</b> 99239x <b>0.00</b> 99217x <b>0.00</b>			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x <b>0.00</b> 12x <b>0.00</b> 13x <b>0.00</b> 14x <b>0.00</b> 15x <b>0.00</b>			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x <b>0.00</b> 55x <b>0.00</b> 56x <b>0.00</b> 57x <b>0.00</b>			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x <b>0.00</b> 99225x <b>0.00</b> 99226x <b>0.00</b>			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

ZZZ Global Code

<b>CPT Code:</b>	90836	<b>Recommended Physician Work RVU: 1.90</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>45.00</b>		
<b>Immediate Post Service-Time:</b>	<b>3.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x <b>0.00</b> 99292x <b>0.00</b>		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x <b>0.00</b> 99232x <b>0.00</b> 99233x <b>0.00</b>		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x <b>0.0</b> 99239x <b>0.0</b> 99217x <b>0.00</b>		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x <b>0.00</b> 12x <b>0.00</b> 13x <b>0.00</b> 14x <b>0.00</b> 15x <b>0.00</b>		
<b>Prolonged Services:</b>	<b>0.00</b>	99354x <b>0.00</b> 55x <b>0.00</b> 56x <b>0.00</b> 57x <b>0.00</b>		
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x <b>0.00</b> 99225x <b>0.00</b> 99226x <b>0.00</b>		

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status?

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service?

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99214	XXX	1.50	RUC Time

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99233	XXX	2.00	RUC Time	21,650,554

CPT Descriptor 1 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99243	XXX	1.88	RUC Time	1

CPT Descriptor 2 Office consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99221	XXX	1.92	RUC Time

CPT Descriptor Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code:** 35      **% of respondents:** 30.7 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 90836</b>	<b>Key Reference CPT Code: 99214</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	0.00	5.00	
Median Intra-Service Time	45.00	25.00	
Median Immediate Post-service Time	3.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
<b>Median Total Time</b>	<b>48.00</b>	<b>40.00</b>	
<b>Other time if appropriate</b>			

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.31	3.06
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.22	3.19
Urgency of medical decision making	3.31	3.13

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.59	3.47
Physical effort required	2.34	2.28

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.19	3.09
Outcome depends on the skill and judgment of physician	3.66	3.53
Estimated risk of malpractice suit with poor outcome	3.13	3.09

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.32	2.27
----------------------------------	------	------

Intra-Service intensity/complexity	3.55	3.45
------------------------------------	------	------

Post-Service intensity/complexity	2.97	2.97
-----------------------------------	------	------

---

### Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

#### Background

We have provided a detailed cover letter regarding the background of this RUC submission which includes this code and the 10 others from the Psychiatry section that were surveyed in March 2012.

The physician specialty societies (the MDs) include the American Psychiatric Association (Psychiatry) and the American Academy of Child and Adolescent Psychiatry (Child Psychiatry).

The 90836, *psychotherapy, 45 minutes with patient and/or family member (list separately in addition to the code for primary service)* had previously been reported as a bundled service (90807, *Psychotherapy 45-50 minutes, office, with medical evaluation and management services*; and 90819, *Psychotherapy 45-50 minutes, facility, with medical evaluation and management services*) that captured the work of the psychotherapy and the E/M services in one code. The psychotherapy with medical evaluation and management codes varied only by time with the level of E/M work remaining constant. The newly approved framework describes the work more accurately, allowing for the differentiation of the E/M work based on the actual level of service provided. Psychiatrists will select the appropriate evaluation and management code based on the key elements, adding on the psychotherapy add-on code based only on the time spent providing psychotherapy. There is minimal overlap between the E/M service and the psychotherapy procedure. The information collected during the E/M portion of the service informs the psychotherapy process and the time spent collecting that data during the E/M portion is not counted in the time spent providing psychotherapy.

#### Survey process

The survey for the 90836 was sent to a random sample of psychiatrist members of the American Psychiatric Association (APA) and the American Academy of Child and Adolescent Psychiatry (AACAP). This code can be used in all settings (i.e., outpatient, inpatient, residential care, nursing facility). The reference service list was the same list used in all of the other ZZZ surveys for this family of codes and was reviewed and approved by the RUC Research Subcommittee. A typical vignette was developed with assistance of experts from APA and AACAP.

As noted in our submission to the Practice Expense Subcommittee, there has been a shift in practice over the years, and while approximately half of the practicing psychiatrists employ administrative staff, a lesser number employ clinical staff. As a result, our PE submission did not include any clinical staff time. This is another argument for the RVW recommendation since this increased work is done entirely by the treating provider.

#### Analysis and recommendations from the expert panel

The associations convened a joint society expert panel with broad representation from each group to review the survey data and make recommendations.

The expert panel reviewed the number of responses and the service performance rate. As with the 90833, there were a number of respondents who indicated they had never performed the service. The expert panel believes these individuals were unfamiliar with the survey process and did not recognize a current service being described in a different way. Of the 114 survey respondents, 75 percent found the vignette to be typical. Those that did not find the vignette typical were primarily individuals who specialized in child and adolescent or geriatric psychiatry.

The expert panel supports the median survey times of 45 minutes of intra-service time. As with the 90833, the expert panel believes that additional post-service documentation requirements for psychotherapy services due to payer requirements adds additional time that is not captured in the evaluation and management codes billed with these services, particularly in light of not employing clinical staff. The expert panel supports adding an additional 3 minutes post-service time to the 90836 to account for that work. Based on the above, **we recommend 0 minutes pre-, 45 minutes intra-, and 3 minutes post- service time.**

The expert panel believes that the median survey RVW of 1.90 appropriately represents the typical work of this service. This is supported by a comparison of the intensity and complexity measures of the surveyed code with the key reference service. Thirty percent of the survey respondents chose 99214, *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family, (5, 25, 10; RVW 1.50)* as the reference service. The expert panel reviewed the intensity and complexity measures and found that the respondents rated the surveyed code higher in every category with the exception of the post-service period, which was rated equally. The expert panel concurred that the higher measures of intensity and complexity coupled with the significantly longer intra-service time of the surveyed code supported the median value of 1.90 which is less than the current value for the codes this add-on replaces, 90807 (0,50,0; RVW 2.02) and 90819 (0, 45, 0; RVW 2.05)

In comparing the surveyed code with 99221, *Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit. (10, 30, 10; RVW 1.92)*, the expert panel reported that the typical work of a 45 minute psychotherapy session is similar to that of the lowest level initial hospital care code.

The expert panel compared the 90836 to 99233, *Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit. (10, 30, 15; RVW 2.0)* and believes that the work in the surveyed code is similar given the increased service time of the surveyed code in comparison with the typical time of the 99233 code.

The expert panel also concluded that the 99243, *Office consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family (5, 28, 7; RVW 1.88)* was similar in work and the differences in RVWs could be accounted for due to the longer intra-service time of the surveyed code.

The expert panel also reviewed the survey data for the entire family of psychotherapy codes and found relativity across the survey results, including the results for 90845, psychoanalysis, which was reviewed by the RUC in September 2011 with reaffirmation requested at this meeting. The panel found that the median RVWs of the 90833, 90836, 90838 codes (psychotherapy when done in conjunction with an E/M service) were equal to or just below that of the 90832, 90834, 90837 codes (psychotherapy only). There is also relativity when compared with other forms of psychotherapy (90845, 90846 and 90847).

#### **Recommendation:**

In summary, based on comparisons to the reference code, MPC codes, and other codes, **we recommend the**

**median RVW of 1.90, and median times of 0 minutes pre, 45 minutes intra, and 3 minutes post time for a total time of 48 minutes for 90836.**

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.  
☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.  
☐ Multiple codes allow flexibility to describe exactly what components the procedure included.  
☐ Multiple codes are used to maintain consistency with similar codes.  
☐ Historical precedents.  
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 90807, 90819

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Psychiatry How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 4231608

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare payments are approximately 25% of total physician and clinical services expenses in US.

Specialty Psychiatry Frequency 3785326 Percentage 89.45 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

795,328 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on latest RUC database.

Specialty Psychiatry Frequency 715795 Percentage 89.99 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States?

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 90846

### Services Reported with Multiple CPT Codes – Psychotherapy when performed with an E/M Service

CPT Code	Global Day	Work RVU	Pre-Service	Intra-Service	Post-Service	Total Time
99212	XXX	0.48	2	10	4	16
99213	XXX	0.97	3	15	5	23
99214	XXX	1.5	5	25	10	40
99215	XXX	2.11	5	35	15	55
99224	XXX	0.76	5	10	5	20
99225	XXX	1.39	10	20	10	40
99226	XXX	2	10	30	15	55
99231	XXX	0.76	5	10	5	20
99232	XXX	1.39	10	20	10	40
99233	XXX	2	10	30	15	55
99307	XXX	0.76	5	10	5	20
99308	XXX	1.16	7	15	9	31
99309	XXX	1.55	10	25	10	45
90833	ZZZ	1.5		30	3	33
90836	ZZZ	1.9		45	3	48
90838	ZZZ	2.1		60	3	63

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

---

CPT Code:90837      Tracking Number LL8

Original Specialty Recommended RVU: **2.25**Presented Recommended RVU: **2.25**

Global Period: XXX

RUC Recommended RVU: **3.00**

CPT Descriptor: Psychotherapy, 60 minutes with patient and/or family member

(Use the 90785 in conjunction with (90832, 90833, 90834, 90836, 90837, 90838 when psychotherapy includes interactive complexity services)

---

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: Psychotherapy for adult with anxiety and depressive symptoms who is on several medications for two co-morbid medical conditions. Patient has returned to work after a recent psychiatric hospitalization for depression. Psychosocial stressors at work and home have increased anxiety and depression since discharge.

Percentage of Survey Respondents who found Vignette to be Typical: 81%

**Site of Service (Complete for 010 and 090 Globals Only)**


---

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&amp;M service later on the same day 0%

**Moderate Sedation**


---

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

---

Description of Pre-Service Work: Prepare to see patient and/or family member. Review record. Communicate with other professionals and significant others such as guardians, caretakers, and family members.

Description of Intra-Service Work: Face-to-face therapeutic communication with patient and/or family member. Obtain objective information and interval history. Examine mental state. Evaluate and explore intensity and complexity of symptoms, feelings, thoughts, and behaviors in the context of psychosocial and health stressors and coping styles. Use a range of psychotherapy approaches to reduce distress, morbidity, and address ongoing behavioral and mental status changes in the patient.

Description of Post-Service Work: Arrange for further services. Coordinate care in writing or by telephone with patient, family, and other professionals such as a primary care provider. Document intra-service and post-service work activities. Provide written or telephone reports to third-party payers.



**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2012				
<b>Presenter(s):</b>	Jeremy Musher, MD, Sherry Barron-Seabrook, MD; James Georgoulakis, PhD; Doris Tomer, LCSW				
<b>Specialty(s):</b>	American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, American Psychological Association, National Association of Social Workers				
<b>CPT Code:</b>	90837				
<b>Sample Size:</b>	1873	<b>Resp N:</b>	185	<b>Response:</b>	9.8 %
<b>Description of Sample:</b>	Random and Convenience				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	10.00	100.00	300.00	1500.00
<b>Survey RVW:</b>	0.98	1.95	2.25	3.00	4.00
<b>Pre-Service Evaluation Time:</b>			10.00		
<b>Pre-Service Positioning Time:</b>			0.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.00		
<b>Intra-Service Time:</b>	0.00	55.00	60.00	60.00	120.00
<b>Immediate Post Service-Time:</b>	<b>15.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

<b>CPT Code:</b>	90837	<b>Recommended Physician Work RVU: 3.00</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		5.00	0.00	5.00
<b>Pre-Service Positioning Time:</b>		0.00	0.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	0.00	0.00
<b>Intra-Service Time:</b>		60.00		
<b>Immediate Post Service-Time:</b>	<b>10.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00

<b>Sub Obs Care:</b>	<b>0.00</b>	99224x <b>0.00</b>	99225x <b>0.00</b>	99226x <b>0.00</b>
----------------------	-------------	--------------------	--------------------	--------------------

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
96152	XXX	0.46	RUC Time

CPT Descriptor Health and behavior intervention, each 15 minutes, face-to-face; individual

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99215	XXX	2.11	RUC Time	9,976,351

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99222	XXX	2.61	RUC Time	7,451,227

CPT Descriptor 2 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99204	XXX	2.43	RUC Time

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code:** 62      **% of respondents:** 33.5 %

**TIME ESTIMATES (Median)**

	<u>CPT Code:</u>	<u>Key Reference CPT Code:</u>	<u>Source of Time</u>
	90837	96152	RUC Time
Median Pre-Service Time	5.00	4.00	

Median Intra-Service Time	60.00	15.00
Median Immediate Post-service Time	10.00	5.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>75.00</b>	<b>24.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.83	3.59
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.60	3.48
Urgency of medical decision making	3.53	3.28

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.27	4.02
Physical effort required	1.93	1.98

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.52	3.26
Outcome depends on the skill and judgment of physician	4.17	3.91
Estimated risk of malpractice suit with poor outcome	3.09	3.02

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.53	2.40
Intra-Service intensity/complexity	4.28	3.91
Post-Service intensity/complexity	3.10	2.98

## Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

### Background

We have provided a detailed cover letter regarding the background of this RUC submission which includes this code and the 10 others from the Psychiatry section that were surveyed in March 2012.

The physician specialty societies (the *MDs*) include the American Psychiatric Association (Psychiatry) and the American Academy of Child and Adolescent Psychiatry (Child Psychiatry). The psychologist and clinical social worker specialty societies (the *Non-MDs*) include the American Psychological Association (Psychology) and the National Association of Social Workers (Social Work).

The 90837, Psychotherapy, 60 minutes with patient and/or family member had previously been reported as 90808 (Psychotherapy 75-80 minutes, outpatient) and 90819 (Psychotherapy, 75-80 minutes, facility). The 90837 will be used in all settings (i.e., outpatient, inpatient, residential care, nursing facility).

### Survey process

The survey was sent randomly to members of Psychiatry, Child Psychiatry, Psychology, and Social Work. In addition to a random sample, Psychology conducted a convenience sample of 100 psychologists attending a conference in Washington, DC. The in-person survey was monitored by AMA RUC staff and the chair of the RUC HCPAC. The reference service list was the same list used in all of the other XXX surveys for this family of codes and was reviewed and approved by the RUC Research Subcommittee. The societies worked jointly to develop a typical vignette.

As noted in our submission to the Practice Expense Subcommittee, there has been a shift in practice over the years, and while approximately half of the practicing psychiatrists employ administrative staff, a lesser number employ clinical staff. These numbers are even lower for psychologists, clinical social workers and other qualified healthcare providers. As a result, our PE submission did not include any clinical staff time. This is another argument for the RVW recommendation since this increased work is done entirely by the treating provider.

### Analysis and recommendations from the expert panel

The associations convened a joint society expert panel with broad representation from each group to review the survey data and make recommendations.

The expert panel reviewed the survey results citing that 81 percent of the 185 survey respondents found the vignette typical and the median service performance rate was 100, which is a reasonable number for this service.

The survey results regarding time are 10 minutes pre-service, 60 minutes intra-service, and 15 minutes post-service. Support for the median RVW of 2.25 can be found in the comparison of the surveyed code with the key reference service. Thirty-three percent of the survey respondents chose 96152, *Health and behavior intervention, each 15 minutes, face-to-face; individual*, as the key reference service. An analysis of the intensity and complexity measures shows that the respondents rated the surveyed code higher in every measure except one - physical effort. The panel believes the increased intensity and complexity in addition to the total time of the service supports the median value.

In addition, the panel compared the surveyed code to 99215, *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.*(5, 35, 15; RVW 2.11) with a total time of 55 minutes. The panel believes that substantially increased time of the 90837 more than accounts for any variation in the

intensity of the two services. The value is further supported by the fact that the surveyed code can be used in any setting (outpatient, inpatient, residential care, nursing facility) where the intensity of the patient encounter can vary greatly.

Additional support comes from the comparison of the surveyed code to 99222, *Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit (15, 40, 20; RVW 2.61) which has a time that is similar to the surveyed code and with the larger RVW of the 99222 accounting for any increased intensity.*

Finally, the expert panel also compared the median survey results of the 90837 to the other median survey results and found that the median maintains relativity of values within the family of psychotherapy codes.

### Recommendations

In summary, based on the comparisons to the key reference service and MPC codes **we recommend an RVW of 3.00 with 5 pre-, 60 intra-, and 10 post-service minutes for a total time of 82 minutes for 90837.**

### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

### FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 90808, 90821

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Psychiatry                      How often? Sometimes

Specialty Psychology                      How often? Sometimes

Specialty Social Work                      How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 1681744

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare payments are approximately 25% of total physician and clinical services expenses in US.

Specialty Psychiatry	Frequency 89083	Percentage 5.29 %
Specialty Psychology	Frequency 631443	Percentage 37.54 %
Specialty Social Work	Frequency 886103	Percentage 52.68 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 421,766 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on most current RUC database.

Specialty Psychiatry	Frequency 22271	Percentage 5.28 %
Specialty Psychology	Frequency 157861	Percentage 37.42 %
Specialty Social Work	Frequency 221526	Percentage 52.52 %

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 90846

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:90838      Tracking Number LL9

Original Specialty Recommended RVU: **2.10**Presented Recommended RVU: **2.10**

Global Period: ZZZ

RUC Recommended RVU: **2.50**

CPT Descriptor: Psychotherapy, 60 minutes with patient and/or family member when performed with an Evaluation and Management service

(List separately in addition to the code for primary procedure)

(Use 90833 in conjunction with 99201-99255, 99304-99337, 99341-99350)

(Use the 90785 in conjunction with (90832, 90833, 90834, 90836, 90837, 90838 when psychotherapy includes interactive complexity services)

(Use the appropriate prolonged services code (99354-99357) for psychotherapy services 68 minutes or longer)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: Psychotherapy for adult with anxiety and depressive symptoms who is on several medications for these conditions and two co-morbid medical conditions. Patient has returned to work after a recent psychiatric hospitalization for depression. Psychosocial stressors at work and home have increased anxiety and depression since discharge.

Percentage of Survey Respondents who found Vignette to be Typical: 74%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

**Description of Pre-Service Work:**

Description of Intra-Service Work: Data from various sources, including past interactions with the patient, current history and mental status findings, information which may have come to light from other historians or outside records, and the patient's behavior, descriptions, and responses to intra-session interventions, are all reviewed or considered and a working therapeutic interpretation, behavioral treatment plan or supportive intervention strategy is formulated and enacted. Examples of the focus of this intervention could include a current acute situation, suicidal thought/ safety plan, or a pattern of dysfunctional behavior. Evidence of behavioral change, demonstration of insight, or reduction in symptoms (anxiety, depression, irritability, etc.) is sought based on the psychotherapeutic interventions.

Description of Post-Service Work: Documentation of the symptoms and behaviors that are the focus of the treatment, as well as the specific psychotherapeutic intervention and work done in the session.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2012				
<b>Presenter(s):</b>	Jeremy Musher, MD, Sherry Barron-Seabrook, MD				
<b>Specialty(s):</b>	American Psychiatric Association, American Academy of Child and Adolescent Psychiatry				
<b>CPT Code:</b>	90838				
<b>Sample Size:</b>	1797	<b>Resp N:</b>	114	<b>Response:</b> 6.3 %	
<b>Description of Sample:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	5.00	30.00	100.00	3000.00
<b>Survey RVW:</b>	0.65	1.92	2.10	2.50	5.00
<b>Pre-Service Evaluation Time:</b>			0.00		
<b>Pre-Service Positioning Time:</b>			0.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.00		
<b>Intra-Service Time:</b>	15.00	55.00	60.00	70.00	120.00
<b>Immediate Post Service-Time:</b>	<b>0.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:

ZZZ Global Code

<b>CPT Code:</b>	90838	<b>Recommended Physician Work RVU: 2.50</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		0.00	0.00	0.00
<b>Pre-Service Positioning Time:</b>		0.00	0.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	0.00	0.00
<b>Intra-Service Time:</b>		60.00		
<b>Immediate Post Service-Time:</b>	<b>3.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00		



**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99354	ZZZ	1.77	RUC Time

CPT Descriptor Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient Evaluation and Management service)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99387	XXX	2.50	RUC Time	0

CPT Descriptor 1 Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99233	XXX	2.00	RUC Time	21,650,554

CPT Descriptor 2 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99221	XXX	1.92	RUC Time

CPT Descriptor Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 35      % of respondents: 30.7 %

**TIME ESTIMATES (Median)**

	CPT Code: 90838	Key Reference CPT Code: 99354	Source of Time RUC Time
Median Pre-Service Time	0.00	0.00	

Median Intra-Service Time	60.00	60.00
Median Immediate Post-service Time	3.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>63.00</b>	<b>60.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.03	4.03
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.14	4.24
Urgency of medical decision making	3.97	3.86

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.48	4.45
Physical effort required	2.83	2.59

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.03	3.87
Outcome depends on the skill and judgment of physician	4.39	4.42
Estimated risk of malpractice suit with poor outcome	3.87	3.84

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.64	2.58
Intra-Service intensity/complexity	4.55	4.55
Post-Service intensity/complexity	3.42	3.42

## Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

### Background

We have provided a detailed cover letter regarding the background of this RUC submission which includes this code and the 10 others from the Psychiatry section that were surveyed in March 2012.

The 90838, *psychotherapy, 60 minutes with patient and/or family member (list separately in addition to the code for primary service)* had previously been reported as a bundled service (90809, *Psychotherapy 75-80 minutes, office, with medical evaluation and management services*; and 90822, *Psychotherapy 75-80 minutes, facility, with medical evaluation and management services*) that captured the work of the psychotherapy and the E/M services in one code. The psychotherapy with medical evaluation and management codes varied only by time with the level of E/M work remaining constant. The newly approved framework describes the work more accurately, allowing for the differentiation of the E/M work based on the actual level of service provided. Psychiatrists will select the appropriate evaluation and management code based on the key elements, adding on the psychotherapy add-on code based only on the time spent providing psychotherapy. There is minimal overlap between the E/M service and the psychotherapy procedure. The information collected during the E/M portion of the service informs the psychotherapy process and the time spent collecting that data during the E/M portion is not counted in the time spent providing psychotherapy.

### Survey process

The survey for the 90838 was sent to a random sample of psychiatrist members of the American Psychiatric Association (APA) and the American Academy of Child and Adolescent Psychiatry (AACAP). This code can be used in all settings (i.e., outpatient, inpatient, residential care, nursing facility). The reference service list was the same list used in all of the other ZZZ surveys for this family of codes and was reviewed and approved by the RUC Research Subcommittee. A typical vignette was developed with assistance of experts from APA and AACAP.

As noted in our submission to the Practice Expense Subcommittee, there has been a shift in practice over the years, and while approximately half of the practicing psychiatrists employ administrative staff, a lesser number employ clinical staff. As a result, our PE submission did not include any clinical staff time. This is another argument for the RVW recommendation since this increased work is done entirely by the treating provider.

### Analysis and recommendations from the expert panel

The associations convened a joint society expert panel with broad representation from each group to review the survey data and make recommendations.

The expert panel reviewed the number of responses and the service performance rate. It was the opinion of the expert panel that this has not generally been a high volume service. As with the 90833 and the 90836, there were a number of respondents who indicated they had never performed the service however the expert panel believes these individuals were unfamiliar with the survey process and did not recognize a current service being described in a different way. Of the 114 survey respondents, 74 percent found the vignette to be typical. Many of those that did not find the patient typical were primarily individuals who specialized in child and adolescent or geriatric psychiatry who simply said their typical patient was not an adult.

The expert panel supports the median survey time of 60 minutes of intra service time. As with the 90833 and 90836, the expert panel believes that additional post-service documentation requirements for psychotherapy services due to payer requirements adds additional time that is not captured in the evaluation and management codes billed with these services, particularly in light of not employing clinical staff. The expert panel supports adding an additional 3 minutes post-service time to the 90838 to account for that work. Based on the above, **we recommend 0 minutes pre, 60 minutes intra, and 3 minutes post service time.**

Thirty percent of the survey respondents chose 99354, *Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or*

*other outpatient Evaluation and Management service*) (0, 60, 0; RVW 1.77), as the key reference service. A review of the intensity and complexity measures shows that the respondents rated the surveyed code the same or higher in a majority of the areas. The expert panel believes that this increased work substantiates the higher median RVW of 2.10 proposed by the survey respondents.

The expert panel compared 90838 to 99233, *Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit* (10, 30, 15; RVW 2.0), which was the second highest code chosen for comparison by the survey respondents. The panel believed this code supported the median value of the surveyed code, which is substantially longer in intra-service time than this reference code.

An additional comparison of 90838 to 99387, *Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older* (4, 45, 10; RVW 2.5), supports the median value of 2.10 of the surveyed code which has longer intra-service time and is focused on an existing illness and specific psychotherapeutic interventions.

And the expert panel believed that 99404, *Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes* (0, 60, 0; RVW 1.95) provided another strong comparison.

The expert panel also compared 90838 to 90845, psychoanalysis, which has a slightly shorter intra-service time and a RUC recommended RVW of 2.10 based on the RUC's review of that code at its September 2011 meeting. The expert panel believes the work of the two services is similar and thus supportive of the median RVW.

As with the 90836, the median survey RVW of 2.10 is substantially less than the current values of the psychotherapy with E/M service codes this code is replacing, 90809 (0, 80, 0; RVW 2.95) and 90822 (0, 78, 0; RVW 2.99).

The expert panel also reviewed the survey data for the entire family of psychotherapy codes and found relativity across the survey results, including the results for 90845, psychoanalysis, which was reviewed by the RUC in September 2011 with reaffirmation requested at this meeting. The panel found that the median RVWs of the 90833, 90836, 90838 codes (psychotherapy when done in conjunction with an E/M service) were equal to or just below that of the 90832, 90834, 90837 codes (psychotherapy only). There is also relativity when compared with other forms of psychotherapy (90845, 90846 and 90847).

### Recommendation

In summary, based on comparisons to the reference code, MPC codes, and other codes, **we recommend an RVW of 2.50, and median times of 60 intra, and 3 post for a total time of 63 minutes for 90838.**

### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.

- ☐ Multiple codes are used to maintain consistency with similar codes.  
☐ Historical precedents.  
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 90809, 90822

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Psychiatry                      How often? Sometimes

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 164976

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare payments are approximately 25% of total payments for physician and clinical services in US

Specialty Psychiatry                      Frequency 139921                      Percentage 84.81 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

31,122 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on most recent RUC database.

Specialty Psychiatry                      Frequency 26453                      Percentage 84.99 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

## Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 90846

**Services Reported with Multiple CPT Codes – Psychotherapy when performed with an E/M Service**

<b>CPT Code</b>	<b>Global Day</b>	<b>Work RVU</b>	<b>Pre-Service</b>	<b>Intra-Service</b>	<b>Post-Service</b>	<b>Total Time</b>
99212	XXX	0.48	2	10	4	16
99213	XXX	0.97	3	15	5	23
99214	XXX	1.5	5	25	10	40
99215	XXX	2.11	5	35	15	55
99224	XXX	0.76	5	10	5	20
99225	XXX	1.39	10	20	10	40
99226	XXX	2	10	30	15	55
99231	XXX	0.76	5	10	5	20
99232	XXX	1.39	10	20	10	40
99233	XXX	2	10	30	15	55
99307	XXX	0.76	5	10	5	20
99308	XXX	1.16	7	15	9	31
99309	XXX	1.55	10	25	10	45
90833	ZZZ	1.5		30	3	33
90836	ZZZ	1.9		45	3	48
90838	ZZZ	2.1		60	3	63

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
2010 FIVE YEAR REVIEW SUMMARY OF RECOMMENDATION**

CPT Code: 90845      Tracking Number  
Global Period: XXX

Specialty Society Recommended RVU: **2.10**  
RUC Recommended RVU: **2.10**

CPT Descriptor: Psychoanalysis

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 37-year-old man with dysthymia and narcissistic personality disorder manifested by entitlement, inability to be intimate, and extreme variability of self esteem is seen in the second year of psychoanalysis, just prior to going on a business trip. Argumentative and easily offended, he accuses the analyst of being insensitive and detached, and angrily rejects any effort to explore the basis of his mood or behavior.

Percentage of Survey Respondents who found Vignette to be Typical: 80%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 2%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Preparing to see patient; refreshing memory about recent sessions; assessing and managing one's own psychological reactions to the patient.

Description of Intra-Service Work: In person therapeutic communication with patient; implicitly obtaining information and observing the patient's mental state; evaluating and exploring the intensity of symptoms, feelings, thoughts, conflicts, fantasies, behaviors, and dreams as necessary; exploring the patient's and one's own feelings, fantasies and thoughts about the evolving therapeutic relationship as a model for gaining perspective on significant difficulties in the patient's other relationships (transference and countertransference); introducing the impact of the patient's engagement on the analyst as a data source for grasping the patient's effects on other relationships; providing psychological interpretations regarding defenses, conflicts and tendencies in patient's personality and relationships, including awareness of mental process, self-esteem, self-regulation, and impulse control; addressing impediments to ongoing behavioral change that could reduce distress and promote well-being.

Description of Post-Service Work: Documenting the services provided intra-service including reviewing content and process of session, reflection on the psychoanalyst's reactions to the patient's affects, communications and behavior in the session and identifying issues requiring follow-up at next/future sessions; related consultation with peers and review of literature pertinent to the case.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	09/2011				
<b>Presenter(s):</b>	Jeremy Musher, MD; James Georgoulakis, PhD; Doris Tomer, LCSW				
<b>Specialty(s):</b>	American Psychiatric Association, American Psychological Association, National Association of Social Workers				
<b>CPT Code:</b>	90845				
<b>Sample Size:</b>	1321	<b>Resp N:</b>	55	<b>Response:</b> 4.1 %	
<b>Sample Type:</b>	Random	<b>Additional Sample Information:</b>			
	<b>Low</b>	<b>25<sup>th</sup> %</b>	<b>Median*</b>	<b>75<sup>th</sup> %</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	0.00	<b>125.00</b>	450.00	1600.00
<b>Survey RVW:</b>	0.10	1.86	<b>2.10</b>	2.70	200.00
<b>Pre-Service Evaluation Time:</b>			<b>10.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>0.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>0.00</b>		
<b>Intra-Service Time:</b>	10.00	45.00	<b>50.00</b>	60.00	90.00
<b>Immediate Post Service-Time:</b>	<b>10.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

<b>CPT Code:</b>	90845	<b>Recommended Physician Work RVU: 2.10</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments to Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>5.00</b>	<b>0.00</b>	<b>5.00</b>
<b>Pre-Service Positioning Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>50.00</b>		
<b>Immediate Post Service-Time:</b>	<b>5.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00



**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99404	XXX	1.95	RUC Time

CPT Descriptor**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99215	XXX	2.11	RUC Time	10,112,992

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99233	XXX	2.00	RUC Time	21,952,122

CPT Descriptor 2 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99387	XXX	2.06	RUC Time

CPT Descriptor Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 18      % of respondents: 32.7 %**

**TIME ESTIMATES (Median)**

	<u>CPT Code:</u> <u>90845</u>	<u>Key Reference CPT Code:</u> <u>99404</u>	<u>Source of Time</u> <u>RUC Time</u>
Median Pre-Service Time	5.00	0.00	
Median Intra-Service Time	50.00	60.00	
Median Immediate Post-service Time	5.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
<b>Median Total Time</b>	<b>60.00</b>	<b>60.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.17	3.78
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.72	3.67
--	------	------

Urgency of medical decision making	3.61	3.50
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.56	3.67
--------------------------	------	------

Physical effort required	2.28	2.28
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.61	3.44
---	------	------

Outcome depends on the skill and judgment of physician	4.67	3.83
--	------	------

Estimated risk of malpractice suit with poor outcome	3.50	3.39
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.33	3.11
----------------------------------	------	------

Intra-Service intensity/complexity	4.44	3.89
------------------------------------	------	------

Post-Service intensity/complexity	3.33	3.11
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**

Psychoanalysis, CPT code 90845, was put forward along with a majority of the codes within the psychiatry section of CPT as part of the fourth Five-Year Review process. As noted in the attached letter from the specialty societies, we believe there has been a change in the work required in this service. Our letter to CMS highlights the changes in the patient population with references substantiating the increased complexity of the patients. We have also provided additional information under the section on compelling evidence for changes in technique since this code was last reviewed by the RUC in 1995.

Recommendations regarding this code were originally submitted for the September 2010 RUC meeting along with 16 additional codes that were identified as being misvalued. During that presentation the specialties requested that entire tab be referred to the CPT Editorial Panel to more accurately describe the service. The RUC supported the referral to CPT and a CPT Workgroup was established to address these issues.

During the review process, a recommendation was made to remove psychoanalysis from the CPT Workgroup process and forward it on to the RUC for review. It was the opinion of all of the provider groups that the work inherent in providing psychoanalysis was the same regardless of who was performing the procedure and there was no need to further refine the descriptor for that service. A request was made and granted by the AMA RUC staff to add this to code to the RUC's September agenda using the data from our original survey.

### Survey Process and Data

The following three groups surveyed 90845: the American Psychiatric Association (Psychiatry), the American Psychological Association (Psychology) and the National Association of Social Workers (Social Work). The survey included two separate reference service lists (RSL), one used by the psychiatry, and one used by the psychology and social work. The separate RSL's were reviewed and approved by the RUC Research Subcommittee. Together the societies convened a joint society expert panel ("expert panel") to review the survey data and make recommendations.

### Analysis and recommendations from the expert panel

**Time:** The survey median results regarding time are 10 minutes pre, 50 minutes intra, and 10 minutes post service. The expert panel supported the median time of 50 minutes for the intra-service time however thought that the median values for the pre and post service times were an overestimation. According to the experts, the patient is typically seen face to face for 50 minutes and the total encounter lasts approximately 60 minutes. The panel reviewed the 25th percentile of 5 minutes of pre and 5 minutes for post service work and agreed these times were more representative of what typically occurs. The 5 minutes of pre and post time combined with the intra-service time of 50 minutes results in a total time of 60 minutes. **Therefore we recommend 5 minutes pre, 50 minutes intra and 5 minutes post service time for a total time of 60 minutes.**

**RVW:** As noted above, two separate reference service lists were used for this survey effort resulting in two different codes being selected as the key reference service. Responses by psychologists and social workers who were using a common reference service list outnumbered the responses by psychiatrists which impacted the selection of the key reference service.

The expert panel reviewed the number of times each specialty billed this code using the RUC database and compared it to the response rate by specialty to the RUC survey. They found that psychiatry was under-represented and psychology and social work over-represented in the results.

Specialty	2010 Medicare Claims (Frequency)		Percentage of Responses by Specialty	RVW Median	Median Time			
	%	# Claims			Pre	Intra	Post	Total Time
Psychiatry	50%	2709	36%	2.50	5	50	10	65
Psychology	36%	1950	43%	2.10	10	55	10	75
Social Work	0.12%	7	21%	1.95	15	50	15	80

The key reference service for the combined survey results was 99404, *Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes* (RVW of 1.95 with time of 0, 60, 0, pre, intra and post respectively and a total time of 60 minutes) which was selected by 17 of the 34 psychologists and social workers completing the survey.

An analysis of the intensity and complexity measures shows that respondents thought the intensity and complexity of the work of psychoanalysis was greater in every measure – in particular technical skill (4.53 for 90845 and 3.65 for 99404) and

outcome (4.65 for 90845 and 3.76 for 99404) -- than the key reference service except one, physical effort, validating the median value of 2.10.

Six of the 19 psychiatrists responding to the survey chose CPT code 99215, *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family* (RVW of 2.11, with times of 5, 35, 15 pre, intra and post respectively and a total time of 55 minutes) as the key reference service.

Again, an analysis of the intensity and complexity measures show that respondents indicated that the work was more intense and/or complex in a majority of the categories, again with the greatest difference in the area of technical skill required (4.83 for 90845 and 3.83 for 99215) and outcome dependent on the skill and judgment of the physician (4.50 for 90845 and 3.50 for 99215), further substantiating the median RVW of 2.10.

The expert panel concurred with the survey median RVW of 2.10, agreeing that psychoanalysis was more intense, required greater technical effort and relied more heavily on the skill and judgment of the clinician than the key reference services cited.

The current RVW for 90845 is 1.79, we guide you to the compelling evidence section for details regarding two compelling evidence criteria which the expert panel believed were met - changes in physician work due to patient population and technique. In addition to the reference service codes identified above, the following service is provided for comparison to support our recommended RVW and times:

CPT 99233, *Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit, with a work RVW of 2.00 and 55 minutes of total time (10 pre, 30 intra, 15 post service).*

This comparison code, coupled with the median survey results, supports our recommendation of the median value of 2.10 for 90845, Psychoanalysis. **Therefore we recommend the median RVW of 2.10 with times of 5 pre, 50 intra and 5 post service for a total time of 60 minutes.**

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 90845

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**Compelling Evidence**

The RUC operates with the initial presumption that the current values assigned to the codes under review are correct. The argument for a change must be substantial and meet the RUC's compelling evidence standards listed in the Instructions Document. Please list your compelling evidence below (if appropriate).

As noted in the letter to CMS, psychoanalysis and the other codes within the psychiatry section were identified by the specialty societies as being misvalued predominately because of changes in the patient population and in the case of psychoanalysis, due to changes to the technique since the code was originally valued in 1995 as described below. The following outlines those changes in addition to the original arguments in the letter to CMS as part of the five-year review process.

(1) Change in the patient population: Psychoanalysts traditionally treated a wide variety of conditions which included a considerable number of high functioning patients who came to treatment for what might be regarded today as relatively minor psychological problems. Patients with such conditions are now often treated in a variety of newer treatment modalities (such as short term cognitive-behavioral and psychodynamic psychotherapies, CPT 90806 or 90807) rather than psychoanalysis. As a result there has been a change in the overall severity of the clinical population engaged in full psychoanalytic treatment (CPT 90845) with an increased number of patients suffering from narcissistic and borderline conditions, as well as patients with dual diagnoses, including bipolar disorder and some forms of substance abuse. Such patients tend to be more unstable both within and outside the treatment setting, and may require a much more active approach on the part of the psychoanalyst. This change in the overall composition of the patient population has resulted in a greater degree of work effort on the part of psychoanalysts, as well as increased stress borne out of concern for possible transitory negative effects (including transitory increases in suicidal ideation) which may occur as an effect of such intensive treatment and which must be carefully managed.

(2) Change in the technique employed in psychoanalytic practice: Traditionally, psychoanalytic treatment (CPT 90845) had been based in a model originated in theoretical writings of Freud and carried into actual practice by psychoanalysts during the mid-20th century. In this model the analyst tended to be silent a great deal of the time, listening closely to the patient's associations and intervening sparsely with interpretations with the aim of augmenting the patient's self-understanding. As a result of growing understanding of the actual role of the psychoanalyst's presence in the session the focus has shifted to a greater emphasis on the interaction between the psychoanalyst and the patient as the data for gaining understanding of the patient's internal dynamics. Technically, this focus on the interpersonal process between them is a further development of the fundamental concepts of transference, counter-transference, and therapeutic change. This technical change had already started to become evident in the 1990's but is now a widely regarded important feature of psychoanalytic treatment. As a result of this technical change the psychoanalyst is required to be much more intently focused on the minute to minute interaction during the session, considerably more active during the session, and much more focused on his or her internal feeling states both within and between the analytic sessions. This substantially increases the psychoanalyst's intensity and complexity effort during the session, when compared with the earlier model.

**Five-Year Review Specific Questions**

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%).

Has the work of performing this service changed in the past 5 years? Yes 40% No 60%

A. This service represents new technology? Yes 32% No 68%

Of survey respondents, who said yes, the new technology affected the work:

Less Work: 0% Same Work: 14% More Work: 86%

B. This service reflects new technology that has become more familiar: Yes 14% No 86%

C. Patients requiring this service are now:

More complex (more work) 91% Less complex (less work) 0% No change in complexity 9%

D. The typical site-of-service has changed:

From outpatient to inpatient 9% From inpatient to outpatient 9% No change 82%

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:90846      Tracking Number LL13

Original Specialty Recommended RVU: **2.40**

Global Period: XXX

Presented Recommended RVU: **2.40**RUC Recommended RVU: **2.40**

CPT Descriptor: Family psychotherapy (without the patient present)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: Parents of a 16 year old girl who is defiant, unruly, failing in school, and recently caught smoking marijuana seek help in managing the child. The child refuses to come in for treatment. The parents disagree on how to manage the child.

Percentage of Survey Respondents who found Vignette to be Typical: 82%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Prepare office for family; review patient's records, including information from outside sources; communicate with other professionals.

Description of Intra-Service Work: Face to face interaction with the patient's family; obtain interval history of the patient; provide psychoeducation regarding the patient's problems and the role family members have in perpetuating or diminishing them; formulation of treatment goals; and, development of systemic strategies to achieve desired goals.

Description of Post-Service Work: Arrange for further services; provide electronic, written or telephone communication with other family and other professionals (e.g., physicians, teachers, psychotherapists); document the services provided; provide written, electronic or telephone reports to Medicare or other third party payers.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2012				
<b>Presenter(s):</b>	Jeremy Musher, MD; Sherry Barron-Seabrook, MD; James Georgoulakis, PhD; Doris Tomer, LCSW				
<b>Specialty(s):</b>	American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, American Psychological Association, National Association of Social Workers				
<b>CPT Code:</b>	90846				
<b>Sample Size:</b>	2031	<b>Resp N:</b>	123	<b>Response:</b>	6.0 %
<b>Description of Sample:</b>	Random and Convenience				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	10.00	<b>25.00</b>	60.00	520.00
<b>Survey RVW:</b>	1.10	1.95	<b>2.40</b>	3.00	4.21
<b>Pre-Service Evaluation Time:</b>			<b>10.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>0.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>0.00</b>		
<b>Intra-Service Time:</b>	15.00	45.00	<b>50.00</b>	60.00	90.00
<b>Immediate Post Service-Time:</b>	<b>15.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

<b>CPT Code:</b>	90846	<b>Recommended Physician Work RVU: 2.40</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>5.00</b>	<b>0.00</b>	<b>5.00</b>
<b>Pre-Service Positioning Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>50.00</b>		
<b>Immediate Post Service-Time:</b>	<b>10.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00



Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00
---------------	-------------	-------------	-------------	-------------

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99215	XXX	2.11	RUC Time

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99386	XXX	2.33	RUC Time	

CPT Descriptor 1 Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99204	XXX	2.43	RUC Time	8,436,133

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99310	XXX	2.35	RUC Time

CPT Descriptor Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention.

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 22      % of respondents: 17.8 %

**TIME ESTIMATES (Median)**CPT Code:  
**90846**Key Reference  
CPT Code:  
99215Source of Time  
RUC Time

Median Pre-Service Time	5.00	5.00
Median Intra-Service Time	50.00	35.00
Median Immediate Post-service Time	10.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>65.00</b>	<b>55.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)**(of those that selected Key  
Reference code)**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.76	3.81
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.43	3.43
Urgency of medical decision making	3.71	3.71

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.29	4.19
--------------------------	------	------

Physical effort required	1.81	1.81
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.62	3.52
Outcome depends on the skill and judgment of physician	4.33	4.38
Estimated risk of malpractice suit with poor outcome	2.95	3.10

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.76	2.62
Intra-Service intensity/complexity	4.19	4.19

Post-Service intensity/complexity

3.19

3.10

## Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

### Background

We have provided a detailed cover letter regarding the background of this RUC submission which includes this code and the 10 others from the Psychiatry section that were surveyed in March 2012.

The physician specialty societies (the *MDs*) include the American Psychiatric Association (Psychiatry) and the American Academy of Child and Adolescent Psychiatry (Child Psychiatry). The psychologist and clinical social worker specialty societies (the *Non-MDs*) include the American Psychological Association (Psychology) and the National Association of Social Workers (Social Work).

This code, 90846, Family Psychotherapy (without the patient present) is an existing code and was not revised during the CPT process.

### Survey Process

The survey was sent randomly to members of Psychiatry, Child Psychiatry, Psychology, and Social Work. In addition to a random sample, psychology conducted a convenience sample of 100 psychologists attending a conference in Washington, DC. The in-person survey was monitored by AMA RUC staff and the chair of the RUC HCPAC.

The reference service list was the same list used in all of the other XXX surveys for this family of codes and was reviewed and approved by the RUC Research Subcommittee.

As noted in our submission to the Practice Expense Subcommittee, there has been a shift in practice over the years, and while approximately half of the practicing psychiatrists employ administrative staff, a lesser number employ clinical staff. These numbers are even lower for psychologists, clinical social workers, and other qualified healthcare providers. As a result, our PE submission did not include any clinical staff time. This is another argument for the RVW recommendation since this increased work is done entirely by the treating provider.

### Analysis and recommendations from the expert panel

The associations convened a joint society expert panel with broad representation from each group to review the survey data and make recommendations.

82 percent of the 123 survey respondents indicated that the vignette described the typical patient.

As noted in the work descriptor, the pre-service time is spent collecting and reviewing medical records and other data prior to the family visit. The post time is spent scheduling the next appointment, developing a written treatment plan, following up with other providers/agencies regarding findings, writing referrals for other services, and any other activities that result from the treatment decisions made during the session, again, without benefit of clinical staff to assist. **Therefore we recommend 5 minutes pre-, 50 minutes intra-, and 10 minutes post-service time for a total time of 65 minutes.**

The key reference service for the survey results was 99215, *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's*

*needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family (5, 35, 15; RVW 2.11), which was selected by 18% of the survey respondents.*

An analysis of the intensity and complexity measures shows that respondents thought the intensity and complexity of the work of family therapy (without the patient present) was equal to or higher than the majority of the measures. In particular, the respondents indicated that the technical skill required and the risk of complications was greater in the surveyed code than in the reference code. They rated the intra-service intensity/complexity the same as the reference code with the pre- and post-service periods rated higher for the surveyed code. The expert panel reviewed this data, comparing the reference service code RVW and time to the surveyed code. They agreed that the difference in RVW could be accounted for by the increased time required, as well as by the increased intensity and complexity in specific measures and support the survey median RVW of 2.40.

An additional comparison can be made to 99386, *Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years, (5, 40, 10; RVW 2.33)* with a total time of 55 minutes. The increased RVW of the surveyed code accounts for the increased time of the service.

The expert panel also identified 99204, *Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family, with a work RVW of 2.43 and 45 minutes of total time (5 pre, 30 intra, 10 post service).* In comparing the work of the surveyed code to 99204, the expert panel noted that the difference in time between the two codes supports the median RVW and makes up for any difference in intensity between work for the benefit of an established patient versus work associated with a new patient.

One last comparison was made with 99310, *Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention (15, 35, 20; RVW 2.35), with a total time of 70 minutes.* The times and RVW values are similar, again, with the increased intra-service time accounting for the slightly higher RVW of the surveyed code.

Finally, the expert panel compared the results from this survey process with the results from the 2010 survey of this code. The panel thinks that the differences in the median RVWs between the 2012 survey and the 2010 survey (2.40 RVWs vs. 2.00 RVWs) can be accounted for by the increased number of responses (123 responses in the 2012 survey as compared to 76 responses in the 2010 survey) and an increase in the median service performance rate. The expert panel thinks the current survey results are more reliable than the previous survey effort and there is appropriate relativity between the 2012 median value of 2.40 and the values for other psychotherapy services being presented at this meeting.

#### **Recommendation:**

The comparisons above support our recommendation of the median value of 2.40 for 90846, Family psychotherapy (without the patient present). **Therefore we recommend the median RVW of 2.40 with times of 10 pre-, 50 intra-, and 15 post-service for a total time of 65 minutes for code 90846.**

#### **SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 90846

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Psychiatry                      How often? Sometimes

Specialty Psychology                      How often? Sometimes

Specialty Social Work                      How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 104808

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare payments are approximately 25% of total physician and clinical services expenses in US.

Specialty Psychiatry	Frequency 30195	Percentage 28.80 %
----------------------	-----------------	--------------------

Specialty Psychology	Frequency 26621	Percentage 25.39 %
----------------------	-----------------	--------------------

Specialty Social Work	Frequency 42856	Percentage 40.89 %
-----------------------	-----------------	--------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 26,202 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on most recent RUC database

Specialty Psychiatry	Frequency 7549	Percentage 28.81 %
----------------------	----------------	--------------------

Specialty Psychology	Frequency 6655	Percentage 25.39 %
----------------------	----------------	--------------------

Specialty Social Work	Frequency 10714	Percentage 40.89 %
-----------------------	-----------------	--------------------

Do many physicians perform this service across the United States? Yes

## Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 90846

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 90847      Tracking Number   LL14

Original Specialty Recommended RVU: **2.50**Presented Recommended RVU: **2.50**

Global Period: XXX

RUC Recommended RVU: **2.50**

CPT Descriptor: Family psychotherapy (conjoint psychotherapy) (with patient present)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: Parents disagree about how to handle a 14 year old gifted child who is failing in school and violating curfew. The child is disrespectful towards the parents and teachers and refuses to follow standard rules in home and in school.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Prepare office for patient and family; review records, including information obtained from outside sources, communicate with other professionals

Description of Intra-Service Work: Face to face interaction with the patient and family; observation and interpretation of communication and behavior interactions among family members; mental status examination of identified patient consistent with current problem(s); formulation of treatment goals; development of systemic strategies to achieve desired goals; and, provision of psychoeducation as indicated.

Description of Post-Service Work: Arrange for further services; provide written, electronic or telephone communication with other family and other professionals (e.g., physicians, teachers, psychotherapists); document the services provided; provide written, electronic or telephone reports to Medicare or other third party payers.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2012				
<b>Presenter(s):</b>	Jeremy Musher, MD; Sherry Barron-Seabrook, MD; James Georgoulakis, PhD; Doris Tomer, LCSW				
<b>Specialty(s):</b>	American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, American Psychological Association, National Association of Social Workers				
<b>CPT Code:</b>	90847				
<b>Sample Size:</b>	2031	<b>Resp N:</b>	123	<b>Response:</b>	6.0 %
<b>Description of Sample:</b>	Random and Convenience				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	20.00	60.00	200.00	1040.00
<b>Survey RVW:</b>	1.10	2.23	2.50	3.17	4.25
<b>Pre-Service Evaluation Time:</b>			10.00		
<b>Pre-Service Positioning Time:</b>			0.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.00		
<b>Intra-Service Time:</b>	15.00	45.00	55.00	60.00	90.00
<b>Immediate Post Service-Time:</b>	<u>15.00</u>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

<b>CPT Code:</b>	90847	<b>Recommended Physician Work RVU: 2.50</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		5.00	0.00	5.00
<b>Pre-Service Positioning Time:</b>		0.00	0.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	0.00	0.00
<b>Intra-Service Time:</b>		55.00		
<b>Immediate Post Service-Time:</b>	<u>10.00</u>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00



Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00
---------------	-------------	-------------	-------------	-------------

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99205	XXX	3.17	RUC Time

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99222	XXX	2.61	RUC Time	7,451,227

CPT Descriptor 1 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99204	XXX	2.43	RUC Time	8,436,133

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordinatio

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99336	XXX	2.46	RUC Time

CPT Descriptor Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes with the patient and/or family or caregiver.

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 28      % of respondents: 22.7 %

**TIME ESTIMATES (Median)**

	CPT Code: 90847	Key Reference CPT Code: 99205
Median Pre-Service Time	5.00	7.00
Median Intra-Service Time	55.00	45.00
Median Immediate Post-service Time	10.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>70.00</b>	<b>67.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)**

(of those that selected Key  
Reference code)

**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.81	3.72
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.69	3.76
Urgency of medical decision making	3.69	3.60

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.58	4.13
--------------------------	------	------

Physical effort required	2.73	2.80
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.50	3.64
Outcome depends on the skill and judgment of physician	4.38	4.20
Estimated risk of malpractice suit with poor outcome	3.12	3.20

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**

**Reference  
Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	2.44	2.19
Intra-Service intensity/complexity	4.44	4.19

Post-Service intensity/complexity

3.15

2.96

## Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

### Background

We have provided a detailed cover letter regarding the background of this RUC submission which includes this code and the 10 others from the Psychiatry section that were surveyed in March 2012.

The physician specialty societies (the *MDs*) include the American Psychiatric Association (Psychiatry) and the American Academy of Child and Adolescent Psychiatry (Child Psychiatry). The psychologist and clinical social worker specialty societies (the *Non-MDs*) include the American Psychological Association (Psychology) and the National Association of Social Workers (Social Work).

This code, 90847, *Family psychotherapy (conjoint psychotherapy) (with patient present)* is an existing code and was not revised during the CPT process. This code can be used in all settings.

### Survey process

The survey was sent randomly to members of Psychiatry, Child Psychiatry, Psychology, and Social Work. In addition to a random sample, Psychology conducted a convenience sample of 100 psychologists attending a conference in Washington, DC. The in-person survey was monitored by AMA RUC staff and the chair of the RUC HCPAC.

The reference service list was the same list used in all of the other XXX surveys for this family of codes and was reviewed and approved by the RUC Research Subcommittee.

As noted in our submission to the Practice Expense Subcommittee, there has been a shift in practice over the years, and while approximately half of the practicing psychiatrists employ administrative staff, a lesser number employ clinical staff. These numbers are even lower for psychologists, clinical social workers, and other qualified healthcare providers. As a result, our PE submission did not include any clinical staff time. This is another argument for the RVW recommendation since this increased work is done entirely by the treating provider.

### Analysis and recommendations from the expert panel

The associations involved in this survey convened a joint society expert panel expert panel with broad representation from each group to review the survey data and make recommendations.

84 percent of the survey respondents indicated that the vignette described the typical patient.

As noted in the work descriptor, the pre-service time is spent collecting and reviewing medical records and other data prior to the family visit. The post-service time is spent scheduling the next appointment, developing a written treatment plan, following up with other providers/agencies regarding findings, writing referrals for other services, and any other activities as a result of the treatment decisions from the session, again, without benefit of clinical staff to assist. **Therefore we recommend 5 minutes pre-, 55 minutes intra-, and 10 minutes post service time for a total time of 70 minutes.**

The key reference service chosen for this code was 99205, *Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the*

*patient and/or family* (7, 45, 15 ; RVW 3.17) with a total time of 67 minutes, which was selected by 23% of the survey respondents.

An analysis of the intensity and complexity measures shows that respondents thought the intensity and complexity of the work of *Family psychotherapy (conjoint psychotherapy) (with patient present)* was greater than the reference code in many of the measures. In particular, the respondents indicated that the intensity/complexity was greater in each of the time segments than for 99205. The panel believes this data supports the median RVW of 2.50.

An additional comparison can be made to 99222, *Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit* (15, 40, 20; RVW 2.61). In comparing the two services, the expert panel noted that the times were similar and the variation of the RVW was accounted for by the increased intensity of a new patient in an inpatient setting.

The expert panel also believes the 99336, *Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes with the patient and/or family or caregiver* (10, 40, 15; RVW 2.46), supports the median RVW of the surveyed code based on the similarities in time.

Finally, the expert panel compared the results of the 2012 survey with those of the 2010 survey. The median RVW increased from 1.94 in the 2010 survey to 2.50 in 2012. As with the 90846, there was an increase in the number of survey respondents from 2010 to 2012 (94 to 123). The panel noted that in 2010 there was variation in the median survey responses between the MD and Non-MD groups, which negatively affected the median RVW when the data was combined. The panel thinks that the use of the common reference service list in 2012 led to more reliable survey data with the difference in the median RVW between MDs and Non-MDs at 0.08. The panel also thinks the median value of 2.50 RVWs is in line with the median value for 90846, *Family psychotherapy (without the patient present)*, noting that the work involved is more difficult when the patient is present.

### Recommendation

These comparison codes and the median survey results support our recommendation of the median value of 2.50 for 90847, *Family psychotherapy (conjoint psychotherapy) (with patient present)*. **Therefore we recommend the median RVW of 2.50 with times of 5 pre-, 55 intra-, and 10 post- service minutes, for a total time of 70 minutes for 90847.**

### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 90847

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Psychiatry                      How often? Sometimes

Specialty Psychology                      How often? Sometimes

Specialty Social Work                      How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 890852

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare payments are approximately 25% of total physician and clinical services expenses in US.

Specialty Psychiatry	Frequency 171400	Percentage 19.24 %
----------------------	------------------	--------------------

Specialty Psychology	Frequency 340395	Percentage 38.21 %
----------------------	------------------	--------------------

Specialty Social Work	Frequency 338257	Percentage 37.97 %
-----------------------	------------------	--------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

222,713 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on most recent RUC database

Specialty Psychiatry	Frequency 42850	Percentage 19.24 %
----------------------	-----------------	--------------------

Specialty Psychology	Frequency 85099	Percentage 38.21 %
----------------------	-----------------	--------------------

Specialty Social Work	Frequency 84564	Percentage 37.96 %
-----------------------	-----------------	--------------------

Do many physicians perform this service across the United States? Yes

## Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 90847

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 90853      Tracking Number LL16

Original Specialty Recommended RVU: **0.59**Presented Recommended RVU: **0.59**

Global Period: XXX

RUC Recommended RVU: **0.59**

CPT Descriptor: Group psychotherapy (other than of a multiple-family group)

(Use 9080XE in conjunction with 90853 for the specified patient when group psychotherapy includes interactive complexity)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: Group psychotherapy for adults with similar comorbid medical conditions and psychiatric diagnoses.

Percentage of Survey Respondents who found Vignette to be Typical: 78%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&amp;M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Review records of each group member; arrange room for the patient group.

Description of Intra-Service Work: Initiation or continuation of psychotherapeutic interventions, including psychoeducation, cognitive behavioral therapy, dialectical behavioral therapy, social skill therapy, psychodynamic therapy, substance abuse therapy and other appropriate techniques. Observation and interpretation of patterns of interaction among patients in group. Interpretation of effects of personality patterns and behaviors on group interactions and on reported behavior outside group. Development of treatment goals for the group as a whole and for individual members.

Description of Post-Service Work: Arrange for further services for each patient; provide written, electronic or telephone communication with each patient's family, if indicated, and other professionals including (e.g. physicians, psychotherapists, courts); document the services provided for each patient; provide written, electronic or telephone reports to Medicare or other third party payers.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2012				
<b>Presenter(s):</b>	Jeremy Musher, MD; Sherry Barron-Seabrook, MD; James Georgoulakis, PhD; Doris Tomer, LCSW				
<b>Specialty(s):</b>	American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, American Psychological Association, National Association of Social Workers				
<b>CPT Code:</b>	90853				
<b>Sample Size:</b>	1792	<b>Resp N:</b>	82	<b>Response:</b>	4.5 %
<b>Description of Sample:</b>	Random and Convenience				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	10.00	<b>45.00</b>	98.00	700.00
<b>Survey RVW:</b>	1.00	2.40	<b>3.00</b>	3.55	9.78
<b>Pre-Service Evaluation Time:</b>			<b>15.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>0.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>0.00</b>		
<b>Intra-Service Time:</b>	45.00	60.00	<b>60.00</b>	90.00	180.00
<b>Immediate Post Service-Time:</b>	<b>20.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

<b>CPT Code:</b>	90853	<b>Recommended Physician Work RVU: 0.59</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>3.00</b>	<b>0.00</b>	<b>3.00</b>
<b>Pre-Service Positioning Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>10.00</b>		
<b>Immediate Post Service-Time:</b>	<b>3.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00

<b>Sub Obs Care:</b>	<b>0.00</b>	99224x <b>0.00</b>	99225x <b>0.00</b>	99226x <b>0.00</b>
----------------------	-------------	--------------------	--------------------	--------------------

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
96153	XXX	0.10	RUC Time

CPT Descriptor Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99223	XXX	3.86	RUC Time	11,496,707

CPT Descriptor 1 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
97804	XXX	0.25	RUC Time

CPT Descriptor Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 34      % of respondents: 41.4 %

**TIME ESTIMATES (Median)**

	<b>CPT Code:</b> <b>90853</b>	<b>Key Reference CPT Code:</b> <b>96153</b>	<b>Source of Time</b>
Median Pre-Service Time	3.00	1.00	
Median Intra-Service Time	10.00	3.00	
Median Immediate Post-service Time	3.00	1.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	



Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>16.00</b>	<b>5.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.55	3.23
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.23	3.13
--	------	------

Urgency of medical decision making	2.90	2.77
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.13	3.90
--------------------------	------	------

Physical effort required	2.45	2.29
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.77	2.57
---	------	------

Outcome depends on the skill and judgment of physician	4.00	3.70
--	------	------

Estimated risk of malpractice suit with poor outcome	2.52	2.47
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.61	2.38
----------------------------------	------	------

Intra-Service intensity/complexity	4.45	4.19
------------------------------------	------	------

Post-Service intensity/complexity	2.91	2.69
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

## Background

We have provided a detailed cover letter regarding the background of this RUC submission which includes this code and the 10 others from the Psychiatry section that were surveyed in March 2012.

The physician specialty societies (the *MDs*) include the American Psychiatric Association (Psychiatry) and the American Academy of Child and Adolescent Psychiatry (Child Psychiatry). The psychologist and clinical social worker specialty societies (the *Non-MDs*) include the American Psychological Association (Psychology) and the National Association of Social Workers (Social Work).

This code, 90853, *Group psychotherapy (other than of a multifamily group)* is an existing code and was not revised during the CPT process. This code can be used in all settings.

## Survey Process

The survey was sent to all psychiatrist members of the American Group Psychotherapy Association, and randomly to members of Child Psychiatry, Psychology, and Social Work. In addition to a random sample, Psychology conducted a convenience sample of 100 psychologists attending a conference in Washington, DC. This in-person survey was monitored by AMA RUC staff and the chair of the RUC HCPAC. The reference service list was the same list used in all of the other XXX surveys for this family of codes and was reviewed and approved by the RUC Research Subcommittee.

The RUC Research Subcommittee also approved adding to additional questions to the RUC survey regarding group psychotherapy. The societies asked to include a question as to the typical number of patients seen in a typical group session and they asked to include an instruction for the survey respondents to calculate the time and the RVW of the procedure as a whole rather than on a per patient basis. The societies were concerned that survey respondents many respond in an inconsistent way if those questions were not included. The RUC Research Subcommittee approved the request.

As noted in our submission to the Practice Expense Subcommittee, there has been a shift in practice over the years, and while approximately half of the practicing psychiatrists employ administrative staff, a lesser number employ clinical staff. These numbers are even lower for psychologists, clinical social workers, and other qualified healthcare providers. As a result, our PE submission did not include any clinical staff time. This is another argument for the RVW recommendation since this increased work is done entirely by the treating provider.

## Analysis and recommendations from the expert panel

The associations convened a joint society expert panel with broad representation from each group to review the survey data and make recommendations.

78 percent of the 82 survey respondents indicated that the vignette described the typical patient and the expert panel concluded that the service performance rate seemed reasonable

The expert panel noted that the median intra-service time of 60 minutes appeared less than what is typical. A review of the data from the 2010 RUC survey of this code shows that the intra-service time was 90 minutes at the median and 75<sup>th</sup> percentile. Further discussions with experts in group psychotherapy confirmed that the standard length of a typical group psychotherapy visit was 76 to 90 minutes which was reported in the results of a 2010 survey by the American Group Psychotherapy Association. The pre and post service times appeared to be in the appropriate range and in line with the current.

The expert panel does not believe the survey results accurately represent the work of these procedures. We believe that survey respondents were confused by this new way of considering time and work, by using the total work and time of the entire group, rather than considering it by individual patient work and time. This led to an under reporting of values. Despite the increased complexity of patients since the last survey, we don't have credible survey evidence to increase the values, and therefore recommend that the current values should be maintained. We also believe the research Subcommittee should investigate options for future surveys that address procedure codes that describe services provided to groups of patients. The panel requests that the current values be maintained on the basis of the following comparisons.

*In comparing 97804, Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes (2,6,2; RVW 0.25), and 99411, Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes 10, 30, 5; RVW 0.15) to 90853, Group Psychotherapy, the expert panel noted that the complexity of the intra-service work is greater with the surveyed code due to the interpersonal dynamic between participants in the psychotherapeutic process.*

The panel also believed that the work of the 90853 was similar to that of the 99223, Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit. (15, 55, 20; RVW 3.86) which has a similar total time and the higher RVW of the 99223 accounts for the increased intensity of the inpatient service.

### Recommendation

**We recommend maintaining the current RVW of 0.59 with times of 3 pre-, 10 intra-, and 3 post-service minutes for a total time of 16 minutes (per patient) for 90853.**

### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

### FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 90853

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Psychiatry                      How often? Commonly

Specialty Psychology                      How often? Commonly

Specialty Social Work                      How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 5061420

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare payments are approximately 25% of total physician and clinical services expenses in US.

Specialty Psychiatry	Frequency 1464775	Percentage 28.94 %
Specialty Psychology	Frequency 907513	Percentage 17.93 %
Specialty Social Work	Frequency 1912711	Percentage 37.79 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,265,355 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on most recent RUC database.

Specialty Psychiatry	Frequency 366194	Percentage 28.94 %
Specialty Psychology	Frequency 226878	Percentage 17.92 %
Specialty Social Work	Frequency 478178	Percentage 37.79 %

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 90853

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**Table 2**  
**Tab 26 - RUC Summary Data RUC App Values**

**ISSUE:** Psychotherapy

**TAB:** 26

Tracking Code	Global	Source	CPT	DESC	Resp	IWPUT	RVW					Total Time	PRE-TIME	INTRA-TIME					IMMD
							MIN	25th	MED	75th	MAX		MED	MIN	25th	MED	75th	MAX	POST
	XXX	REF BOTH MDs & Non	99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3	86	0.0595			3.17			67	7			45			15
	XXX	CURRENT	90801	Psychiatric diagnostic interview examination		0.0224			2.80			125	10			60			55
LL2	XXX	SVY	90791	Psychiatric diagnostic evaluation	202	0.0369	0.75	2.25	3.00	3.20	6.00	95	15	15	50	60	60	180	20
	XXX	Other	99244	Office consultation for a new or established patient, which requires these 3 key components: A		0.0615			3.02			65	10			40			15
	XXX	Other	95974	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude		0.0313			3.00			110	30			60			20
	XXX	Other	75559	Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress		0.0478			2.95			75	15			50			10
LL2	XXX	REC	90791	Psychiatric diagnostic evaluation		0.0388			3.00			90	10			60			20
	XXX	REF	99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3	35	0.0595			3.17			67	7			45			15
	XXX	CURRENT	90801	Psychiatric diagnostic interview examination		0.0224			2.80			125	10			60			55
LL3	XXX	SVY	90792	Psychiatric diagnostic evaluation with medical services	82	0.0430	1.00	3.00	3.25	3.80	15.00	90	10	30	50	60	75	180	20
	XXX	Other	99254	Office consultation for a new or established patient, which requires these 3 key components: A		0.0557			3.29			80	15			45			20
	XXX	Other	99350	Home visit for the evaluation and management of an established patient, which requires at least 2 of these		0.0333			3.28			110	15			75			20
	XXX	Other	99235	Observation or inpatient hospital care, for the evaluation and management of a patient including		0.0498			3.24			84	14			50			19.5
LL3	XXX	REC	90792	Psychiatric diagnostic evaluation with medical services		0.0430			3.25			90	10			60			20

**Table 2**  
**Tab 26 - RUC Summary Data RUC App Values**

Tracking Code	Global	Source	CPT	DESC	Resp	IWPUT	RVW					Total Time	PRE-TIME	INTRA-TIME					IMMD
							MIN	25th	MED	75th	MAX		MED	MIN	25th	MED	75th	MAX	POST
	XXX	REF	96152	Health and behavior intervention, each 15 minutes, face-to-face: individual	115	0.0172			0.46			24	4			15			5
	XXX	CURRENT	90804	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient		0.0403			1.21			30				30			
	XXX	CURRENT	90816	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital		0.0439			1.25			29				29			
LL4	XXX	SVY	90832	Psychotherapy, 30 minutes with patient and/or family member	185	0.0351	0.45	1.00	1.50	1.75	4.00	50	10	1	30	30	30	75	10
	XXX	MPC	99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires		0.0466			1.50			40	5			25			10
	XXX	Other	99252	Inpatient consultation for a new or established patient, which requires these 3 key components: An		0.0466			1.50			40	5			25			10
	XXX	Other	94005	Home ventilator management care plan oversight of a patient (patient not present) in home, domiciliary or		0.0331			1.50			55	15			25			15
LL4	XXX	REC	90832	Psychotherapy, 30 minutes with patient and/or family member		0.0388			1.50			45	5			30			10
	XXX	REF	96152	Health and behavior intervention, each 15 minutes, face-to-face: individual	115	0.0172			0.46			24	4			15			5
	XXX	CURRENT	90806	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient		0.0372			1.86			50				50			
	XXX	CURRENT	90818	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital		0.0402			1.89			47				47			
LL6	LL6	SVY	90834	Psychotherapy, 45 minutes with patient and/or family member	185	0.0335	0.98	1.50	2.00	2.35	4.00	67	10	10	45	45	45	95	12
	XXX	MPC	99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires		0.0475			2.11			55	5			35			15
	XXX	MPC	94002	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or		0.0439			1.99			60	15			30			15
	XXX	Other	99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual		0.0325			1.95			60	0			60			0
LL6	XXX	REC	90834	Psychotherapy, 45 minutes with patient and/or family member		0.0370			2.00			60	5			45			10
	XXX	REF	96150	Health and behavior assessment (eg, health-focused clinical interview, behavioral observations)	27	0.0214			0.50			23	3			15			5
	XXX	CURRENT	90808	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient		0.0349			2.79			80				80			
	XXX	CURRENT	90821	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital		0.0354			2.83			80				80			
LL8	XXX	SVY	90837	Psychotherapy, 60 minutes with patient and/or family member	185	0.0282	0.98	1.95	2.25	3.00	4.00	85	10	0	55	60	60	120	15
	XXX	Other	99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3		0.0698			2.43			45	5			30			10
	XXX	Other	99349	Home visit for the evaluation and management of an established patient, which requires at least 2 of these		0.0443			2.33			65	10			40			15
	XXX	MPC	99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires		0.0475			2.11			55	5			35			15
LL8	XXX	REC	90837	Psychotherapy, 60 minutes with patient and/or family member		0.0444			3.00			75	5			60			10

6/27/2023

2 of 4

Post Presentation/  
RUC Approved Values

**Table 2**  
**Tab 26 - RUC Summary Data RUC App Values**

Tracking Code	Global	Source	CPT	DESC	Resp	IWPUT	RVW					Total Time	PRE-TIME	INTRA-TIME					IMMD
							MIN	25th	MED	75th	MAX		MED	MIN	25th	MED	75th	MAX	POST
	XXX	REF	99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient	64	0.0466			1.50			40	5			25			10
	XXX	CURRENT	90805	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient		0.0457			1.37			30				30			
	XXX	CURRENT	90817	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital		0.0564			1.41			25				25			
LL5	ZZZ	SVY	+90833	Psychotherapy, 30 minutes with patient and/or family member	114	0.0500	0.48	1.25	1.50	1.60	3.50	30		5	25	30	35	75	
	XXX	Other	99382	Initial comprehensive preventive medicine evaluation and management of an individual including an age		0.0550			1.60			35	5			25			5
	XXX	REF	99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires	64	0.0466			1.50			40	5			25			10
	XXX	Other	99252	Inpatient consultation for a new or established patient, which requires these 3 key components: An		0.0466			1.50			40	5			25			10
LL5	ZZZ	REC	+90833	Psychotherapy, 30 minutes with patient and/or family member		0.0478	1.50					33				30			3
	XXX	REF	99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires	35	0.0466			1.50			24	5			25			10
	XXX	CURRENT	90807	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient		0.0404			2.02			50				50			
	XXX	CURRENT	90819	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital		0.0456			2.05			45				45			
LL7	ZZZ	SVY	+90836	Psychotherapy, 45 minutes with patient and/or family member	114	0.0422	0.65	1.70	1.90	2.00	4.00	45		10	40	45	50	90	
	XXX	Other	99221	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key		0.0491			1.92			50	10			30			10
	XXX	MPC	99243	Office consultation for a new or established patient, which requires these 3 key components: A detailed		0.0575			1.88			40	5			28			7
LL7	ZZZ	REC	+90836	Psychotherapy, 45 minutes with patient and/or family member		0.0407	1.90					48				45			3
	ZZZ	REF	99354	Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the	35	0.0214			1.77			60				60			
	XXX	CURRENT	90809	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient		0.0369			2.95			80				80			
	XXX	CURRENT	90822	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital		0.0381			2.99			79				79			
LL9	ZZZ	SVY	+90838	Psychotherapy, 60 minutes with patient and/or family member	114	0.0350	0.65	1.92	2.10	2.50	5.00	60		15	55	60	70	120	
	XXX	MPC	99233	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least		0.0480			2.00			55	10			30			15
	XXX	Other	99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual		0.0325			1.95			60	0			60			0
LL9	ZZZ	REC	+90838	Psychotherapy, 60 minutes with patient and/or family member		0.0405	2.50					63				60			3

6/27/2023

**Table 2**  
**Tab 26 - RUC Summary Data RUC App Values**

Tracking Code	Global	Source	CPT	DESC	Resp	IWPUT	RVW					Total Time	PRE-TIME	INTRA-TIME					IMMD
							MIN	25th	MED	75th	MAX		MED	MIN	25th	MED	75th	MAX	POST
	XXX	REF	99215	Office or other outpatient visit for the evaluation and management of an established patient Physicians	22	0.0475			2.11			55	5			35			15
	XXX	CURRENT	90846	Family psychotherapy (without the patient present)		0.0366			1.83			50				50			
LL13	XXX	SVY	90846	Family psychotherapy (without the patient present)	123	0.0368	1.10	1.95	2.40	3.00	4.21	75	10	15	45	50	60	90	15
	XXX	MPC	99204	Office or other outpatient visit for the evaluation and management of a new patient which requires these 3		0.0698			2.43			45	5			30			10
	XXX	Other	99349	Home visit for the evaluation and management of an established patient which requires at least 2 of these		0.0443			2.33			65	10			40			15
LL13	XXX	REC	90846	Family psychotherapy (without the patient present)		0.0413			2.40			65	5			50			10
	XXX	REF	99205	Office or other outpatient visit for the evaluation and management of a new patient physicians typically	28	0.0595			3.17			67	7			45			15
	XXX	CURRENT	90847	Family psychotherapy (conjoint psychotherapy) (with patient present)	83	0.0326			2.21			76	5			50			21
LL14	XXX	SVY	90847	Family psychotherapy (conjoint psychotherapy) (with patient present)	123	0.0353	1.10	2.23	2.50	3.17	4.25	80	10	15	45	55	60	90	15
	XXX	MPC	99222	Initial hospital care, per day, for the evaluation and management of a patient which requires these 3 key		0.0457			2.61			75	15			40			20
	XXX	Other	99336	Domiciliary or rest home visit for the evaluation and management of an established patient which requires		0.0475			2.46			65	10			40			15
LL14	XXX	REC	90847	Family psychotherapy (conjoint psychotherapy) (with patient present)		0.0393			2.50			70	5			55			10
	XXX	REF BOTH MDs & Non	96153	Health and behavior intervention, each 15 minutes, face-to-face: group (2 or more patients)	34	0.0184			0.10			5	1			3			1
	XXX	CURRENT	90853	Group psychotherapy (other than of a multiple-family group)		0.0261			0.59			24	2			14			8
LL15	XXX	SVY/Session	90853	Group psychotherapy (other than of a multiple-family group)	82	0.0369	1.00	2.40	3.00	3.55	9.78	95	15	45	60	60	90	180	20
LL15	XXX	SVY/Patient	90853	Group psychotherapy (other than of a multiple-family group)		0.0369	0.17	0.40	0.50	0.59	1.63	16	3	8	10	10	15	30	3
	XXX	Other	76881	Ultrasound, extremity, nonvascular, real-time with image documentation: complete		0.0271			0.63			25	5			15			5
	XXX	MPC	97002	Physical therapy re-evaluation		0.0246			0.60			25	2			18			5
LL15	XXX	REC	90853	Group psychotherapy (other than of a multiple-family group)		0.0456			0.59			16	3			10			3



**Table 1**  
**Tab 26 - Summary**

Tracking Number	Description	Code	Current RVW	Survey RVW 25%	Survey RVW Median	Society REC	FINAL RUC Approved	FINAL RUC App Pre	FINAL RUC App Intra	FINAL RUC App Post	Total	IWPUT REC
<b>Diagnostic Interview</b>												
LL2	Psych diag interview	9080D1	2.80	2.25	3.00	3.00	3.00	10	60	20	90	0.0388
LL3	Psych diag interview w/ med services	9080D2	2.80	3.00	3.25	3.25	3.25	10	60	20	90	0.0430
<b>Psychotherapy</b>												
LL4	Psychotherapy, 30 minutes	908P10	1.21/1.25	1.00	1.50	1.50	1.50	5	30	10	45	0.0388
LL6	Psychotherapy, 45 minutes	908P20	1.86/1.89	1.50	2.00	2.00	2.00	5	45	10	60	0.0370
LL8	Psychotherapy, 60 minutes	908P30	2.79/2.83	1.95	2.25	2.25	3.00	5	60	10	75	0.0444
<b>Psychotherapy Add-On to E&amp;M</b>												
LL5	+Psychotherapy, 30 minutes	+908P10X	1.37*/1.41*	1.25	1.50	1.50	1.50	0	30	3	33	0.0478
LL7	+Psychotherapy, 45 minutes	+908P20X	2.02*/2.05*	1.70	1.90	1.90	1.90	0	45	3	48	0.0407
LL9	+Psychotherapy, 60 minutes	+908P30X	2.95*/2.99*	1.92	2.10	2.10	2.50	0	60	3	63	0.0405
<b>October 2011 RUC meeting</b> <span style="float:right"><b>RUC Approved 10/2011</b></span>												
LL12	Psychoanalysis	90845	1.79	1.86	2.10	2.10	2.10	5	50	5	60	0.0375
<b>Family &amp; Group Psychotherapy</b>												
LL13	Family Psychotherapy w/o pt	90846	1.83	1.95	2.40	2.40	2.40	5	50	10	65	0.0413
LL14	Family Psychotherapy conjoint	90847	2.21	2.23	2.50	2.50	2.50	5	55	10	70	0.0393
LL15	Group Psychotherapy	90853	0.59	0.40	0.50	0.59	0.59	3	10	3	16	0.0456
4/16/2012 * RVW reflects an existing coding structure that does not directly crosswalk to the add on codes, E&M RVW should be considered.												
Remaining codes carrier priced												

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor:

Psychiatric diagnostic evaluation code

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor:

Psychiatric diagnostic evaluation code

Global Period: XXX

Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor:

Psychiatric diagnostic evaluation with medical services

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor:

Psychiatric diagnostic evaluation with medical services

Global Period: XXX

Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor:

Psychotherapy, 30 minutes with patient and/or family member

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor:

Psychotherapy, 30 minutes with patient and/or family member

Global Period: XXX

Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor:

Psychotherapy, 30 minutes with patient and/or family member when performed with an Evaluation and Management service

Global Period: ZZZ Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A



**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor:

Psychotherapy, 30 minutes with patient and/or family member when performed with an Evaluation and Management service

(List separately in addition to the code for primary procedure)

Global Period: ZZZ

Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor:

Psychotherapy, 45 minutes with patient and/or family member

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor:

Psychotherapy, 45 minutes with patient and/or family member

Global Period: XXX

Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor:

Psychotherapy, 45 minutes with patient and/or family member when performed with an Evaluation and Management service

(List separately in addition to the code for primary procedure)

Global Period: ZZZ Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor:

Psychotherapy, 45 minutes with patient and/or family member when performed with an Evaluation and Management service

(List separately in addition to the code for primary procedure)

Global Period: ZZZ

Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor:

Psychotherapy, 60 minutes with patient and/or family member

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor:

Psychotherapy, 60 minutes with patient and/or family member

Global Period: \_XXX\_\_\_\_\_

Meeting Date: \_April 2012\_\_\_\_\_

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor:

Psychotherapy, 60 minutes with patient and/or family member when performed with an Evaluation and Management service

(List separately in addition to the code for primary procedure)

Global Period: ZZZ Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A



**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor:

Psychotherapy, 60 minutes with patient and/or family member when performed with an Evaluation and Management service

(List separately in addition to the code for primary procedure)

Global Period: ZZZ

Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor:  
Psychoanalysis

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor:  
Psychoanalysis

Global Period: XXX

Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor:

Family psychotherapy (without the patient present)

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor:

Family psychotherapy (without the patient present)

Global Period: XXX

Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor:

Family psychotherapy (conjoint psychotherapy) (with patient present)

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor:

Family psychotherapy (conjoint psychotherapy) (with patient present)

Global Period: XXX

Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor:

Group psychotherapy (other than of a multiple-family group)

(Use 9080XE in conjunction with 90853 for the specified patient when group psychotherapy includes interactive complexity)

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A



**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor:

Group psychotherapy (other than of a multiple-family group)

(Use 9080XE in conjunction with 90853 for the specified patient when group psychotherapy includes interactive complexity)

Global Period: XXX Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Specialty Society Practice Expense Committee for the psychiatric codes consisted of representatives from the American Psychiatric Association, the Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the National Association of Social Workers. An expert panel that included psychiatrists, psychologists, and clinical social workers, was developed to review practice expense across the spectrum of care for the psychiatric codes. It was agreed that there is no clinical service labor for any of the psychiatric codes. The groups will be requesting expenses related to medical supplies and equipment only.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA
1																											
2																											
3	Meeting Date: April, 2012 Tab: 26, Psychotherapy Specialty: Psychiatry, Child Psychiatry, Psychology, Social Work	CMS Code	Staff Type	90791 Psychiatric diagnostic evaluation code	90792 Psychiatric diagnostic evaluation with medical services	90832 Psychotherapy, 30 minutes with patient and/or family member	90834 Psychotherapy, 45 minutes with patient and/or family member	90837 Psychotherapy, 60 minutes with patient and/or family member (Use the 9080XE in	90833 Psychotherapy, 30 minutes with patient and/or family member when performed with an Evaluation and	90836 Psychotherapy, 45 minutes with patient and/or family member when performed with an Evaluation and	90838 Psychotherapy, 60 minutes with patient and/or family member when performed with an Evaluation and	90845 Psychoanalysis	90846 Family psychotherapy (without the patient present)	90847 Family psychotherapy (conjoint psychotherapy) (with patient present)	90853 Group psychotherapy (other than of a multiple-family group) (Use 9080XE in												
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
6	TOTAL CLINICAL LABOR TIME			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
7	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
9	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
55	MEDICAL SUPPLIES	CODE	UNIT																								
57	Tissues		box	0.05		0.05		0.05		0.05		0.05		0.05		0.05		0.05		0.05		0.05		0.05		0.05	
58	Patient education booklet	SK062	item	1		1																					
59	assessment monitoring instruments	SK005	item	1		1		0.25		0.25		0.25		0.25		0.25		0.25									
60	Reproduced patient worksheet		each					0.5		0.5		0.5		0.5		0.5		0.5									
61																											
62																											
63	EQUIPMENT	CODE																									
64	One Couch/ Two Chairs			1		1		1		1		1		1		1		1		1		1		1		1	
65	Chairs (8)																								1		
66																											
67																											
68																											
69																											

Tab 26 PE Comparison Codes

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1				REFERENCE CODE						REFERENCE CODE					
2				90801		90791		90792		90804		90816		90832	
3	Meeting Date: April, 2012 Tab: 26, Psychotherapy Specialty: Psychiatry, Child Psychiatry, Psychology, Social Work	CMS Code	Staff Type	Psychiatric Diagnostic Interview Examination		Psychiatric diagnostic evaluation		Psychiatric diagnostic evaluation with medical services		Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approx. 20 to 30 minutes face-to-face with the patient		Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient		Psychotherapy, 30 minutes with patient and/or family member	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
6	TOTAL CLINICAL LABOR TIME			57.0	6.0	0.0	0.0	0.0	0.0	20.0	0.0	0.0	6.0	0.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			4.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			44.0	0.0	0.0	0.0	0.0	0.0	15.0	0.0	0.0	0.0	0.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			9.0	6.0	0.0	0.0	0.0	0.0	4.0	0.0	0.0	6.0	0.0	0.0
10	PRE-SERVICE														
11	Start: Following visit when decision for surgery or procedure made														
12	Other Clinical Activity - specify: Review/Read reports		L037D	4						1					
13	End: When patient enters office/facility for surgery/procedure														
14	SERVICE PERIOD														
15	Start: When patient enters office/facility for surgery/procedure:														
16	Greet patient, provide gowning, ensure appropriate medical records are available		L037D	3						3					
17	Obtain vital signs		L037D	5											
18	Provide pre-service education/obtain consent		L037D	12						3					
23	Other: review history, systems and medications		L037D	15											
24	Other: coordination home or outpatient care		L037D	9											
25	Other		L037D							9					
26	Intra-service														
27	Post-Service														
28	End: Patient leaves office														
29	POST-SERVICE Period														
30	Start: Patient leaves office/facility														
31	Conduct phone calls/call in prescriptions		L037D	9						4					
38	Total Office Visit Time			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
39	Other Clinical Activity - specify: Coordination of care		L037D		6								6		
40	End: with last office visit before end of global period														
41	MEDICAL SUPPLIES														
43	Tissues		box			0.05		0.05						0.05	
44	Patient education booklet		SK062 item			1		1							
45	assessment monitoring instruments		SK005 item	1		1		1		1				0.25	
46	Reproduced patient worksheet		each											0.5	
47	EQUIPMENT														
48	One Couch/ Two Chairs					1		1						1	
49	Chairs (8)														

Tab 26 PE Comparison Codes

	A	B	C	P	Q	R	S	T	U	V	W	X	Y	Z	AA
1				REFERENCE CODE				REFERENCE CODE				REFERENCE CODE			
2				90806		90818		90834		90808		90821		90837	
3	Meeting Date: April, 2012 Tab: 26, Psychotherapy Specialty: Psychiatry, Child Psychiatry, Psychology, Social Work			Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approx. 45 to 50 minutes face-to-face with the patient		Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient		Psychotherapy, 45 minutes with patient and/or family member		Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approx. 75 to 80 minutes face-to-face with the patient		Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient		Psychotherapy, 60 minutes with patient and/or family member	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
6	TOTAL CLINICAL LABOR TIME			11.0	0.0	0.0	6.0	0.0	0.0	11.0	0.0	0.0	6.0	0.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			1.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			6.0	0.0	0.0	0.0	0.0	0.0	6.0	0.0	0.0	0.0	0.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			4.0	0.0	0.0	6.0	0.0	0.0	4.0	0.0	0.0	6.0	0.0	0.0
10	PRE-SERVICE														
11	Start: Following visit when decision for surgery or procedure made														
12	Other Clinical Activity - specify: Review/Read reports		L037D	1						1					
13	End: When patient enters office/facility for surgery/procedure														
14	SERVICE PERIOD														
15	Start: When patient enters office/facility for surgery/procedure:														
16	Greet patient, provide gowning, ensure appropriate medical records are available		L037D	3						3					
17	Obtain vital signs		L037D												
18	Provide pre-service education/obtain consent		L037D	3						3					
23	Other: review history, systems and medications		L037D												
24	Other: coordination home or outpatient care		L037D												
25	Other		L037D												
26	Intra-service														
27	Post-Service														
28	End: Patient leaves office														
29	POST-SERVICE Period														
30	Start: Patient leaves office/facility														
31	Conduct phone calls/call in prescriptions		L037D	4						4					
38	Total Office Visit Time			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
39	Other Clinical Activity - specify: Coordination of care		L037D				6						6		
40	End: with last office visit before end of global period														
41	MEDICAL SUPPLIES														
43	Tissues		box					0.05						0.05	
44	Patient education booklet		SK062 item												
45	assessment monitoring instruments		SK005 item	1				0.25		1				0.25	
46	Reproduced patient worksheet		each					0.5						0.5	
47	EQUIPMENT														
48	One Couch/ Two Chairs							1						1	
49	Chairs (8)														

	A	B	C	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM
1				REFERENCE CODE				REFERENCE CODE				REFERENCE CODE			
2				90805	90817	90833	90807	90819	90836						
3	Meeting Date: April, 2012 Tab: 26, Psychotherapy Specialty: Psychiatry, Child Psychiatry, Psychology, Social Work	CMS Code	Staff Type	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approx. 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services	Psychotherapy, 30 minutes with patient and/or family member when performed with an Evaluation and Management service	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approx. 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services	Psychotherapy, 45 minutes with patient and/or family member when performed with an Evaluation and Management service						
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			XXX	XXX	XXX	XXX	ZZZ	ZZZ	XXX	XXX	XXX	XXX	ZZZ	ZZZ
6	TOTAL CLINICAL LABOR TIME			20.0	0.0	0.0	6.0	0.0	0.0	20.0	0.0	0.0	6.0	0.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			1.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			15.0	0.0	0.0	0.0	0.0	0.0	15.0	0.0	0.0	0.0	0.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			4.0	0.0	0.0	6.0	0.0	0.0	4.0	0.0	0.0	6.0	0.0	0.0
10	PRE-SERVICE														
11	Start: Following visit when decision for surgery or procedure made														
12	Other Clinical Activity - specify: Review/Read reports		L037D	1						1					
13	End: When patient enters office/facility for surgery/procedure														
14	SERVICE PERIOD														
15	Start: When patient enters office/facility for surgery/procedure:														
16	Greet patient, provide gowning, ensure appropriate medical records are available		L037D	3						3					
17	Obtain vital signs		L037D	4						4					
18	Provide pre-service education/obtain consent		L037D	3						3					
23	Other: review history, systems and medications		L037D	5						5					
24	Other: coordination home or outpatient care		L037D												
25	Other		L037D												
26	Intra-service														
27	Post-Service														
28	End: Patient leaves office														
29	POST-SERVICE Period														
30	Start: Patient leaves office/facility														
31	Conduct phone calls/call in prescriptions		L037D	4						4					
38	Total Office Visit Time			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
39	Other Clinical Activity - specify: Coordination of care		L037D				6						6		
40	End: with last office visit before end of global period														
41	MEDICAL SUPPLIES CODE UNIT														
43	Tissues		box					0.05						0.05	
44	Patient education booklet	SK062	item												
45	assessment monitoring instruments	SK005	item	1				0.25		1				0.25	
46	Reproduced patient worksheet		each					0.5						0.5	
47	EQUIPMENT CODE														
48	One Couch/ Two Chairs							1						1	
49	Chairs (8)														

Tab 26 PE Comparison Codes

	A	B	C	AN	AO	AP	AQ	AR	AS	AT	AU	AV	AW
1				REFERENCE CODE				REFERENCE CODE		REFERENCE CODE			
2				90809		90822		90838		90845		90845	
3	Meeting Date: April, 2012 Tab: 26, Psychotherapy Specialty: Psychiatry, Child Psychiatry, Psychology, Social Work	CMS Code	Staff Type	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approx. 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services		Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services		Psychotherapy, 60 minutes with patient and/or family member when performed with an Evaluation and Management service		Psychoanalysis		Psychoanalysis	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			XXX	XXX	XXX	XXX	ZZZ	ZZZ	XXX	XXX	XXX	XXX
6	TOTAL CLINICAL LABOR TIME			20.0	0.0	0.0	6.0	0.0	0.0	4.0	0.0	0.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			1.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			15.0	0.0	0.0	0.0	0.0	0.0	3.0	0.0	0.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			4.0	0.0	0.0	6.0	0.0	0.0	0.0	0.0	0.0	0.0
10	PRE-SERVICE												
11	Start: Following visit when decision for surgery or procedure made												
12	Other Clinical Activity - specify: Review/Read reports		L037D	1						1			
13	End: When patient enters office/facility for surgery/procedure												
14	SERVICE PERIOD												
15	Start: When patient enters office/facility for surgery/procedure:												
16	Greet patient, provide gowning, ensure appropriate medical records are available		L037D	3						3			
17	Obtain vital signs		L037D	4									
18	Provide pre-service education/obtain consent		L037D	3									
23	Other: review history, systems and medications		L037D	5									
24	Other: coordination home or outpatient care		L037D										
25	Other		L037D										
26	Intra-service												
27	Post-Service												
28	End: Patient leaves office												
29	POST-SERVICE Period												
30	Start: Patient leaves office/facility												
31	Conduct phone calls/call in prescriptions		L037D	4									
38	Total Office Visit Time			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
39	Other Clinical Activity - specify: Coordination of care		L037D				6						
40	End: with last office visit before end of global period												
41	MEDICAL SUPPLIES CODE UNIT												
43	Tissues		box					0.05				0.05	
44	Patient education booklet	SK062	item										
45	assessment monitoring instruments	SK005	item	1				0.25		1			
46	Reproduced patient worksheet		each					0.5					
47	EQUIPMENT CODE												
48	One Couch/ Two Chairs							1				1	
49	Chairs (8)												



Tab 26 PE Comparison Codes

	A	B	C	AX	AY	AZ	BA	BB	BC	BD	BE	BF	BG	BH	BI
				REFERENCE CODE				REFERENCE CODE				REFERENCE CODE			
				90846		90846		90847		90847		90853		90853	
3	Meeting Date: April, 2012 Tab: 26, Psychotherapy Specialty: Psychiatry, Child Psychiatry, Psychology, Social Work			Family psychotherapy (without the patient present)		Family psychotherapy (without the patient present)		Family psychotherapy (conjoint psychotherapy) (with patient present)		Family psychotherapy (conjoint psychotherapy) (with patient present)		Group psychotherapy (other than of a multiple-family group)		Group psychotherapy (other than of a multiple-family group)	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
6	TOTAL CLINICAL LABOR TIME			11.0	6.0	0.0	0.0	20.0	6.0	0.0	0.0	11.0	6.0	0.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			1.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			6.0	0.0	0.0	0.0	15.0	0.0	0.0	0.0	10.0	0.0	0.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			4.0	6.0	0.0	0.0	4.0	6.0	0.0	0.0	1.0	6.0	0.0	0.0
10	PRE-SERVICE														
11	Start: Following visit when decision for surgery or procedure made														
12	Other Clinical Activity - specify: Review/Read reports		L037D	1				1							
13	End: When patient enters office/facility for surgery/procedure														
14	SERVICE PERIOD														
15	Start: When patient enters office/facility for surgery/procedure:														
16	Greet patient, provide gowning, ensure appropriate medical records are available		L037D	3				3				3			
17	Obtain vital signs		L037D					4				2			
18	Provide pre-service education/obtain consent		L037D	3				3				3			
23	Other: review history, systems and medications		L037D					5				2			
24	Other: coordination home or outpatient care		L037D												
25	Other		L037D												
26	Intra-service														
27	Post-Service														
28	End: Patient leaves office														
29	POST-SERVICE Period														
30	Start: Patient leaves office/facility														
31	Conduct phone calls/call in prescriptions		L037D	4				4				1			
38	Total Office Visit Time			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
39	Other Clinical Activity - specify: Coordination of care		L037D		6				6				6		
40	End: with last office visit before end of global period														
41	MEDICAL SUPPLIES CODE UNIT														
43	Tissues		box			0.05				0.05				0.05	
44	Patient education booklet	SK062	item												
45	assessment monitoring instruments	SK005	item												
46	Reproduced patient worksheet		each												
47	EQUIPMENT CODE														
48	One Couch/ Two Chairs					1				1					
49	Chairs (8)													1	

AMA/Specialty Society RVS Update Committee Summary of Recommendations  
*Codes Reported Together 75% or More*  
*CMS Request to Re-Review Families of Recently Reviewed CPT Codes*  
*CMS Request Final Rule 2013*

April 2013

**Evoked Potentials and Reflex**

In February 2010, CPT code pairs 95925 *Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs*/95926 *Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs* and 95928 *Central motor evoked potential study (transcranial motor stimulation); upper limbs*/95929 *Central motor evoked potential study (transcranial motor stimulation); lower limbs* were identified by the Codes Reported Together 75% or More screen. At the request of the RUC, the specialty societies submitted a coding proposal which was approved by the CPT Editorial Panel to create two bundled codes which will allow providers to report short latency somatosensory evoked potential studies of the upper and lower limbs and central motor evoked potential study of the upper and lower limbs. At the February 2011 RUC meeting, the RUC reviewed the survey results for new codes 95938 *Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs* and 95939 *Central motor evoked potential study (transcranial motor stimulation); in upper and lower limbs*. The specialty had obtained strong, valid survey results for code 95938, but not for 95939, as only 31% of the respondents indicated the vignette was typical. The RUC and specialty societies agreed that a new survey should be conducted and the survey results presented at the April 2011 RUC meeting with an inpatient vignette scenario. The RUC reviewed these services and submitted recommendations for CPT 2012.

In the Final Rule for 2013, CMS accepted the RUC recommended values on an interim basis, but determined that there are valuation and time inaccuracies, both across the evoked potential study codes and relative to the new bundled codes. For example, for CPT codes 95925 and 95926, CMS does not believe that the correct intra-service time for CPT code 95938 can be the sum of the intra-service times of CPT codes 95925 and 95926, as CMS is confident that there are efficiencies that result from performing these services together. Given these anomalous relationships, CMS requested public comments on the appropriate work and time values for codes 95925, 95926, 95928, 95929, 95938 and 95939.

The RUC agreed with the specialty society that these codes represent two distinct families. The RUC reaffirmed that there was an error in the time file for 95938 and the correct times are 10 minutes pre, 20 minutes intra and 10 minutes post. After correcting this error, the time for codes 95925, 95926 and 95938 are rational. For the second family, the RUC noted that code 95939 was surveyed in April 2011 and recommended that the specialty societies resurvey codes 95928 and 95929 and develop PE inputs for April 2013.



**95928 Central motor evoked potential study (transcranial motor stimulation); upper limbs**

The RUC reviewed the survey data for CPT code 95928 and determined that the survey 25<sup>th</sup> percentile work RVU of 1.50 appropriately accounts for the work required to perform this service. The RUC agreed that 15 minutes pre-service, 40 minutes intra-service and 10 minutes immediate post-service time accurately accounts for the physician time required to perform this service alone. The RUC reiterated that due to the addition of 95939 *Central motor evoked potential study (transcranial motor stimulation); in upper and lower limbs* (work RVU = 2.25 and 15 minutes pre-service, 30 minutes intra-service and 15 minutes immediate post-service time) in CPT 2012, codes 95928 and 95929 are expected now to be performed predominately in the outpatient setting. CPT code 95939 would typically be performed in the inpatient setting where the overall number of muscle sites tested is lower, accounting for the lower intra-service time and a much greater level of intensity than 95928 or 95929. The existing codes, 95928 and 95929 would continue to shift toward being typically performed in non-facility settings, requiring a greater number of muscle sites tested per limb, requiring more intra-service time and physician work. The specialty societies indicated and the RUC agreed that 95939 is a different service, it is an electrical motor evoked potential study, in which the physician delivers 600 volts to the brain. CPT 95939 is more like electroconvulsive shock therapy, but with a much shorter duration so the entire body jerks and all four limbs are moving. Additionally, it is under general anesthesia so the physician can measure the motor pathways directly. CPT code 95939 is more straightforward than 95928 and 95929, but it is also dangerous, so the intensity is greater. Once 95939 was broken out, it described a different service and therefore was appropriately valued differently. The RUC noted that the utilization for 95928 has decreased by 10,000, down to an estimated 1,797 for 2012, as the correct service will now be reported with 95939. The creation of CPT code 95939 represented a 25% savings in work RVUs and substantial overall savings to the Medicare system in 2012.

The RUC compared 95928 to key reference service 95861 *Needle electromyography; 2 extremities with or without related paraspinal areas* (work RVU = 1.54 and 30 minutes intra-service time) and noted that 95928 requires slightly less work, less time and is less intense than 95861.

Therefore, the 25<sup>th</sup> percentile work RVU, which is the current work RVU of 1.50 appropriately places this service relative to other similar services.

**The RUC recommends a work RVU of 1.50 for CPT code 95928.**

**95929 Central motor evoked potential study (transcranial motor stimulation); lower limbs**

The RUC reviewed the survey data for CPT code 95929 and determined that the survey 25<sup>th</sup> percentile work RVU of 1.50 appropriately accounts for the work required to perform this service. The RUC agreed that 15 minutes pre-service, 40 minutes intra-service and 10 minutes immediate post-service time accurately account for the physician time required to perform this service alone. The RUC reiterated that due to the addition of 95939 *Central motor evoked potential study (transcranial motor stimulation); in upper and lower limbs* (work RVU = 2.25 and 15 minutes pre-service, 30 minutes intra-service and 15 minutes immediate post-service time) in CPT 2012, codes 95928 and 95929 are expected now to be performed predominately in the outpatient setting. CPT code 95939 would typically be performed in the inpatient setting where the overall number of muscle sites tested is lower, accounting for the lower intra-service time and a much greater level of intensity than 95928 and 95929. The existing codes, 95928 and 95929 would continue to shift toward being typically performed in non-facility settings, requiring a greater number of muscle sites tested per limb, requiring more intra-service time and physician work. The specialty societies indicated and the RUC agreed that 95939 is a different service, it is an electrical motor evoked potential study, in which the physician delivers 600 volts to the brain. CPT 95939 is

more like electroconvulsive shock therapy but with a much shorter duration so the entire body jerks and all four limbs are moving. Additionally, it is under general anesthesia so the physician can measure the motor pathways directly. CPT code 95939 is more straightforward than 95928 and 95929, but it is also dangerous, so the intensity is greater. Once 95939 was broken out, it described a different service and was therefore valued differently. The RUC noted that the utilization for 95929 has decreased by approximately 18,000, down to an estimated 1,440 for 2012, as the correct service will now be reported with 95939. The creation of CPT code 95939 represented a 25% savings in work RVUs and substantial overall savings to the Medicare system in 2012.

The RUC compared 95929 to key reference service 95861 *Needle electromyography; 2 extremities with or without related paraspinal areas* (work RVU = 1.54 and 30 minutes intra-service time) and noted that 95929 requires slightly less work, less time and is less intense than 95861. Therefore, the 25<sup>th</sup> percentile work RVU, which is the current work RVU of 1.50 appropriately places this service relative to other similar services. **The RUC recommends a work RVU of 1.50 for CPT code 95929.**

#### Work Neutrality

The RUC's recommendation for this family of codes will result in an overall work savings and was redistributed back to the Medicare conversion factor in 2012.

#### Practice Expense:

The RUC accepted the direct PE inputs with minor modifications as recommended by the PE Subcommittee.

CPT Code (●New)	CPT Descriptor	Global Period	Work RVU Recommendation
95928	Central motor evoked potential study (transcranial motor stimulation); upper limbs (Do not report 95928 in conjunction with 95929)	XXX	1.50 (No Change)
95929	lower limbs (Do not report 95929 in conjunction with 95928)	XXX	1.50 (No Change)

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 95928	Tracking Number	Original Specialty Recommended RVU: <b>1.50</b>
		Presented Recommended RVU: <b>1.50</b>
Global Period: XXX		RUC Recommended RVU: <b>1.50</b>

CPT Descriptor: Central motor evoked potential study (transcranial motor stimulation); upper limbs

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A patient presents with subacute arm weakness without sensory disturbances. Imaging shows spondylotic cervical myelopathy. After examination and EMG, the diagnosis remains uncertain. The differential includes cervical myelopathy, amyotrophic lateral sclerosis (ALS), and several peripheral neuromuscular disorders. The patient is referred for central motor evoked potential testing to determine whether there is a central motor pathway impairment and to provide a baseline for assessment of progression.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 6%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Review request to determine which muscles to evaluate and special needs to be met during testing. Consult with referring physicians to establish patient testing plan.

Description of Intra-Service Work: Apply silver-silver chloride electrodes over the biceps, triceps, abductor pollicis brevis and abductor digiti minimi muscles in belly-tendon recording derivation. Apply gel. Secure electrodes. Check impedances, and reapply electrodes as needed. Prior to performing transcranial magnetic stimulation, perform routine motor nerve conduction studies with F-waves in order to establish baseline compound muscle action potentials (CMAP) and determine peripheral conduction. This should include stimulation at Erb's point and distal segments of the nerve. Determine the optimal scalp location for head coil using stepwise stimulus location changes and adjustments of intensity. At the optimal location for the first muscle tested, usually abductor digiti minimi, determine the resting motor evoked potential (MEP) threshold using in 5% increments of maximal stimulator output. After determining the threshold, record MEPs during modest tonic isometric contraction using stimulation 25% of maximum output above threshold. Measure the transcranial MEP amplitude and onset latency and compare to baseline nerve conduction studies. Measure the abductor digiti minimi CMAP obtained with supramaximal electrical stimulation of the ulnar nerve. Calculate the relative abductor digiti minimi MEP amplitude as a percentage of the CMAP amplitude. Measure the MEP to cervical stimulation. Calculate central motor conduction time (CMCT) by subtracting latencies for scalp and cervical stimulation tests. Measure the dissociation between MEP threshold and the cortical stimulation silent period (CSSP) by reducing the stimulator output in 5% increments until stimulation no longer altered the appearance of the average rectified abductor digiti minimi EMG. Measure the dissociation between excitatory and inhibitory effects of transcranial stimulation (MEP facilitation failure) as EMG inhibition without a

preceding MEP at 2 or more stimulus intensities. Replicate data. Store the signals for later review and analysis. Repeat this procedure for 3-4 selected muscles on the same limb. Repeat this procedure on the other upper extremity.

Description of Post-Service Work: Review data, eliminate unreliable data, compare patient results to predetermined limits of normality using three criteria: (1) abnormal excitation using MEP threshold and MEP/CMAP ratio; (2) failure of MEP facilitation; (3) abnormal CMCT; and (4) CSSP. Determine appropriate clinical comments based on the patient's presenting problem and test results. Dictate, review and verify report. Verbal interpretation to referring physician if applicable. Respond to any questions from referring physician, or any patient problems.

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)		04/2013				
Presenter(s):	Marianna Spanaki, MD, PhD; Marc Nuwer, MD, PhD; Joseph Zuhosky, MD					
Specialty(s):	American Academy of Neurology, American Association of Neuromuscular & Electrodiagnostic Medicine, American Academy of Physical Medicine and Rehabilitation, American Clinical Neurophysiology Society					
CPT Code:	95928					
Sample Size:	65	Resp N:	19	Response: 29.2 %		
Description of Sample:	The societies used a combined sample of members and physicians who indicated they perform the service and names supplied by a manufacturer					
		Low	25 <sup>th</sup> pctl	Median*	75 <sup>th</sup> pctl	High
Service Performance Rate		0.00	2.50	15.00	52.50	350.00
Survey RVW:		0.60	1.50	1.60	2.12	8.02
Pre-Service Evaluation Time:				15.00		
Pre-Service Positioning Time:				0.00		
Pre-Service Scrub, Dress, Wait Time:				0.00		
Intra-Service Time:		10.00	25.00	40.00	60.00	360.00
Immediate Post Service-Time:	10.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00		
Discharge Day Mgmt:	0.00	99238x 0.00	99239x 0.00	99217x 0.00		
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00	15x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00	
Sub Obs Care:	0.00	99224x 0.00	99225x 0.00	99226x 0.00		

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

<b>CPT Code:</b>	95928	<b>Recommended Physician Work RVU: 1.50</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		15.00	0.00	15.00
<b>Pre-Service Positioning Time:</b>		0.00	0.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	0.00	0.00
<b>Intra-Service Time:</b>		40.00		
<b>Immediate Post Service-Time:</b>	<b>10.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00
---------------	-------------	-------------	-------------	-------------

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
95861	XXX	1.54	RUC Time

CPT Descriptor Needle electromyography; 2 extremities with or without related paraspinal areas.**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99203	XXX	1.42	RUC Time	9,479,309

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
95861	XXX	1.54	RUC Time	382,803

CPT Descriptor 2 Needle electromyography; 2 extremities with or without related paraspinal areas

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 5      % of respondents: 26.3 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 95928</b>	<b>Key Reference CPT Code: 95861</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	15.00	10.00	
Median Intra-Service Time	40.00	29.00	
Median Immediate Post-service Time	10.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	

Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>65.00</b>	<b>49.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.80	3.60
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.80	3.60
--	------	------

Urgency of medical decision making	3.80	3.40
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.40	4.20
--------------------------	------	------

Physical effort required	3.80	3.60
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.40	2.80
---	------	------

Outcome depends on the skill and judgment of physician	4.00	4.00
--	------	------

Estimated risk of malpractice suit with poor outcome	3.80	3.40
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.60	3.20
----------------------------------	------	------

Intra-Service intensity/complexity	4.20	3.60
------------------------------------	------	------

Post-Service intensity/complexity	3.20	3.40
-----------------------------------	------	------

---

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

A new bundled code (95939) was established in 2012 for the reporting of combined upper and lower motor evoked potential study tests. The majority of the utilization of motor evoked potential studies (90%) utilization is seen in 95939, with 10% being represented in the separate upper and lower limb studies.

Prior to the survey the specialty societies requested the Research Subcommittee approve a survey sample as there is a limited number of physicians who perform the service. 2216 physicians were contacted via AAN Sections, only 21 of which responded they perform the service; a list of physician names was obtained from an equipment manufacturer, however only one physician responded to the initial email and that individual did not complete the survey. The remaining names were obtained from the societies by physicians self-reporting they perform the service. The final sample size was 65 with a total response number of 28.

A consensus panel representing members from the surveying specialties met via conference call to develop recommendations. Upon reviewing the survey data it became apparent, based upon comments, that several of the survey respondents (9) were reporting 95928 in conjunction with intra-operative monitoring which is not typical for the service. The panel performed a data analysis on the respondents (19) who perform the service separate from intra-operative monitoring, per current coding, as well. The societies agreed to remove data representing inaccurate reporting of the service to better reflect the time and intensity involved in 95928.

The small sample size led to poor survey data which is statistically inadequate, but the data we did gather is consistent with existing values. As a result we relied upon an expert panel to validate our recommendations.

The 25<sup>th</sup> percentile RVW of 1.50 from the 19 who report the service based upon current coding is consistent with the existing RVW as well as the Median RVW 1.54 of the entire survey respondent results (28). Therefore we recommend maintaining the existing RVW of 1.50.

The panel agreed with the survey median pre-service time of 15 minutes as well as the post-service time of 10 minutes. The survey median intra service time of 40 minutes is an appropriate representation of the work performed as well.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION



How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95928

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology                      How often? Rarely

Specialty Physical Medicine & Rehabilitation                      How often? Rarely

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 7480

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimated the national frequency would be 4 times the Medicare frequency

Specialty Neurology	Frequency 5760	Percentage 77.00 %
---------------------	----------------	--------------------

Specialty PM&R	Frequency 598	Percentage 7.99 %
----------------	---------------	-------------------

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1870

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This number is 10% of the 2011 Medicare claims data. We estimate that 90% of motor evoked potential studies are performed via the combined upper and lower limb code.

Specialty Neurology	Frequency 1440	Percentage 77.00 %
---------------------	----------------	--------------------

Specialty PM&R	Frequency 150	Percentage 8.02 %
----------------	---------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? No

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 95928

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 95929	Tracking Number	Original Specialty Recommended RVU: <b>1.50</b>
		Presented Recommended RVU: <b>1.50</b>
Global Period: XXX		RUC Recommended RVU: <b>1.50</b>

CPT Descriptor: Central motor evoked potential study (transcranial motor stimulation); lower limbs

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A patient presents with subacute leg weakness without sensory disturbances. Imaging shows lumbar stenosis with myelopathy. After examination and EMG, the diagnosis remains uncertain. The differential includes lumbar myelopathy, lumbar stenosis with secondary spinal cord compression, and several peripheral neuromuscular disorders. The patient is referred for central motor evoked potential testing to determine whether there is a central motor pathway impairment and to provide a baseline for assessment of progression.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 7%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 6%

Description of Pre-Service Work: Review request to determine which muscles to evaluate and special needs to be met during testing. Consult with referring physicians to establish patient testing plan.

Description of Intra-Service Work: Apply silver-silver chloride electrodes over tibialis anterior, gastrocnemius, abductor hallucis, and abductor digiti minimi muscles in belly-tendon recording derivation. Apply gel. Secure electrodes. Check impedances, and reapply electrodes as needed. Obtain motor nerve conduction studies with F-waves and establish baseline compound muscle action potentials (CMAP) and determine peripheral conduction. Determine optimal scalp location for head coil using stepwise stimulus location changes and adjustments of intensity. Determine the resting motor evoked potential (MEP) threshold and record MEP during modest tonic isometric contraction. Also measure the transcranial MEP amplitude and onset latency and compare to baseline nerve conduction studies.

Measure CMAP obtained with supramaximal electrical stimulation and calculate the relative MEP amplitude. Measure the MEP to lumbar stimulation and calculate the relative MEP amplitude. Calculate central motor conduction time (CMCT) by subtracting latencies for scalp and lumbar stimulation tests or peripheral nerve conduction times using a formula. Measure the dissociation between MEP threshold and the cortical stimulation silent period (CSSP). Measure the dissociation between excitatory and inhibitory effects of transcranial stimulation (MEP facilitation failure).

Replicate data and store signals for later review and analysis. Repeat procedure for 3 other selected muscles on same limb. Repeat this procedure for other lower extremity.

Description of Post-Service Work: Review data, eliminate unreliable data, compare patient results to predetermined limits of normality using three criteria: (1) abnormal excitation using MEP threshold and MEP/CMAP ratio; (2) failure of MEP

facilitation; (3) abnormal CMCT; and (4) CSSP. Determine appropriate clinical comments based on the patient's presenting problem and test results. Dictate, review and verify report. Verbal interpretation to referring physician if applicable. Respond to any questions from referring physician, or any patient problems.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	Marianna Spanaki, MD, PhD; Marc Nuwer, MD, PhD; Joseph Zuhosky, MD				
<b>Specialty(s):</b>	American Academy of Neurology, American Association of Neuromuscular & Electrodiagnostic Medicine, American Academy of Physical Medicine and Rehabilitation, American Clinical Neurophysiology Society				
<b>CPT Code:</b>	95929				
<b>Sample Size:</b>	65	<b>Resp N:</b>	19	<b>Response:</b> 29.2 %	
<b>Description of Sample:</b>	The societies used a combined sample of members and physicians who indicated they perform the service and names supplied by a manufacturer				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	1.50	15.00	52.50	350.00
<b>Survey RVW:</b>	0.60	1.50	1.70	2.17	8.02
<b>Pre-Service Evaluation Time:</b>			15.00		
<b>Pre-Service Positioning Time:</b>			0.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.00		
<b>Intra-Service Time:</b>	10.00	28.00	40.00	60.00	360.00
<b>Immediate Post Service-Time:</b>	<b>10.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00			
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00 99239x 0.00 99217x 0.00			
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00 99225x 0.00 99226x 0.00			

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

<b>CPT Code:</b>	95929	<b>Recommended Physician Work RVU: 1.50</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		15.00	0.00	15.00
<b>Pre-Service Positioning Time:</b>		0.00	0.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	0.00	0.00
<b>Intra-Service Time:</b>		40.00		
<b>Immediate Post Service-Time:</b>	<b>10.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00 99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00 99232x 0.00 99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0 99239x 0.0 99217x 0.00		
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00		
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00		

<b>Sub Obs Care:</b>	<b>0.00</b>	99224x <b>0.00</b>	99225x <b>0.00</b>	99226x <b>0.00</b>
----------------------	-------------	--------------------	--------------------	--------------------

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
95925	XXX	0.54	RUC Time

CPT Descriptor Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99203	XXX	1.42	RUC Time	9,479,309

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
95861	XXX	1.54	RUC Time	382,803

CPT Descriptor 2 Needle electromyography; 2 extremities with or without related paraspinal areas

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 6      % of respondents: 31.5 %

**TIME ESTIMATES (Median)**

	<b>CPT Code:</b> 95929	<b>Key Reference CPT Code:</b> 95925	<b>Source of Time</b> RUC Time
Median Pre-Service Time	15.00	6.50	
Median Intra-Service Time	40.00	15.00	
Median Immediate Post-service Time	10.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	

Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>65.00</b>	<b>31.50</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key  
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.17	3.83
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.17	3.50
--	------	------

Urgency of medical decision making	2.83	2.67
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.50	3.67
--------------------------	------	------

Physical effort required	3.67	3.00
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.50	2.17
---	------	------

Outcome depends on the skill and judgment of physician	4.33	4.00
--	------	------

Estimated risk of malpractice suit with poor outcome	2.50	2.33
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.50	3.00
----------------------------------	------	------

Intra-Service intensity/complexity	4.33	3.83
------------------------------------	------	------

Post-Service intensity/complexity	3.00	2.67
-----------------------------------	------	------

---

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

A new bundled code (95939) was established in 2012 for the reporting of combined upper and lower motor evoked potential study tests. The majority of the utilization of motor evoked potential studies (90%) utilization is seen in 95939, with 10% being represented in the separate upper and lower limb studies.

Prior to the survey the specialty societies requested the Research Subcommittee approve a survey sample as there is a limited number of physicians who perform the service. 2216 physicians were contacted via AAN Sections, only 21 of which responded they perform the service; a list of physician names was obtained from an equipment manufacturer, however only one physician responded to the initial email and that individual did not complete the survey. The remaining names were obtained from the societies by physicians self-reporting they perform the service. The final sample size was 65 with a total response number of 28

A consensus panel representing members from the surveying specialties met via conference call to develop recommendations. Upon reviewing the survey data it became apparent, based upon comments, that several of the survey respondents (9) were reporting 95929 in conjunction with intra-operative monitoring which is not typical for the service. The panel performed a data analysis on the respondents (19) who perform the service separate from intra-operative monitoring, per current coding, as well. The societies agreed to remove data representing inaccurate reporting of the service to better reflect the time and intensity involved in 95929.

The small sample size led to poor survey data which is statistically inadequate, but the data we did gather is consistent with existing values. As a result we relied upon an expert panel to validate our recommendations.

The 25<sup>th</sup> percentile RVW of 1.50 from the 19 who report the service based upon current coding is consistent with the existing RVW as well as the Median RVW 1.54 of the entire survey respondent results (26). Therefore we recommend maintaining the existing RVW of 1.50.

The panel agreed with the survey median pre-service time of 15 minutes as well as the post-service time of 10 minutes. The survey median intra service time of 40 minutes is an appropriate representation of the work performed as well.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95929

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
 If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology                      How often? Rarely

Specialty Physical Medicine & Rehabilitation                      How often? Rarely

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 7736

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimated the national frequency would be 4 times the Medicare frequency.

Specialty Neurology                      Frequency 6034                      Percentage 77.99 %

Specialty PM&R                      Frequency 735                      Percentage 9.50 %

Specialty                      Frequency                      Percentage                      %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,934

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This number is 10% of the 2011 Medicare claims data. We estimate that 90% of motor evoked potential studies are performed via the combined upper and lower limb code.

Specialty Neurology                      Frequency 1511                      Percentage 78.12 %

Specialty PM&R                      Frequency 212                      Percentage 10.96 %

Specialty                      Frequency                      Percentage                      %

Do many physicians perform this service across the United States? No

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 95929

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.



SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	AT
12	ISSUE: Evoked Potentials and Reflex																				
13	TAB: 36																				
14	NOTE: data below is from 19 survey respondents who perform the service separate from intra-operative monitoring, per current coding																				
15						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	
16	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	
17	REF	95861	Needle EMG, 2 extremities		0.038			1.54			49	10					29			10	
18	CURRENT	95928	Central MEP study, upper limbs		0.014			1.50			90	15					60			15	
19	SVY	95928	Central MEP study, upper limbs	19	0.026	0.60	1.50	1.60	2.12	8.02	65	15			10	25	40	60	360	10	
20	REC	95928	Central MEP study, upper limbs		0.024	1.50					65	15			40					10	
21																					
22	NOTE: data below is from 9 survey respondents who perform 95928 in conjunction with intra-operative monitoring which is not typical for the service																				
23						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	
24	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	
25	REF	95925	Short-latency SEP study, upper limbs		0.011			0.54			31.5	6.5					15			10	
26	SVY	95928	Central MEP study, upper limbs	9	0.027	0.65	0.90	1.00	1.54	4.00	40	10			4	10	25	35	240	5	
27																					
28	NOTE: data below is from all responses including those who indicated they perform the service in conjunction with intra-operative monitoring																				
29	which is not typical for the service																				
30						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	
31	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	
32	REF	95925	Short-latency SEP study, upper limbs		0.011			0.54			31.5	6.5					15			10	
33	SVY	95928	Central MEP study, upper limbs	28	0.030	0.60	0.99	1.54	2.06	8.02	58	15			4	24	33	60	360	10	
34																					
35																					
36	NOTE: data below is from 19 survey respondents who perform the service separate from intra-operative monitoring, per current coding																				
37						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	
38	REF	95925	Short-latency SEP study, upper limbs		0.011			0.54			31.5	6.5					15			10	
39	CURRENT	95929	Central MEP study, lower limbs		0.015			1.50			85	15					55			15	
40	SVY	95929	Central MEP study, lower limbs	19	0.029	0.60	1.50	1.70	2.17	8.02	65	15			10	28	40	60	360	10	
41	REC	95929	Central MEP study, lower limbs		0.024	1.50					65	15					40			10	
42																					
43	NOTE: data below is from 9 survey respondents who perform 95929 in conjunction with intra-operative monitoring which is not typical for the service																				
44						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	
45	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	
46	REF	95925	Short-latency SEP study, upper limbs		0.011			0.54			31.5	6.5					15			10	
47	SVY	95929	Central MEP study, lower limbs	9	0.025	0.65	0.90	1.00	1.54	4.10	42	12			4	10	25	35	60	5	
48																					
49	NOTE: data below is from all responses including those who indicated they perform the service in conjunction with intra-operative monitoring																				
50	which is not typical for the service																				
51						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	
52	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	
53	REF	95925	Short-latency SEP study, upper limbs		0.011			0.54			31.5	6.5					15			10	
54	SVY	95929	Central MEP study, lower limbs	28	0.030	0.60	1.04	1.54	2.14	8.02	58	15			4	25	33	60	360	10	

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor:

**95928 Central motor evoked potential study (transcranial motor stimulation); upper limbs**

Global Period: XXX\_\_ Meeting Date: April 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

**A consensus panel representing members from the surveying specialties met via conference call and email to develop recommendations.**

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

**We provided the PE inputs for 95928 as they were approved at the April 2012 RUC meeting. The societies agree the inputs have not changed since that time.**

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:

4. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Review requisition. Assess for contraindications. e.g. implanted devices, skull defects, history of seizures. Assess for confounding factors, e.g. diabetes, peripheral neuropathy, known neuromuscular disorders. Obtain authorization from insurance carrier. Give patient instructions for test preparation (regarding skin and hair lotion, anxiolytic instructions, etc.) and what to expect on the day of testing. Check availability of nurse to administer any medication. Prepare room, supplies, and equipment.

Intra-Service Clinical Labor Activities:

Greet and gown patient. Take history and perform brief exam of head and limbs. Establish patient testing strategy. Explain procedure. Review with supervising physician for special needs or problems. Position the patient on a comfortable exam table. Assist physician in conducting the test. Together, place electrodes in correct muscles and identify best places to try first as stimulation sites. Coach the patient to relax better despite the brain stimulation. Coach the patient to improve the test by slightly contracting muscle being tested. Test the first muscle in the first limb, requiring series of stimulation trials, excluding trials with muscle contamination. Continue trials with slight variations in stimulation site and stimulus

intensity. Identify the optimal stimulus sites and intensity for best motor responses. Repeat testing on first muscle in the first limb two or three times. Repeat the procedure with the stimulator moved to the spine. Repeat the procedure with the stimulator moved over the plexus. Measure distances among the stimulation sites and recording site. Repeat the three-site procedure for the second and the third muscles on the first limb. Repeat that whole procedure for second limb. Remove electrodes and clean up patient. Release patient. Give discharge instructions.

Post-Service Clinical Labor Activities:

Complete worksheets and technical interpretation. Clean room and equipment. Restock supplies. Prepare data for interpretation. Place data on storage disk. Complete medical records and other forms.

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor:

**Central motor evoked potential study (transcranial motor stimulation); lower limbs**

Global Period: XXX Meeting Date: April 2013  

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

**A consensus panel representing members from the surveying specialties met via conference call and email to develop recommendations.**

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

**We provided the PE inputs for 95929 as they were approved at the April 2012 RUC meeting. The societies agree the inputs have not changed since that time.**

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:

4. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Review requisition. Assess for contraindications. e.g. implanted devices, skull defects, history of seizures. Assess for confounding factors, e.g. diabetes, peripheral neuropathy, known neuromuscular disorders. Obtain authorization from insurance carrier. Give patient instructions for test preparation (regarding skin and hair lotion, anxiolytic instructions, etc.) and what to expect on the day of testing. Check availability of nurse to administer any medication. Prepare room, supplies, and equipment

Intra-Service Clinical Labor Activities:

Greet and gown patient. Take history and perform brief exam of head and limbs. Establish patient testing strategy. Explain procedure. Review with supervising physician for special needs or problems. Position the patient on a comfortable exam table. Assist physician in conducting the test. Together, place electrodes in correct muscles and identify best places to try first as stimulation sites. Coach the patient to relax better despite the brain stimulation. Coach the patient to improve the test by slightly contracting muscle being tested. Test the first muscle in the first limb, requiring series of stimulation trials, excluding trials with muscle contamination. Continue trials with slight variations in stimulation site and stimulus

intensity. Identify the optimal stimulus sites and intensity for best motor responses. Repeat testing on first muscle in the first limb two or three times. Repeat the procedure with the stimulator moved to the spine. Repeat the procedure with the stimulator moved over the plexus. Measure distances among the stimulation sites and recording site. Repeat the three-site procedure for the second and the third muscles on the first limb. Repeat that whole procedure for second limb. Remove electrodes and clean up patient. Release patient. Give discharge instructions.

Post-Service Clinical Labor Activities:

Complete worksheets and technical interpretation. Clean room and equipment. Restock supplies. Prepare data for interpretation. Place data on storage disk. Complete medical records and other forms.

	A	B	C	D	E	F	G	H	I	J	K
1				REFERENCE CODE			REFERENCE CODE				
2	Revised PE Spreadsheet			95928		95928		95929		95929	
3	Meeting Date: April 2013 Tab: 36 Specialty: AAN, AANEM, AAPMR, ACNS	CMS Code	Staff Type	Central motor evoked potential study (transcranial motor stimulation); upper limbs		Central motor evoked potential study (transcranial motor stimulation); upper limbs		Central motor evoked potential study (transcranial motor stimulation); lower limbs		Central motor evoked potential study (transcranial motor stimulation); lower limbs	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			XXX		XXX		XXX		XXX	
6	TOTAL CLINICAL LABOR TIME	L047B	REET	94.0	0.0	79.0	0.0	94.0	0.0	79.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L047B	REET	8.0	0.0	8.0	0.0	8.0	0.0	8.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L047B	REET	86.0	0.0	71.0	0.0	86.0	0.0	71.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L047B	REET	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
10	PRE-SERVICE										
11	Start: Following visit when decision for surgery or procedure made										
12	Complete pre-service diagnostic & referral forms	L047B	REET	2		2		2		2	
13	Coordinate pre-surgery services										
14	Schedule space and equipment in facility										
15	Provide pre-service education/obtain consent	L047B	REET	3		3		3		3	
16	Follow-up phone calls & prescriptions										
17	Other Clinical Activity - specify: Review requisition. Assess for special needs. Give patient instructions for test preparation (eg, hair lotion) and what to expect on the day of testing.	L047B	REET	3		3		3		3	
18	End: When patient enters office/facility for surgery/procedure										
19	SERVICE PERIOD										
20	Start: When patient enters office/facility for surgery/procedure:										
21	Greet patient, provide gowning, ensure appropriate medical records are available	L047B	REET	3		3		3		3	
22	Obtain vital signs										
23	Provide pre-service education/obtain consent										
24	Prepare room, equipment, supplies	L047B	REET	2		2		2		2	
25	Setup scope (non facility setting only)										
26	Prepare and position patient/ monitor patient/ set up IV										
27	Sedate/apply anesthesia										
28	Intra-service										
29	Assist physician in performing procedure	L047B	REET	75		60		75		60	
30	Post-Service										
31	Monitor pt. following service/check tubes, monitors, drains										
32	Clean room/equipment by physician staff	L047B	REET	3		3		3		3	
33	Clean Scope										
34	Clean Surgical Instrument Package										
35	Complete diagnostic forms, lab & X-ray requisitions	L047B	REET	3		3		3		3	
36	Review/read X-ray, lab, and pathology reports										
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions										
38	Other Clinical Activity - specify:										

AMA Specialty Society Recommendation

	A	B	C	D	E	F	G	H	I	J	K
1				REFERENCE CODE				REFERENCE CODE			
2	<b>Revised PE Spreadsheet</b>			<b>95928</b>		<b>95928</b>		<b>95929</b>		<b>95929</b>	
3	<b>Meeting Date: April 2013</b> <b>Tab: 36</b> <b>Specialty: AAN, AANEM, AAPMR, ACNS</b>	<b>CMS Code</b>	<b>Staff Type</b>	Central motor evoked potential study (transcranial motor stimulation); upper limbs		Central motor evoked potential study (transcranial motor stimulation); upper limbs		Central motor evoked potential study (transcranial motor stimulation); lower limbs		Central motor evoked potential study (transcranial motor stimulation); lower limbs	
4	<b>LOCATION</b>			<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>	<b>Non Fac</b>	<b>Facility</b>
5	<b>GLOBAL PERIOD</b>			<b>XXX</b>		<b>XXX</b>		<b>XXX</b>		<b>XXX</b>	
39	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			n/a		n/a		n/a		n/a	
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)			n/a		n/a		n/a		n/a	
41	Dischrg mgmt (1.0 x 99239) (enter 15 min)			n/a		n/a		n/a		n/a	
42	<b>End: Patient leaves office</b>										
43	<b>POST-SERVICE Period</b>										
44	<b>Start: Patient leaves office/facility</b>										
45	Conduct phone calls/call in prescriptions										
46	<b>Office visits: List Number and Level of Office Visits</b>			<b># visits</b>	<b># visits</b>	<b># visits</b>	<b># visits</b>	<b># visits</b>	<b># visits</b>	<b># visits</b>	<b># visits</b>
47	99211 16 minutes		16								
48	99212 27 minutes		27								
49	99213 36 minutes		36								
50	99214 53 minutes		53								
51	99215 63 minutes		63								
52	<b>Total Office Visit Time</b>			<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>
53	Other Clinical Activity - <i>specify:</i>										
54	<b>End: with last office visit before end of global period</b>										
55	<b>MEDICAL SUPPLIES</b>										
		<b>CODE</b>	<b>UNIT</b>								
56	pack, minimum multi-specialty visit	SA048	pack	1		1		1		1	
57	Electrode, EEG (single)	SD165	item	12		12		12		12	
58	gauze, sterile 4 in X 4 in (10 pack)	SG056	item	1		1		1		1	
59	electrode, skin prep gel (NuPrep)	SJ022	ml	2		2		2		2	
60	electrode, ground	SD059	item	1		1		1		1	
61	tape, porous-hypoallergenic 2 in (Scanpore)	SG077	inch	24		24		24		24	
62	paper, recording (per sheet)	SK059	item	6		6		6		6	
63	drape, non sterile, sheet 40in x 60 in	SB006	item	1		1		1		1	
64	acetone	SL001	ml	7		7		7		7	
65	glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)	SM018	oz	0.17		0.17		0.17		0.17	
66	measuring tape, paper	SK048	item	1		1		1		1	
67	swab-pad, alcohol	SJ053	item	1		1		1		1	
68	electrode conductive gel	SJ020	ml	1		1		1		1	
69	Emory board	SK021	item	1		1		1		1	
70	<b>EQUIPMENT</b>										
		<b>CODE</b>									
71	EMG-NCV-EP system, 8 channel	EQ024		86		65		86		65	
72	Table, Exam	EF023		86		65		86		65	
73	magnetic stimulator system (BiStim)	EQ180		86		65		86		65	
74	magnetic stimulator hand coil (70-90mm)	EQ178		86		65					
75	magnetic stimulator leg coil (110mm)	EQ179						86		65	
76	printer, laser, paper	ED032		10		10		10		10	
77											

AMA/Specialty Society RVS Update Committee Summary of Recommendations  
*CMS Request Final Rule for 2013*

April 2013

**Negative Pressure Wound Therapy**

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

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

In April 2013, industry individuals have again submitted a CCP to create two category I codes to describe these services with the use of a disposable device. Depending on Panel Action, at the May CPT meeting, this issue may be on the LOI for the October 2013 RUC meeting.



<b>CPT Code (•New)</b>	<b>CPT Descriptor</b>	<b>Global Period</b>	<b>Work RVU Recommendation</b>
G0456	Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area less than or equal to 50 square centimeters	XXX	No Specialty Society Interest – No RUC recommendation at this time
G0457	Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area greater than 50 square centimeters	XXX	No Specialty Society Interest – No RUC recommendation at this time

AMA/Specialty Society RVS Update Committee Summary of Recommendations  
*CMS High Expenditure Procedural Codes Screen*  
*CMS Request: Final Rule for 2013*

April 2013

**Pharmacologic Management with Psychotherapy**

Specific psychotherapy codes were identified through the CMS High Expenditure Procedural codes screen. However, the specialties were already in the process of revising this entire section as indicated from the Fourth Five-Year Review. In April 2012, the specialty societies indicated and the RUC and HCPAC agreed that codes 90785, 90839, 90840 and 90863 be carrier priced to allow for education and experience with a significantly different coding structure. This would allow providers to gain experience with the codes prior to conducting a HCPAC survey. After a year of experience with the new coding structure the specialties would conduct surveys for these services for review of work and direct PE inputs at the April 2013 HCPAC meeting. In the Final Rule for 2013 CMS assigned interim values to the new psychotherapy codes and indicated that they will re-review all assumptions when they review all recommended values for this family of CPT codes.

**90863 Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)**

The HCPAC reviewed the survey results from 32 psychologists who practice in the two states that allow clinical psychologists to perform pharmacologic management under state scope of practice laws, for CPT code 90863. The HCPAC noted that the respondents chose 99213 *Evaluation and Management Office Visit* (work RVU = 0.97 and 15 minutes intra-service time) as the key reference service. The HCPAC noted that when the RUC reviewed the Psychotherapy performed with an Evaluation and Management service (E/M), codes 90833, 90836 and 90838, the RUC assumed the typical E/M reported would be a 99212. The HCPAC determined that the survey median work RVU of 0.98 was not appropriate as this service is an add-on code for Psychotherapy codes 90832, 90834 and 90837 and would result in too high of a work RVU compared to the RUC recommended Psychotherapy with E/M codes. The HCPAC determined that the survey respondents 25<sup>th</sup> percentile intra-service time of 15 minutes and a cross-walk to the work of 99212 (work RVU=0.48 and 16 minutes total time) was more appropriate. Additionally, a work RVU of 0.48 would appropriately align this service relative to the Psychotherapy with E/M services. **The HCPAC recommends a work RVU of 0.48 for CPT code 90863.**

**Practice Expense:**

The HCPAC reviewed the direct practice expense inputs and recommends 5 minutes of clinical staff for the *Medical/Technical Assistant* (L026A) to obtain vital signs (blood pressure, respiratory rate, heart rate, height, weight and temperature) and 15 minutes of equipment time for *One Couch and Two Chairs* (EFO42).

CPT Code (●New)	CPT Descriptor	Global Period	Work RVU Recommendation
90863	<p>Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)</p> <p>(Use 90863 in conjunction with 90832, 90834, 90837)</p> <p>(For pharmacologic management with psychotherapy services performed by a physician or other qualified health care professional who may report evaluation and management codes, use the appropriate evaluation and management codes 99201-99255 , 99281- 99285 ,99304- 99337 , 99341- 99350 and the appropriate psychotherapy with evaluation and management service 90833, 90836, 90838)</p> <p>(Do not count time spent on providing pharmacologic management services in the time used for selection of the psychotherapy service)</p>	ZZZ	0.48

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 90863	Tracking Number	Original Specialty Recommended RVU: <b>0.98</b>
		Presented Recommended RVU: <b>0.98</b>
Global Period: ZZZ		RUC Recommended RVU: <b>0.48</b>

CPT Descriptor: Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 66-year-old married female with Major Depressive Disorder diagnosis; established patient on anti-depressant medication with psychotherapy. Patient is experiencing increased lability, depressed mood, and sleep disturbance following recent move from independent living in family home to senior citizen apartments.

Percentage of Survey Respondents who found Vignette to be Typical: 66%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

**Description of Pre-Service Work:**

Description of Intra-Service Work: A problem-focused single-system psychiatric examination is performed and medical decision making of a scope, nature and complexity necessary for the initiation, continuance, modification or discontinuance of psychopharmacologic management of the patient occurs. Therapeutic drug monitoring protocols are ordered and reviewed, as clinically indicated and in accordance to recognized and appropriate standards of care, and necessary changes to drug regimens, if any, are undertaken when required. Side-effects to drug therapies, other adverse drug effects or complications and potential drug-disease interactions are identified and managed as needed.

**Description of Post-Service Work:**

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2013				
<b>Presenter(s):</b>	James Georgoulakis				
<b>Specialty(s):</b>	American Psychological Association Practice Organization				
<b>CPT Code:</b>	90863				
<b>Sample Size:</b>	42	<b>Resp N:</b>	32	<b>Response:</b> 76.1 %	
<b>Description of Sample:</b>	Limited distribution, using lists of licensing boards compared with APAPO member lists and removing those identified as government. This distribution method was reviewed and approved by the AMA Research subcommittee. Additionally a contracted company was utilized to place reminder calls; the caller had no clinical background and was used to boost response rate to obtain a valid number of completed surveys.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	49.00	100.00	350.00	2250.00
<b>Survey RVW:</b>	0.50	0.98	1.50	1.70	2.00
<b>Pre-Service Evaluation Time:</b>			0.00		
<b>Pre-Service Positioning Time:</b>			0.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.00		
<b>Intra-Service Time:</b>	10.00	15.00	20.00	23.00	45.00
<b>Immediate Post Service-Time:</b>	<u>0.00</u>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: ZZZ Global Code

<b>CPT Code:</b>	90863	<b>Recommended Physician Work RVU: 0.48</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		0.00	0.00	0.00
<b>Pre-Service Positioning Time:</b>		0.00	0.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	0.00	0.00
<b>Intra-Service Time:</b>		15.00		
<b>Immediate Post Service-Time:</b>	<u>0.00</u>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<u>0.00</u>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00

<b>Prolonged Services:</b>	<u><b>0.00</b></u>	99354x <b>0.00</b>	55x <b>0.00</b>	56x <b>0.00</b>	57x <b>0.00</b>
<b>Sub Obs Care:</b>	<u><b>0.00</b></u>	99224x <b>0.00</b>	99225x <b>0.00</b>	99226x <b>0.00</b>	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99213	XXX	0.97	CMS Time File

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99202	XXX	0.93	RUC Time	3,072,627

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99213	XXX	0.97	RUC Time	100,268,622

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
76810	ZZZ	0.98	RUC Time

CPT Descriptor Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 12      % of respondents: 37.5 %

**TIME ESTIMATES (Median)**

	CPT Code: 90863	Key Reference CPT Code: 99213	Source of Time RUC Time
Median Pre-Service Time	0.00	3.00	
Median Intra-Service Time	15.00	15.00	
Median Immediate Post-service Time	0.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
<b>Median Total Time</b>	<b>15.00</b>	<b>23.00</b>	
<b>Other time if appropriate</b>			

**INTENSITY/COMPLEXITY MEASURES (Mean)**

(of those that selected Key  
Reference code)

**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.42	3.27
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.17	3.27
Urgency of medical decision making	3.42	3.45

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.17	3.82
Physical effort required	2.00	2.30

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.25	3.36
Outcome depends on the skill and judgment of physician	4.25	4.09
Estimated risk of malpractice suit with poor outcome	3.33	3.27

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity		
Intra-Service intensity/complexity	3.25	3.20
Post-Service intensity/complexity		

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**Background**

The American Psychological Association Practice Organization (APAPO) is submitting recommendations to the HCPAC on one new code within the psychiatry family of CPT that is currently carrier priced: **CPT 90863, Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (Global ZZZ)**. In 2012, these services were reported with CPT 90862 *Pharmacologic management, including prescription use and review of medications with no more than minimal medical psychotherapy* (RVW 0.95, Pre time 5 minutes, Intra time 25 minutes, Post time 23 minutes, total 53 minutes) which was deleted effective January 1, 2013 as part of a restructure of the psychiatry family of services. The new service, 90863 is an add-on service primarily developed for licensed psychologists, and would be billed when performed, in addition to one of these three new psychotherapy services, CPT 90832 *Psychotherapy, 30 minutes with patient and/or family member*, 90834 *Psychotherapy, 45 minutes with patient and/or family member* or 90837 *Psychotherapy, 60 minutes with patient and/or family member*.

**History**

In 2010, the APAPO as part of a joint society group put forward 36 codes as part of the fourth Five Year Review process. These codes comprised the bulk of the services within the Psychiatry section of CPT. In October of 2010, the RUC accepted the compelling evidence arguments for the family of psychiatric services. The RUC also agreed to refer the majority of the codes to the newly-formed CPT Editorial Panel workgroup. In February, 2012, the CPT Editorial Panel approved a new coding framework of which 90863 was included. At the April 2012 RUC meeting, seventeen (one by reaffirmation from the Oct 2011 meeting) of the new or revised codes were reviewed with recommended work and PE values sent to CMS. The RUC also approved carrier pricing for the remaining four new/revised codes, (including 90863) to allow the societies time for education and for members to gain experience with the significantly different coding structure, and to afford the RUC and societies time to assess options for conducting the survey of the remaining codes, that would require survey tool modifications, as well as, distribution modifications.

**Survey process**

At the February 2013 research committee conference call, the APAPO requested and the research committee approval, survey tool modifications as requested, review of a proposed RSL (approved with modifications) and modifications to the typical random survey method for 90863. As described in our letter to the research committee the distribution method presented challenges; there is a limited pool of potential survey participants as only approximately 100 psychologists, in two states, can presently prescribe psychotropic medication(s). The APAPO obtained the lists of providers from the licensing boards, removed duplicates, compared to the members lists and then removed those identified as Department of Defense, the Indian Health System and the U.S. Public Health Service. The APAPO identified a total of 42 potential survey participants and sent these individuals our on-line survey. Additionally, we hired an outside company (with no clinical expertise) to make reminder phone calls to those that had not yet completed the survey to ensure that the small pool did complete the survey to reach the minimum required 30 completed surveys.

**Analysis and recommendations from the expert panel**



The societies convened an expert panel, with representation from the two states and from varying practice sizes to review the survey data and make recommendations. The expert panel reviewed the number of responses 32 compared to the distribution of 42 and were pleased with the 76 percent response rate. We note the reminder phone calls by the contractor is credited with the high response rate.

Sixty six percent of the survey respondents told us the vignette was typical, those 11 that did not say it was typical, either did not tell us why (left blank) or if they did tell us, there were no identified clinical indication patterns, four cited age of the patient for the reason. The expert panel reviewed the survey median performance rate of 100; the panel believes this supports the notion that those taking the survey are familiar with the service, only two responded they did not perform the survey code in the past year. At the request of the research committee, we run the additional report (see standard RUC summary excel file details) of those that performed the Ref. Service code (RC) chosen versus those that did not perform the RC they chose, as well, we are providing here the breakdown of the selected RC; only eight of the 32 survey respondents told us they did not perform the RC chosen, of those 1 chose 96150, 1 chose 99213, 2 choose 99214, 2 choose 99359 and finally 2 choose 99355. Of note, the 25 percentile remained essentially unchanged, as the RUC summary excel table shows.

The expert panel reviewed the survey times and agreed that the median Intra time of 20 minutes, correctly represents the time of the service. The expert panel then reviewed the RVW survey data compared to the Key Reference service chosen 99213 with (RVW 0.97 3, 15, 5 total time 23 minutes) MPC service, they also reviewed the 2012 service 90862 RVW 0.95 5, 25, 23 total 23) and 99202 RVW 0.93, 2, 15, 5, total time 22 minutes) MPC service. In general, the expert panel believes that the survey median RVW 1.50 overstates the value in comparison to the other services reviewed however, the survey 25<sup>th</sup> percentile represents the work and the relativity between the services. The expert panel also stated that the work of the 99213 is a very close match to the work of 90863 and commented that the complexity of the specialty of psychotropic medications added a slight added complexity therefore justifying this add on service with a slightly higher RVW to the XXX global service. Finally as another comparator outside our specialty we offer, CPT 76810 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)* global ZZZ add on service, RVW 0.98, intra time 20 minutes.

---

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. CPT 90832, 90834, 90837.
- 

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 90863

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Psychology                      How often? Sometimes

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 175000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Our expert panel, in combination with the frequency of those taking the survey assisted in providing our estimates.

Specialty Psychology                      Frequency 175000                      Percentage 100.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare status indicator I.

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? No

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 90832

**ISSUE:** Pharmacologic management

**TAB:** 40

Source	CPT	Short DESC	Resp	IWPUT	RVW					Total Time	PRE EVAL	INTRA					IMMD POST	SURVEY EXPERIENCE				
					MIN	25th	MED	75th	MAX			MIN	25th	MED	75th	MAX		MIN	25th	MED	75th	MAX
Key REF	99213	Office visit for the E/M of an established patient...Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.	12	0.0527			0.97			23	3			15			5					
2012 XXX	90862	Pharmacologic management, including prescription use and review of medication with no more than minimal medical psychotherapy		0.0129			0.95			53	5			25			23					
Other Comparison	99212	Office or other outpatient visit for the evaluation and management of an established patient		0.0346			0.48			16	2			10			4					
Did Not Perform RS	90863	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services	8	0.0775	0.75	0.99	1.55	1.61	1.77	20		10	15	20	23	45		0	15	48	850	2240
Perform RS	90863	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services	24	0.0688	0.50	0.98	1.38	1.70	2.00	20		10	15	20	23	45		0	69	100	250	1200
SVY	90863	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services	32	0.0750	0.50	0.98	1.50	1.70	2.00	20		10	15	20	23	45		0	49	100	350	2240
REC	90863	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services		0.024	0.48					20				20								

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Facility Direct Inputs**

CPT Long Descriptor:

**Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)**

Global Period: **ZZZ** Meeting Date: **April 2013**

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

**An expert panel of psychologists was convened to review practice expenses for this code submission. The panel included practicing psychologists from Louisiana and New Mexico, the two states in the U.S. where psychologists are licensed to prescribe. These members of the expert panel are engaged in large institutional practices as well as smaller private practices.**

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

**The expert panel chose the 2012 CPT code 90862 as the comparator as this is the code providers used prior to 2013. Additionally, we have provided the most likely psychotherapy base service 90832 since this code (90863) is an add-on code to be reported only with psychotherapy services.**

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time: **Does not apply**

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence: **Does not apply**

5. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities: **Phone calls between visits with patient, family, pharmacy.**

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor:

**Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)**

Global Period: **ZZZ** Meeting Date: **April 2013**

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

**An expert panel of psychologists was convened to review practice expenses for this code submission. The panel included practicing psychologists from Louisiana and New Mexico, the two states in the U.S. where psychologists are licensed to prescribe. These members of the expert panel are engaged in large institutional practices as well as smaller private practices.**

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

**The expert panel chose the 2012 CPT code 90862 as the comparator as this is the code providers used prior to 2013. Additionally, we have provided the most likely psychotherapy base service 90832 since this code (90863) is an add-on code to be reported only with psychotherapy services.**

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time. **Does not apply**

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence. **Does not apply**

5. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: **Obtain prior authorization, and records.**

Intra-Service Clinical Labor Activities: **Greet patient, obtain vital signs, review completed forms with patient for accuracy, check current medications, education/instruction/counseling.**

Post-Service Clinical Labor Activities: **Phone calls between visits with patient, family, pharmacy.**

	A	B	C	D	E	F	G	H	I
1				PRIMARY PROCEDURE				REFERENCE CODE	
2	<b>Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.</b>			90832		90863		90862	
3	Meeting Date: April 2013	CMS Code	Staff Type NOTE: 90862 previously had staff type L037D RN/LPN/MTA we are requesting staff type L026A Medical/Technical Assistant	Psychotherapy, 30 minutes with patient and/or family member		Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)		Pharmacologic management, including prescription, use and review of medication with no more than minimal medical psychotherapy	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD					XXX	XXX		
6	TOTAL CLINICAL LABOR TIME			0.0	0.0	5.0	0.0	26.0	6.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0	2.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			0.0	0.0	5.0	0.0	19.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0	5.0	6.0
10	PRE-SERVICE								
11	Start: Following visit when decision for surgery or procedure made								
12	Complete pre-service diagnostic & referral forms	L026A	Med/TA			0		2	
13	Coordinate pre-surgery services								
14	Schedule space and equipment in facility								
15	Provide pre-service education/obtain consent								
16	Follow-up phone calls & prescriptions								
17	*Other Clinical Activity - specify:								
18	End: When patient enters office/facility for surgery/procedure								
19	SERVICE PERIOD								
20	Start: When patient enters office/facility for surgery/procedure:								
21	Greet patient, provide gowning, ensure appropriate medical records are available	L026A	Med/TA			0		3	
22	Obtain vital signs	L026A	Med/TA			5		5	
23	Provide pre-service education/obtain consent	L026A	Med/TA			0		5	
24	Prepare room, equipment, supplies								
25	Setup scope (non facility setting only)								
26	Prepare and position patient/ monitor patient/ set up IV								
27	Sedate/apply anesthesia								
28	*Other Clinical Activity - specify:								
29	review history, system, medications	L026A	Med/TA			0		6	
30	Intra-service								
31	Assist physician in performing procedure								
32	Post-Service								
33	Monitor pt. following service/check tubes, monitors, drains								
34	Clean room/equipment by physician staff								
35	Clean Scope								
36	Clean Surgical Instrument Package								
37	Complete diagnostic forms, lab & X-ray requisitions								
38	Review/read X-ray, lab, and pathology reports								
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions								
40	*Other Clinical Activity - specify:								
41	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			n/a		n/a		n/a	
42	Dischrg mgmt (1.0 x 99238) (enter 12 min)			n/a		n/a		n/a	
43	Dischrg mgmt (1.0 x 99239) (enter 15 min)			n/a		n/a		n/a	
44	End: Patient leaves office								

	A	B	C	D	E	F	G	H	I
1				PRIMARY PROCEDURE				REFERENCE CODE	
2	<b>Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.</b> <b>**Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.</b>			90832		90863		90862	
3	Meeting Date: April 2013	CMS Code	Staff Type NOTE: 90862 previously had staff type L037D RN/LPN/MTA we are requesting staff type L026A Medical/ Technical Assistant	Psychotherapy, 30 minutes with patient and/or family member		Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)		Pharmacologic management, including prescription, use and review of medication with no more than minimal medical psychotherapy	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD					XXX	XXX		
45	POST-SERVICE Period								
46	Start: Patient leaves office/facility								
47	Conduct phone calls/call in prescriptions	L026A	Med/TA			0	0	5	6
48	Office visits: List Number and Level of Office Visits			# visits	# visits	# visits	# visits	# visits	# visits
49	99211 16 minutes		16						
50	99212 27 minutes		27						
51	99213 36 minutes		36						
52	99214 53 minutes		53						
53	99215 63 minutes		63						
54	Total Office Visit Time			0.0	0.0	0.0	0.0	0.0	0.0
55	*Other Clinical Activity - specify:								
56	End: with last office visit before end of global period								
57	MEDICAL SUPPLIES** CODE UNIT								
58	pack, minimum multi-specialty visit	SA048	pack						
59	Tissues (Kleenex)	SK114	item	0.05					
60	assessment monitoring instruments	SK005	item	0.25				1	
61	Reproduced patient worksheet	SK115	item	0.5					
62	EQUIPMENT CODE								
63	One Couch and Two Chairs	EF042		30		15			

AMA/Specialty Society RVS Update Committee Summary of Recommendations  
*CMS Request/Speech-Language Pathology Request*

January 2013

**Speech Evaluation**

CPT Code 92506 *Evaluation of speech, language, voice, communication, and/or auditory processing* was requested to be reviewed via Speech-Language Pathology Request/CMS Request. In February 2010, after reviewing the survey data for this service, ASHA agreed that more than one service is being represented under this code and requested the service be referred to the CPT Editorial Panel for further clarification. The HCPAC recommended that 92506 be referred to the CPT Editorial Panel to clearly describe the services being performed. In October 2012, the CPT Editorial Panel deleted 92506 and created four new codes to more accurately describe and differentiate speech-language pathology evaluation services.

**92521 Evaluation of speech fluency (eg, stuttering, cluttering)**

The HCPAC reviewed the survey results of 91 speech-language pathologists and determined that the survey median work RVU of 1.75 and 5 minutes pre-time, 90 minutes intra-time and 15 minutes immediate post-service time appropriately accounts for the work and time required to perform this service. The HCPAC compared the surveyed code to key reference service 96105 *Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour* (work RVU = 1.75 and 4 minutes pre-time, 60 minutes intra-time and 5 minutes post-time) and determined that 92521 requires 30 minutes more intra-service to assess the impact of stuttering, measure the frequency, duration and type of stuttering, administer fluency test measures, obtain and analyze a speech sample and identify other deficits all in a slow and calm pace to allow a proper response time for the patient. Additionally, the HCPAC agreed that immediate post-service time is appropriate to communicate the information to the parent as the typical patient is a child. **The HCPAC recommends a work RVU of 1.75 for CPT code 92521.**

**92522 Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)**

The HCPAC reviewed the survey results of 165 speech-language pathologists and determined 92609 *Therapeutic services for the use of speech-generating device, including programming and modification* (work RVU = 1.50 and 60 minutes intra-service time) requires the same work and intra-service time to perform and recommends crosswalking 92522 to 92609. The HCPAC determined that 92522 requires 5 minutes more immediate post-service time than 92521 to account for the additional number of tests included in the protocol for evaluation of speech sound production, resulting in 5 minutes pre-time, 60 minutes intra-time, and 20 minutes immediate post-time. **The HCPAC recommends a work RVU of 1.50 for CPT code 92522.**



**92523 Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)**

The HCPAC reviewed the survey results from 151 speech-language pathologists for CPT 92523 and determined that the survey respondents appropriately accounted for the time required to perform this service with time components of: 7 minutes pre-time, 120 minutes intra-time and 30 minutes immediate post-service time. However, they did not appropriately value the work compared to the key reference service. Key reference service 96105 *Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour* (work RVU = 1.75 and 4 minutes pre-time, 60 minutes intra-time and 5 minutes post-time) describes 60 minutes of work, whereas 92523 requires 120 minutes. The survey respondents did not take into account the timed code when calculating the work RVU. The HCPAC noted that 92523 includes the work described in 92522 as well as evaluation of language comprehension and expression. ASHA indicated and the HCPAC agreed that the intensity of 92523 is different from the first hour of evaluation of speech sound production and the second hour of evaluation of language comprehension. Therefore, the HCPAC recommends a work RVU of 3.36 based on the recommended work RVU for 92522 plus the survey median work of 92523 ( $1.50 + 1.86 = 3.36$ ). For additional support, the HCPAC noted that the recommended work and times for 92522 plus 96116 *Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report* (work RVU = 1.86 and 7 minutes pre-time and 60 minutes intra-service time) also equal 3.36, supporting the work and time required to perform this service. **The HCPAC recommends a work RVU of 3.36 for CPT code 92523.**

**92524 Behavioral and qualitative analysis of voice and resonance**

The HCPAC reviewed the survey results from 59 speech- language pathologists for CPT code 92524 and determined that the survey median work RVU of 1.75 and 5 minutes pre-time, 60 minutes intra and 10 minutes post-service appropriately accounts for the work and time required to perform this service. The specialty indicated and the HCPAC agreed that 10 minutes immediate post-service time is appropriate to account for the treatment recommendations, prognosis and referrals. The HCPAC noted that this procedure is reported approximately 12% of the time with another code (e.g., swallowing evaluation - 92610) on the same date of service. The HCPAC compared the surveyed code to key reference service 92610 *Evaluation of oral and pharyngeal swallowing function* (work RVU = 1.30 and 7 minutes pre-time, 35 minutes intra-time and 10 minutes post-time) and determined that 92524 requires almost twice the time to perform. For additional support, the HCPAC compared the survey code to 96105 *Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour* (work RVU = 1.75 and 4 minutes pre-time, 60 minutes intra and 5 minutes post-time) and determined that these services require the same work and intra-service time. **The HCPAC recommends a work RVU of 1.75 for CPT code 92524.**

**Practice Expense:**

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

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<b>Category I Medicine Special Otorhinolaryngologic Services</b>				
<p>Diagnostic or treatment procedures that are reported as evaluation and management services (eg, otoscopy, anterior rhinoscopy, tuning fork test, removal of non-impacted cerumen) are not reported separately.</p> <p>Special otorhinolaryngologic services are those diagnostic and treatment services not included in an Evaluation and Management service. These services are reported separately, using codes 92502- 92700.</p> <p>Codes <u>92521, 92522, 92523, 92524</u> <del>92506 is</del> <u>are</u> used to report evaluation of speech production, receptive language, and expressive language abilities. Tests may examine speech sound production, <u>voice production, speech fluency</u>, articulatory movements of oral musculature, the patient's ability to understand the meaning and intent of written and verbal expressions, and the appropriate formulation and utterance of expressive thought. In contrast, 92626 and 92627 are reported for an evaluation of auditory rehabilitation status determining the patient's ability to use residual hearing in order to identify the acoustic characteristics of sounds associated with speech communication.</p> <p>(For laryngoscopy with stroboscopy, use 31579)</p>				
D92506		<del>Evaluation of speech, language, voice, communication, and/or auditory processing</del> (92506 has been deleted. To report, see 92521, 92522, 92523, or 92524)	XXX	N/A
●92521	M1	Evaluation of speech fluency (eg, stuttering, cluttering)	XXX	1.75

●92522	M2	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);	XXX	1.50
●92523	M3	with evaluation of language comprehension and expression (eg, receptive and expressive language)	XXX	3.36
●92524	M4	Behavioral and qualitative analysis of voice and resonance	XXX	1.75
<b>Category I</b> <b>Medicine</b> <b>Special Otorhinolaryngologic Services</b> <b>Audiologic Function Tests</b>				
<p>The audiometric tests listed below require the use of calibrated electronic equipment, recording of results and a report with interpretation. Hearing tests (such as whispered voice, tuning fork) that are otorhinolaryngologic Evaluation and Management services are not reported separately. All services include testing of both ears. Use modifier 52 if a test is applied to one ear instead of two ears. All codes (except 92559) apply to testing of individuals. For testing of groups, use 92559 and specify test(s) used.</p> <p>(For evaluation of speech, language and/or hearing problems through observation and assessment of performance, <del>use 92506</del> <u>see 92521, 92522, 92523, 92524</u>)</p>				
<b>Category I</b> <b>Medicine</b> <b>Special Otorhinolaryngologic Services</b> <b>Evaluative and Therapeutic Services</b>				

Codes 92601 and 92603 describe post-operative analysis and fitting of previously placed external devices, connection to the cochlear implant, and programming of the stimulator. Codes 92602 and 92604 describe subsequent sessions for measurements and adjustment of the external transmitter and re-programming of the internal stimulator.

(For placement of cochlear implant, use 69930)

92616	Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording; (If flexible fiberoptic or endoscopic evaluation of swallowing is performed without cine or video recording, use 92700)
92617	interpretation and report only
92618	Code is out of numerical sequence. See 92601-92633
92620	Evaluation of central auditory function, with report; initial 60 minutes
92621	each additional 15 minutes (List separately in addition to code for primary procedure) (Use 92621 in conjunction with 92620) (Do not report 92620, 92621 in conjunction with <del>92506</del> 92521, 92522, 92523, 92524)
92625	Assessment of tinnitus (includes pitch, loudness matching, and masking) (Do not report 92625 in conjunction with 92562) (For unilateral assessment, use modifier 52)

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 92521      Tracking Number M1      Original Specialty Recommended RVU: **1.75**  
 Presented Recommended RVU: **1.75**  
 Global Period: XXX      RUC Recommended RVU: **1.75**

CPT Descriptor: Evaluation of speech fluency (eg, stuttering, cluttering)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 7-year-old male presents with stuttering that includes behavioral (e.g., repetitions, prolongations, and blocks) and affective (e.g., avoidance and/or reduction of communication interaction) responses that negatively impact his communication function.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

**Description of Pre-Service Work:**

- Review available intake materials
  - Referral information
  - Medical, developmental and/or educational records
  - Prior assessment and treatment records (e.g., speech, language, and hearing testing, previous speech interventions, etc.)
- Consult with other professionals
- Select and prepare appropriate evaluation tools

**Description of Intra-Service Work:**

- Interview patient and/or parent/caregiver to review and clarify the information provided by the intake materials
- Obtain a complete case history
- Determine patient and/or parent/caregiver concerns and expectations
- Assess the emotional, cognitive, and attitudinal impact of stuttering for information concerning speaking frequency and socialization (e.g., Behavior Assessment Battery, Overall Assessment of Speaker's Experience with Stuttering)

- Measure frequency, duration, and type of stuttering, and identify the presence of secondary behaviors (e.g., eye blinking, jaw tremor, facial grimaces, etc.) by:
  - Administering and scoring standardized fluency test measures (e.g., Stuttering Severity Instrument-Fourth Edition, Real Time Frequency Count)
  - Obtaining (e.g., audio or video recording) and analyzing a spontaneous speech sample
- Identify other deficits including speech sound production, language comprehension and expression, voice, swallowing, and hearing
- Analyze and integrate pre-service and intra-service information to formulate findings and recommendations
- Document results

Description of Post-Service Work:

- Provide information to patient and/or parent/caregiver regarding preliminary conclusions, treatment recommendations, and prognosis
- Make referrals for additional assessments and/or treatments as appropriate
- Communicate final findings and recommendations to referral source(s)

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	01/2013				
<b>Presenter(s):</b>	Dee Adams Nikjeh, PhD, CCC-SLP				
<b>Specialty(s):</b>	Speech-Language Pathology				
<b>CPT Code:</b>	92521				
<b>Sample Size:</b>	983	<b>Resp N:</b>	91	<b>Response:</b> 9.2 %	
<b>Description of Sample:</b>	The survey was sent to a random sample of certified speech-language pathologists who volunteered to complete the survey.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	1.00	3.00	4.00	6.50	50.00
<b>Survey RVW:</b>	1.00	1.50	1.75	2.00	6.00
<b>Pre-Service Evaluation Time:</b>			20.00		
<b>Pre-Service Positioning Time:</b>			0.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.00		
<b>Intra-Service Time:</b>	30.00	60.00	90.00	120.00	240.00
<b>Immediate Post Service-Time:</b>	<b>30.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

<b>CPT Code:</b>	92521	<b>Recommended Physician Work RVU: 1.75</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		5.00	0.00	5.00
<b>Pre-Service Positioning Time:</b>		0.00	0.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	0.00	0.00
<b>Intra-Service Time:</b>		90.00		
<b>Immediate Post Service-Time:</b>	<b>15.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
96105	XXX	1.75	RUC Time

CPT Descriptor Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
97001	XXX	1.20	RUC Time	2,040,727

CPT Descriptor 1 Physical therapy evaluation

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
90847	XXX	2.21	RUC Time	243,491

CPT Descriptor 2 Family psychotherapy (conjoint psychotherapy) (with patient present)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
---------------------------------	---------------	-----------------	--------------------

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 36      % of respondents: 39.5 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 92521</b>	<b>Key Reference CPT Code: 96105</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	5.00	4.00	
Median Intra-Service Time	90.00	60.00	
Median Immediate Post-service Time	15.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	



Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>110.00</b>	<b>69.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)**(of those that selected Key  
Reference code)**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.35	3.85
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.58	3.93
Urgency of medical decision making	2.81	3.25

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.33	4.43
Physical effort required	2.62	2.73
<b><u>Psychological Stress (Mean)</u></b>		
The risk of significant complications, morbidity and/or mortality	1.78	2.08
Outcome depends on the skill and judgment of physician	4.10	4.05
Estimated risk of malpractice suit with poor outcome	2.18	2.55

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.62	2.78
Intra-Service intensity/complexity	4.26	4.29
Post-Service intensity/complexity	3.52	3.59

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUR analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

We are recommending a work RVU of 1.75 based on the median of the survey responses and pre, intra and post times of 5, 90, and 15 minutes respectively. We think this value is supported by the reference code, 96105, which is assigned a work

RVU of 1.75 and intra time of 60 minutes. While the intensity measures for the surveyed code is slightly less than that of the reference code, the intra time for the surveyed code is 50% higher. Additionally, with respect to the intensity measures, we would note that the overall assessment of intra time intensity for the surveyed code as compared to the reference code is quite close--4.26 as compared with 4.29. Thus, even at slightly lower intensity, considering the fact that the intra time for the surveyed code is significantly higher, we think the recommended RVW is reasonable in relation to the reference code.

The work RVU of 1.75 is also supported by the two MPC codes we cited, both of which are performed primarily by non-physicians. Specifically, code 97001 (physical therapy evaluation) is assigned a work RVU of 1.20 with 30 minutes of intra time. Our requested RVU is less than 50% higher than code 97001 with 3 times the intra time. The other MPC code we cite is code 90847 (family psychotherapy) with an RVW of 2.21 and 50 minutes of intra time. Code 90847 is performed most frequently by clinical social workers

Finally, the recommended RVW for code 92521 is in line with other evaluation codes in the family of codes used by speech-language pathologists, as illustrated in the table below. In fact, given the recommended RVU and times, we believe the IWP/UT for code 92521 is very low. However, we are accepting the results of the survey and would note that this code will rarely be used in the Medicare population.

CPT Code	Descriptor	IWP/UT	RVW	Total Time	Pre	Intra	Post
<b>92521</b> <b>Survey</b> <b>RVW</b>	<b>Evaluation of speech fluency (eg, stuttering, cluttering)</b>	<b>0.0144</b>	<b>1.75</b>	<b>105</b>	<b>5</b>	<b>90</b>	<b>15</b>
92605	Evaluation for prescription of non-speech-generating augmentative and alternative communication device	0.0180	1.75	90	10	60	20
92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	0.0196	1.85	90	10	60	20
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech	0.0203	1.26	60	7	40	13
96125	Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report	0.0257	1.70	67	7	60	0
92610	Evaluation of oral and pharyngeal swallowing function	0.0263	1.30	52	7	35	10
92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording	0.0320	1.34	47	7	30	10

## SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.

☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. n/a

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 92506

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Speech-Language Pathology                      How often? Commonly

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 11250

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We used a combination of ASHA membership numbers, caseload information derived from major speech & hearing clinics, and Medicare frequency data to arrive at this estimate.

Specialty Speech-Language Pathology                      Frequency 11250                      Percentage 100.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 721

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We used 2011 Medicare claims data for the existing code, 92506, and estimated that only a small percentage of cases billed using 92506 would be for fluency cases (approx. 3.6%), since the typical is patient is a child. The 2011 frequency data for 92506 is 20,721.

Specialty Speech-Language Pathology                      Frequency 721                      Percentage 100.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

## Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 96105



## AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 92522      Tracking Number M2      Original Specialty Recommended RVU: **1.70**  
 Presented Recommended RVU: **1.50**  
 Global Period: XXX      RUC Recommended RVU: **1.50**

CPT Descriptor: Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)

### CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 6-year-old male presents with age-appropriate language comprehension and expression; yet, his speech sound production is unintelligible and negatively impacts his abilities to successfully communicate with others.

Percentage of Survey Respondents who found Vignette to be Typical: 78%

### Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

### Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

### Description of Pre-Service Work:

- Review available intake materials
  - Referral information
  - Medical, developmental and/or educational records
  - Prior assessment and treatment records (e.g. speech, language, and hearing testing, previous speech interventions, etc.)
- Consult with other professionals
- Select and prepare appropriate evaluation tools

### Description of Intra-Service Work:

- Interview parent/caregiver to review and clarify the information provided by the intake materials
- Obtain a complete case history, including the impact of deficits on daily function.
- Determine parent/caregiver concerns and expectations
- Administer and score a standardized evaluation of speech sound production (e.g., *Goldman-Fristoe Test of Articulation, 2<sup>nd</sup> Edition*)

- Evaluate capability to approximate correct production of deficit sounds to determine potential for improved speech sound production
- Evaluate intelligibility and consistency of speech sound production in conversation
- Evaluate precision of rapid articulatory movements
- Identify signs of abnormal oral function and craniofacial abnormalities
- Evaluate the ability to detect and discriminate speech sound components (e.g., Test of Phonological Awareness)
- Identify other deficits including language comprehension and expression, fluency, voice, swallowing, and hearing
- Analyze and integrate pre-service and intra-service information to make a differential diagnosis (e.g., articulation impairment, phonological impairment, motor-speech disorder, etc.)
- Document results

Description of Post-Service Work:

- Provide information to parent/caregiver regarding preliminary conclusions, treatment recommendations, and prognosis
- Make referrals for additional assessments and/or treatments as appropriate
- Communicate final findings and recommendations to referral source(s)

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)		01/2013				
Presenter(s):	Dee Adams Nikjeh, PhD, CCC-SLP					
Specialty(s):	Speech-Language Pathology					
CPT Code:	92522					
Sample Size:	1869	Resp N:	165	Response: 8.8 %		
Description of Sample:	The survey was sent to a random sample of certified speech-language pathologists who volunteered to complete the survey.					
		Low	25 <sup>th</sup> pctl	Median*	75 <sup>th</sup> pctl	High
Service Performance Rate		1.00	12.00	21.00	50.00	1200.00
Survey RVW:		0.60	1.30	1.70	1.94	9.00
Pre-Service Evaluation Time:				20.00		
Pre-Service Positioning Time:				0.00		
Pre-Service Scrub, Dress, Wait Time:				0.00		
Intra-Service Time:		25.00	50.00	60.00	90.00	200.00
Immediate Post Service-Time:		30.00				
Post Operative Visits		Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):		0.00	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):		0.00	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:		0.00	99238x 0.00	99239x 0.00	99217x 0.00	
Office time/visit(s):		0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:		0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:		0.00	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	92522	Recommended Physician Work RVU: 1.50			
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:		5.00	0.00	5.00	
Pre-Service Positioning Time:		0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:		0.00	0.00	0.00	
Intra-Service Time:		60.00			
Immediate Post Service-Time:	20.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	0.00	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	0.00	99224x 0.00	99225x 0.00	99226x 0.00	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
96105	XXX	1.75	RUC Time

CPT Descriptor Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
97001	XXX	1.20	RUC Time	2,040,727

CPT Descriptor 1 Physical therapy evaluation

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
90847	XXX	2.21	RUC Time	243,491

CPT Descriptor 2 Family psychotherapy (conjoint psychotherapy) (with patient present)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
---------------------------------	---------------	-----------------	--------------------

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 79      % of respondents: 47.8 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 92522</b>	<b>Key Reference CPT Code: 96105</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	5.00	4.00	
Median Intra-Service Time	60.00	60.00	
Median Immediate Post-service Time	20.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	



Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>85.00</b>	<b>69.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.55	3.87
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.47	3.93
--	------	------

Urgency of medical decision making	2.67	3.22
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.14	4.32
--------------------------	------	------

Physical effort required	2.53	2.66
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	1.79	2.26
---	------	------

Outcome depends on the skill and judgment of physician	3.92	4.06
--	------	------

Estimated risk of malpractice suit with poor outcome	1.98	2.42
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.49	2.82
----------------------------------	------	------

Intra-Service intensity/complexity	3.82	4.10
------------------------------------	------	------

Post-Service intensity/complexity	3.24	3.46
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUR analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

We are recommending a work RVU of 1.50 based on the median of the survey responses and pre, intra and post times of 5, 60, and 20 minutes respectively. The intra time is consistent with the median survey time. We think this value is supported by the reference code, 96105, which is assigned a work RVU of 1.75, with pre time of 4 minutes, intra time of 60 minutes, and post time of 5 minutes. We recognize that the intensity measures for the surveyed code are valued somewhat less than that of the reference code. However we think the recommended RVW is reasonable in relationship to the surveyed code (1.70 vs. 1.75) in light of the fact that the post time is considerably higher—20 minutes vs. 5 minutes. This time is needed to discuss the results of the evaluation with the parents and to review therapeutic options. We would point out that other SLP evaluation codes reviewed by the HCPAC or the RUC have been assigned comparable post times including code 92607, evaluation for speech generating device, which was assigned post time of 20 minutes and code 96111, developmental testing, with 30 minutes of approved post time.

The work RVU of 1.50 is also supported by the two MPC codes we cited, both of which are performed primarily by non-physicians. Specifically, code 97001 (physical therapy evaluation) is assigned a work RVU of 1.20 with 30 minutes of intra time. Our requested RVU is about 40% higher, but the surveyed code has twice the intra time of 97001. The other MPC code we cite is code 90847 (family psychotherapy) with an RVW of 2.21 and 50 minutes of intra time. Code 90847 is performed most frequently by clinical social workers.

Finally, the recommended RVW for code 92522 is in line with other evaluation codes in the family of codes used by speech-language pathologists, including the following:

CPT Code	Descriptor	IWPUT	RVW	Total Time	Pre	Intra	Post
92605	Evaluation for prescription of non-speech-generating augmentative and alternative communication device	0.0180	1.75	90	10	60	20
<b>92522 ASHA Rec</b>	<b>Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)</b>	<b>0.0190</b>	<b>1.50</b>	<b>85</b>	<b>5</b>	<b>60</b>	<b>20</b>
92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	0.0196	1.85	90	10	60	20
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech	0.0203	1.26	60	7	40	13
96125	Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report	0.0257	1.70	67	7	60	0
92610	Evaluation of oral and pharyngeal swallowing function	0.0263	1.30	52	7	35	10
92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording	0.0320	1.34	47	7	30	10

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.

- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. n/a

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 92506

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Speech-Language Pathology                      How often? Commonly

Specialty                      How often?

Specialty                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 21600

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We used a combination of ASHA membership numbers, caseload information derived from major speech & hearing clinics, and Medicare frequency data to arrive at this estimate.

Specialty Speech-Language Pathology                      Frequency 21600                      Percentage 100.00 %

Specialty                      Frequency                      Percentage                      %

Specialty                      Frequency                      Percentage                      %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 8,000

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We used 2011 Medicare claims data for the existing code, 92506, and estimated that approximately 40% of cases billed using 92506 would be for speech-sound production cases. The 2011 frequency data for 92506 is 20,721.

Specialty Speech-Language Pathology                      Frequency 8000                      Percentage 100.00 %

Specialty                      Frequency                      Percentage                      %

Specialty                      Frequency                      Percentage                      %

Do many physicians perform this service across the United States?

## Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 96105

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 92523      Tracking Number M3      Original Specialty Recommended RVU: **3.72**  
 Presented Recommended RVU: **3.72**  
 Global Period: XXX      RUC Recommended RVU: **3.36**

CPT Descriptor: Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 5-year-old male presents with significant deficits of receptive, expressive, and social language and highly unintelligible speech sound production that limit his abilities to understand and communicate effectively in daily social and educational activities with family and peers.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

**Description of Pre-Service Work:**

- Review available intake materials
  - Referral information
  - Medical, developmental and/or educational records
  - Prior assessment and treatment records (e.g. speech, language, and hearing testing, previous speech interventions, etc.)
- Consult with other professionals
- Select and prepare appropriate evaluation tools

**Description of Intra-Service Work:**

- Interview parent/caregiver to review and clarify the information provided by the intake materials
- Obtain a complete case history, including the impact of deficits on daily function.
- Determine parent/caregiver concerns and expectations
- Speech Sound Production

- Administer and score a standardized evaluation of speech sound production (e.g., Goldman-Fristoe Test of Articulation, 2nd Edition)
- Evaluate capability to approximate correct production of deficit sounds to determine potential for improved speech sound production
- Evaluate intelligibility and consistency of speech sound production in conversation
- Evaluate precision of rapid articulatory movements
- Identify signs of abnormal oral function and craniofacial abnormalities
- Evaluate the ability to detect and discriminate speech sound components (e.g., Test of Phonological Awareness)
- Language
  - Administer and score standardized language test measures (e.g., Preschool Language Assessment Instrument-2, Clinical Evaluation of Language Fundamentals, Comprehensive Assessment of Spoken Language, Test of Language Development, Peabody Picture Vocabulary Test)
  - Administer and score criterion-referenced assessments (e.g., , Children Communication Checklist)
  - Obtain (e.g., audio or video recording) and analyze a spontaneous language sample (e.g., mean length of utterance, complexity of sentence structure, pragmatics, etc.)
- Identify other deficits including fluency, voice, swallowing, and hearing
- Analyze and integrate pre-service and intra-service information to formulate findings and recommendations
- Document results

#### Description of Post-Service Work:

- Provide information to parentt/caregiver regarding preliminary conclusions, treatment recommendations, and prognosis
- Make referrals for additional assessments and/or treatments as appropriate
- Communicate final findings and recommendations to referral source(s)

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)		01/2013					
Presenter(s):	Dee Adams Nikjeh, PhD, CCC-SLP						
Specialty(s):	Speech-Language Pathology						
CPT Code:	92523						
Sample Size:	1952	Resp N:	151	Response: 7.7 %			
Description of Sample:	The survey was sent to a random sample of certified speech-language pathologists who volunteered to complete the survey.						
			Low	25 <sup>th</sup> pctl	Median*	75 <sup>th</sup> pctl	High
Service Performance Rate			1.00	10.00	20.00	50.00	1200.00
Survey RVW:			1.00	1.75	1.86	2.25	10.00
Pre-Service Evaluation Time:					30.00		
Pre-Service Positioning Time:					0.00		
Pre-Service Scrub, Dress, Wait Time:					0.00		
Intra-Service Time:			20.00	75.00	120.00	127.50	360.00
Immediate Post Service-Time:		30.00					
Post Operative Visits		Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):		0.00	99291x 0.00	99292x 0.00			
Other Hospital time/visit(s):		0.00	99231x 0.00	99232x 0.00	99233x 0.00		
Discharge Day Mgmt:		0.00	99238x 0.00	99239x 0.00	99217x 0.00		
Office time/visit(s):		0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00	15x 0.00
Prolonged Services:		0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00	
Sub Obs Care:		0.00	99224x 0.00	99225x 0.00	99226x 0.00		

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

<b>CPT Code:</b>	92523	<b>Recommended Physician Work RVU: 3.36</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		7.00	0.00	7.00
<b>Pre-Service Positioning Time:</b>		0.00	0.00	0.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		0.00	0.00	0.00
<b>Intra-Service Time:</b>		120.00		
<b>Immediate Post Service-Time:</b>	30.00			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	0.00	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	0.00	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	0.00	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	0.00	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	0.00	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	0.00	99224x 0.00	99225x 0.00	99226x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
96105	XXX	1.75	RUC Time

CPT Descriptor Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
90847	XXX	2.21	RUC Time	243,491
<u>CPT Descriptor 1</u> Family psychotherapy (conjoint psychotherapy) (with patient present)				
<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
96116	XXX	1.86	RUC Time

CPT Descriptor Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 92      % of respondents: 60.9 %

**TIME ESTIMATES (Median)**

	<u>CPT Code:</u> <u>92523</u>	<u>Key Reference CPT Code:</u> <u>96105</u>	<u>Source of Time</u> <u>RUC Time</u>
Median Pre-Service Time	7.00	4.00	
Median Intra-Service Time	120.00	60.00	
Median Immediate Post-service Time	30.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	



Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
<b>Median Total Time</b>	<b>157.00</b>	<b>69.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.26	4.13
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.10	4.13
--	------	------

Urgency of medical decision making	3.09	3.32
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.44	4.40
--------------------------	------	------

Physical effort required	3.03	2.89
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.02	2.28
---	------	------

Outcome depends on the skill and judgment of physician	4.26	4.21
--	------	------

Estimated risk of malpractice suit with poor outcome	2.27	2.45
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.15	3.21
----------------------------------	------	------

Intra-Service intensity/complexity	4.40	4.25
------------------------------------	------	------

Post-Service intensity/complexity	3.71	3.63
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

We are recommending a professional work value of 3.36 RVUs and pre, intra, and post times of 7, 120, and 30 minutes respectively.

We recognize that the recommended work value exceeds the median RVW in the survey data (1.86). However, we are convinced that there was a common error made by the survey respondents which led to a severe underestimation of the work RVU for this code. Specifically, in valuing 92523 in relation to the time-based code (96105) which was selected as the reference procedure by the majority of survey respondents, we believe that respondents did not perform the magnitude estimation needed to make a fair comparison of two codes with similar complexity measures yet very different intra-service times.

Code 96105 is defined as assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g., by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour. This code is assigned a work value of 1.75 and pre, intra and post times of 4, 60 and 5 minutes. The report writing is included in the intra time.

The median intra time from the survey for 92523 was 120 minutes and the median recommended work value was 1.86 RVU. A panel of SLPs that was convened to consider the survey data and assist us in developing the professional work value recommendation agreed that 120 minutes was an accurate estimate of the typical intra time required to perform this service.

In further support of the 120 minutes of intra-service time, we have listed examples of standardized tests that are typically performed during an evaluation of speech sound production and language comprehension and expression. The time needed to administer each test can easily fill an interval of 60 to 120 minutes for the language portion alone. Also included in this overall evaluation is an assessment of speech production which can take up to 60 minutes in accordance to the survey specific to speech production evaluation (92522). It is important to emphasize that the language assessment consists of a battery of tests designed to be administered consecutively on the same date of service to create an overall picture of the child's language ability from the perspective of different linguistic domains, when combined with other assessment activities, justify the median intra-time of 120 minutes.

- Goldman-Fristoe Test of Articulation (5 to 15 minutes)
- Test of Phonological Awareness, Second Edition (30-45 minutes)
- Clinical Evaluation of Language Fundamentals, Fourth Edition (30-60 minutes)
- Peabody Picture Vocabulary Test (10-15 minutes)

A battery of tests represents the standard of practice around the country for speech-language pathologists seeing patients with this combination of speech and language problems. We listed the above four tests as an illustrative example. There are many other standardized tests that can be incorporated into the evaluation depending on the age and abilities of the patient. Moreover, the standardized tests may be supplemented by non-standardized tests (such as recording and analyzing a spontaneous speech and language sample) used to explore in greater depth certain domain characteristics noted from the standardized measurements. Note that these tests are not separately billable services but are part of the evaluation.

Since the median intra time was 120 minutes as compared with 60 minutes for the reference code, a work value of 1.86 compared to the 1.75 for the reference makes little sense given the fact that the intra time is twice that of the reference code and the surveyed services had been rated of roughly similar complexity. Therefore, we propose to increase the survey RVW of 1.86 to 3.36 as we are certain this was intended to represent a recommended value on a per hour basis.

In further support of our conclusion that 120 minutes is a reasonable estimate, we would note that the median intra time for 92522, Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria), was 60 minutes. As noted above, code 92523 includes that service plus an evaluation of language comprehension and expression.

Use of the median survey RVW of 1.86 with our recommended pre, intra, and post times of 7, 120, and 30 would result in a rank order anomaly, with an IWPOT well below that of other SLP codes of comparable or lesser complexity, as illustrated in the table below. We have also included in this table the data for code 92523 with our recommended RVW of 3.36 and with the RVW of 1.86 with the time recommendations.

CPT Code	Descriptor	IWPOT	RVW	Total Time	Pre	Intra	Post
----------	------------	-------	-----	------------	-----	-------	------

CPT Code	Descriptor	IWPUT	RVW	Total Time	Pre	Intra	Post
<b>92523 - Survey RVW Rec</b>	<b>Evaluation of speech sound...;with evaluation of language comprehension and expression (eg, receptive and expressive language)</b>	<b>0.0090</b>	<b>1.86</b>	<b>157</b>	<b>7</b>	<b>120</b>	<b>30</b>
92605	Evaluation for prescription of non-speech-generating augmentative and alternative communication device	0.0180	1.75	90	10	60	20
92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	0.0196	1.85	90	10	60	20
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech	0.0203	1.26	60	7	40	13
92608	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)	0.0233	0.70	30	0	30	0
<b>92523 - ASHA RVW Rec</b>	<b>Evaluation of speech sound...;with evaluation of language comprehension and expression (eg, receptive and expressive language)</b>	<b>0.0240</b>	<b>3.36</b>	<b>157</b>	<b>7</b>	<b>120</b>	<b>30</b>
96125	Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report	0.0257	1.70	67	7	60	0
96105 (reference code)	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour	0.0258	1.75	69	4	60	5
92610	Evaluation of oral and pharyngeal swallowing function	0.0263	1.30	52	7	35	10
96111	Developmental testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report	0.0303	2.60	95	5	60	30
92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording	0.0320	1.34	47	7	30	10

In further support we would cite MPC code 90847. This service is defined as family psychotherapy and is assigned an RVW of 2.21 with pre, intra and post time of 5, 50 and 21 minutes respectively. This code is billed predominantly by clinical social workers and clinical psychologists. If one doubled the intra time and RVW for code 90847 this would yield an intra-time of 100 minutes which is lower than the surveyed code but an RVW of 4.42, substantially in excess of the recommended RVW. We think from a rank order perspective this MPC code clearly is supportive of the recommended RVW. We were unable to find an MPC code performed commonly by non-MDs which is assigned intra time or an RVW that would “bracket” the recommended RVW on the high side. However, for another code that would support our recommended RVW which is not an MPC code, we would cite Code 96116. This code, defined as neurobehavioral status exam, is assigned an RVW of 1.86 and pre time of 7 minutes and intra time of 60 minutes. Clinical psychologists perform

the majority of the services. If one doubled the intra time of 96116 to equate it to a 120 minute service and doubled the RVW.

Before initiating the survey of this series of codes, we anticipated that ASHA members would frequently select 96105 (or another time based code) as the reference code largely because there were few non time-based codes with values comparable to the surveyed code which were sufficiently familiar to practicing speech-language pathologists. We also anticipated that there might be substantial misunderstanding by our members taking the survey as to how one should appropriately value the surveyed code to a time based code. With the approval of the Research Subcommittee, we added some language to Question 7 of the survey instrument in an attempt to provide some guidance on this issue. Unfortunately, we do not think our guidance removed the confusion of using a time-based code as the reference code for a non time-based service and we firmly believe the majority of survey respondents estimated the recommended RVW without taking the time into consideration. Due to the survey timeline, we did not have time after getting approval from the Research Committee to “vet” the language and determine if it was sufficiently clear.

We certainly recognize that requesting a value substantially above the median is unusual. However, in this case, we think our request is clearly justified by the survey time data, the relative complexity in comparison with the reference code, and the fact that a rank order anomaly would result from use of the median survey RVW.

If the HCPAC is not convinced by our arguments that the median RVW represented a per hour estimate and not a work value recommendation for a 120 minute service, we would entertain any suggestions to resolve this dilemma including a resurvey of this code by different participants (with clearer explanations) or a targeted resurvey of the respondents who completed the current survey.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. n/a

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 92506

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Speech-Language Pathology

How often? Commonly

Specialty

How often?

Specialty                                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 188000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We used a combination of ASHA membership numbers, caseload information derived from major speech & hearing clinics, and Medicare frequency data to arrive at this estimate.

Specialty Speech-Language Pathology	Frequency 188000	Percentage 100.00 %
-------------------------------------	------------------	---------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 4,000

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We used 2011 Medicare claims data for the existing code, 92506, and estimated that approximately 20% of cases billed using 92506 would be for speech-language cases. The 2011 frequency data for 92506 is 20,721.

Specialty Speech-Language Pathology	Frequency 4000	Percentage 100.00 %
-------------------------------------	----------------	---------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 96105

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 92524      Tracking Number M4      Original Specialty Recommended RVU: **1.75**  
 Presented Recommended RVU: **1.75**  
 Global Period: XXX      RUC Recommended RVU: **1.75**

CPT Descriptor: Behavioral and qualitative analysis of voice and resonance

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 38-year-old female diagnosed with bilateral vocal cord nodules was referred for an evaluation of functional voice use and resonance to facilitate the design of a voice therapy/behavioral treatment plan. The patient complains of progressive hoarseness, inadequate projection, altered resonance, vocal fatigue, and tightness and pain in her throat which compromises her ability to communicate effectively.

Percentage of Survey Respondents who found Vignette to be Typical: 76%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

**Description of Pre-Service Work:**

- Review available intake materials
  - Referral information
  - Medical records
  - Prior assessment and treatment records (e.g., previous voice/speech interventions)
  - Patient's self-assessment of the impact of voice and/or resonance status on daily function (e.g., Voice Handicap Index, Voice-Related Quality of Life)
- Consultation with other professionals
- Select and prepare appropriate evaluation tools

**Description of Intra-Service Work:**

- Interview patient to review and clarify the information provided by the intake materials
- Obtain a complete case history relative to changes of voice, including:
  - Complaint/symptoms, onset, and development

- Causal/contributory/perpetuating factors (e.g., health/medical, lifestyle, environmental)
- Determine patient/caregiver concerns and expectations
- Identify signs of abnormal oral function and craniofacial abnormalities (e.g., cleft lip or palate, occult submucous cleft, neurogenic velopharyngeal dysfunction)
- Perform a systematic auditory-perceptual evaluation of voice and resonance quality while having the patient produce a structured protocol comprised of voice and speech tasks that are designed to elicit salient features to differentiate voice and resonance disorders:
  - Use standard scaling techniques to formally rate the resonance and vocal attributes of overall severity of dysphonia, roughness, breathiness, strain, pitch, and loudness
  - Document/describe the presence of any additional vocal abnormalities (e.g., hard glottal attack, diplophonia, tremor, spasm, etc.)
  - Document/describe the nature (e.g., hyper- or hyponasality) and severity of any abnormalities in resonance
- Assess upper body and extrinsic laryngeal muscle tension through observation and palpation
- Use voice and/or speech facilitating techniques to assess the potential effectiveness of intervention strategies
- Identify other deficits including speech sound production, language comprehension and expression, fluency, swallowing, and hearing
- Analyze and integrate pre-service and intra-service information to formulate findings and recommendations
- Document results

#### Description of Post-Service Work:

- Provide information to patient regarding preliminary conclusions, treatment recommendations, and prognosis
- Make referrals for additional assessments and/or treatments as appropriate
- Communicate final findings and recommendations to referral source(s)

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	01/2013				
<b>Presenter(s):</b>	Dee Adams Nikjeh, PhD				
<b>Specialty(s):</b>	Speech-Language Pathology				
<b>CPT Code:</b>	92524				
<b>Sample Size:</b>	517	<b>Resp N:</b>	59	<b>Response:</b> 11.4 %	
<b>Description of Sample:</b>	The survey was sent to a random sample of certified speech-language pathologists who volunteered to complete the survey.				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	1.00	4.50	<b>12.00</b>	60.00	500.00
<b>Survey RVW:</b>	1.20	1.40	<b>1.75</b>	1.85	4.00
<b>Pre-Service Evaluation Time:</b>			<b>15.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>0.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>0.00</b>		
<b>Intra-Service Time:</b>	30.00	45.00	<b>60.00</b>	90.00	150.00
<b>Immediate Post Service-Time:</b>	<b>30.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00	99217x 0.00	
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

<b>CPT Code:</b>	92524	<b>Recommended Physician Work RVU: 1.75</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments/Recommended Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>5.00</b>	<b>0.00</b>	<b>5.00</b>
<b>Pre-Service Positioning Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>60.00</b>		
<b>Immediate Post Service-Time:</b>	<b>10.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	99217x 0.00
<b>Office time/visit(s):</b>	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
<b>Sub Obs Care:</b>	<b>0.00</b>	99224x 0.00	99225x 0.00	99226x 0.00



**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
92610	XXX	1.30	RUC Time

CPT Descriptor Evaluation of oral and pharyngeal swallowing function**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
97001	XXX	1.20	RUC Time	2,040,727

CPT Descriptor 1 Physical therapy evaluation

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
90847	XXX	2.21	RUC Time	243,491

CPT Descriptor 2 Family psychotherapy (conjoint psychotherapy) (with patient present)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
---------------------------------	---------------	-----------------	--------------------

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 21      % of respondents: 35.5 %

**TIME ESTIMATES (Median)**

	<b>CPT Code: 92524</b>	<b>Key Reference CPT Code: 92610</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	5.00	7.00	
Median Intra-Service Time	60.00	35.00	
Median Immediate Post-service Time	10.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
<b>Median Total Time</b>	<b>75.00</b>	<b>52.00</b>	

Other time if appropriate		
---------------------------	--	--

**INTENSITY/COMPLEXITY MEASURES (Mean)**(of those that selected Key  
Reference code)**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.14	4.10
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.25	4.34
--	------	------

Urgency of medical decision making	3.76	3.90
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.59	4.47
--------------------------	------	------

Physical effort required	2.88	2.85
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.08	3.44
---	------	------

Outcome depends on the skill and judgment of physician	4.44	4.36
--	------	------

Estimated risk of malpractice suit with poor outcome	2.90	3.07
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.42	3.46
----------------------------------	------	------

Intra-Service intensity/complexity	4.32	4.22
------------------------------------	------	------

Post-Service intensity/complexity	3.66	3.54
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

We are recommending a work RVU of 1.75 based on the median of the survey responses and pre, intra and post times of 5, 60, and 10 minutes respectively. We think this value is supported by the reference code, 92610, which is assigned a work

value of 1.30 and pre time of 7 minutes, intra time of 35 minutes, and post time of 10 minutes. The intensity measures are fairly comparable, with the surveyed code ranked slightly higher on 6 of the 11 measures and the reference code ranked higher on 5 of the measures. The intra time intensity of the surveyed code was ranked higher. Given the substantial difference in intra time—60 vs. 35 minutes—and roughly similar intensity, we think the recommended work value of 1.75 is appropriate. Essentially, this means we are requesting a work value 35% higher for a service of similar intensity with 70% more intra time.

The work RVU of 1.75 is also supported by the two MPC codes we cited, both of which are performed primarily by non-physicians. Specifically, code 97001 (physical therapy evaluation) is assigned a work RVU of 1.20 with 30 minutes of intra time. Our requested RVU is about 40% higher but the surveyed code has twice the intra time of 97001. The other MPC code we cite is code 90847, family psychotherapy, with an RVW of 2.21 and 50 minutes of intra time. Code 90847 is performed most frequently by clinical social workers.

Finally, the recommended RVW for code 92524 is in line with other evaluation codes in the family of codes used by speech-language pathologists, including the following:

CPT Code	Descriptor	IWPUT	RVW	Total Time	Pre	Intra	Post
92605	Evaluation for prescription of non-speech-generating augmentative and alternative communication device	0.0180	1.75	90	10	60	20
92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	0.0196	1.85	90	10	60	20
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech	0.0203	1.26	60	7	40	13
<b>92524 ASHA Rec</b>	<b>Behavioral and qualitative analysis of voice and resonance</b>	<b>0.0240</b>	<b>1.75</b>	<b>75</b>	<b>5</b>	<b>60</b>	<b>10</b>
96125	Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report	0.0257	1.70	67	7	60	0
92610	Evaluation of oral and pharyngeal swallowing function	0.0263	1.30	52	7	35	10
92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording	0.0320	1.34	47	7	30	10

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. n/a

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 92506

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Speech-Language Pathology	How often? Commonly
-------------------------------------	---------------------

Specialty	How often?
-----------	------------

Specialty	How often?
-----------	------------

Estimate the number of times this service might be provided nationally in a one-year period? 8000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We used a combination of ASHA membership numbers, caseload information derived from major speech & hearing clinics, and Medicare frequency data to arrive at this estimate.

Specialty Speech-Language Pathology	Frequency 8000	Percentage 100.00 %
-------------------------------------	----------------	---------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 8,000

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We used 2011 Medicare claims data for the existing code, 92506, and estimated that the majority of billings by otolaryngologists were for voice-related cases (approximately 7500) and then raised the number to 500 to account for cases seen in private practice.

Specialty Speech-Language Pathology	Frequency 8000	Percentage 100.00 %
-------------------------------------	----------------	---------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? Yes

## Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 92520



## SS Rec Summary

	A	B	C										D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN		
3	INSTRUCTIONS																																																		
4	Insert information and data into all applicable cells <b>except</b> IWPUT and TOTAL TIME. These cells will automatically calculate.																																																		
5	Hide columns and rows that do not contain data.																																																		
6	REF = Key Reference code data																																																		
7	CURRENT = Current data (Harvard or RUC) for code being surveyed. If this is a new code, this row will be blank.																																																		
8	SVY = Survey data - as it appears on the Summary of Recommendation form.																																																		
9	REC = Specialty Society recommended data as it appears on the Summary of Recommendation form.																																																		
10																																																			
11																																																			
12	ISSUE:		Speech Evaluation																																																
13	TAB:																																																		
14						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day						FAC-obs				Office					Prolonged															
15	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57											
16	REF	96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour		0.026			1.75			69	4					60			5																															
17	SVY	92521	Evaluation of speech fluency (eg, stuttering, cluttering)	91	0.007	1.00	1.50	1.75	2.00	6.00	140	20			30	60	90	120	240	30																															
18	REC	92521	Evaluation of speech fluency (eg, stuttering, cluttering)	91	0.014	1.75					110	5					90			15																															
19																																																			
20						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day						FAC-obs				Office					Prolonged															
21	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57											
22	REF	96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour		0.026			1.75			69	4					60			5																															
23	SVY	92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)	165	0.010	0.60	1.30	1.70	1.94	9.00	110	20			25	50	60	90	200	30																															
24	REC	92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)	165	0.016	1.50					85	5					60			20																															
25																																																			
26						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day						FAC-obs				Office					Prolonged															
27	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57											
28	REF	96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour		0.026			1.75			69	4					60			5																															
29	SVY	92523	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);with evaluation of language comprehension and expression (eg, receptive and expressive language)	151	0.004	1.00	1.75	1.86	2.25	10.00	180	30			20	75	120	128	360	30																															
30	REC	92523	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);with evaluation of language comprehension and expression (eg, receptive and expressive language)	151	0.021	3.36					157	7					120			30																															
31																																																			
32						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day						FAC-obs				Office					Prolonged															
33	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57											
34	REF	92610	Evaluation of oral and pharyngeal swallowing function		0.026			1.30			52	7					35			10																															
35	SVY	92524	Behavioral and qualitative analysis of voice and resonance	59	0.012	1.20	1.40	1.75	1.85	4.00	105	15			30	45	60	90	150	30																															
36	REC	92524	Behavioral and qualitative analysis of voice and resonance	59	0.024	1.75					75	5					60			10																															

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor: **Evaluation of speech fluency (eg, stuttering, cluttering)**

Global Period: XXX Meeting Date: January 24, 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

**The practice expense elements were determined by a consensus panel of speech-language pathologists. The panel drew upon the current practice expense information from the RUC database for CPT code 92506. Specialists in the area of speech fluency were also consulted. New items were added to take into account the use of forms for standardized assessments related to speech fluency.**

**The consensus panel consisted of five certified speech-language pathologists and ASHA's RUC HCPAC Advisor, all of whom are members of ASHA's Health Care Economics Committee. Geographic areas include Florida, Texas, Connecticut, Massachusetts, and Michigan. Practice settings include private practice, large group practice, hospital, academic, and university clinic. Members of the panel include generalists as well as experts in voice, cognitive communication, and speech sound disorders.**

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

**We have chosen CPT 92506 (Evaluation of speech, language, voice, communication, and/or auditory processing) as the reference code because it is the previously-reported code that will be replaced by 92521-92524.**

**Note that there are clinical labor inputs for 92506 because historically, speech-language pathology time was found under practice expense. However, we are not proposing clinical labor time for 92521 because this proposal moves speech-language pathology out of practice expense and into the work RVU column, as has been done over the past few years with the family of speech-language pathology related codes.**

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:

4. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Intra-Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor: **Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);**

Global Period: XXX Meeting Date: January 24, 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

**The practice expense elements were determined by a consensus panel of speech-language pathologists. The panel drew upon the current practice expense information from the RUC database for CPT code 92506. Specialists in the area of speech sound production were also consulted. New items were added to take into account the use of forms for standardized assessments related to speech sound production.**

**The consensus panel consisted of five certified speech-language pathologists and ASHA's RUC HCPAC Advisor, all of whom are members of ASHA's Health Care Economics Committee. Geographic areas include Florida, Texas, Connecticut, Massachusetts, and Michigan. Practice settings include private practice, large group practice, hospital, academic, and university clinic. Members of the panel include generalists as well as experts in voice, cognitive communication, and speech sound disorders.**

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

**We have chosen CPT 92506 (Evaluation of speech, language, voice, communication, and/or auditory processing) as the reference code because it is the previously-reported code that will be replaced by 92521-92524.**

**Note that there are clinical labor inputs for 92506 because historically, speech-language pathology time was found under practice expense. However, we are not proposing clinical labor time for 92522 because this proposal moves speech-language pathology out of practice expense and into the work RVU column, as has been done over the past few years with the family of speech-language pathology related codes.**

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:

4. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Intra-Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A



**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor: **Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)**

Global Period: XXX Meeting Date: January 24, 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

**The practice expense elements were determined by a consensus panel of speech-language pathologists. The panel drew upon the current practice expense information from the RUC database for CPT code 92506. Specialists in the area of speech sound production and language were also consulted. New items were added to take into account the use of forms for standardized assessments related to language evaluation.**

**The consensus panel consisted of five certified speech-language pathologists and ASHA's RUC HCPAC Advisor, all of whom are members of ASHA's Health Care Economics Committee. Geographic areas include Florida, Texas, Connecticut, Massachusetts, and Michigan. Practice settings include private practice, large group practice, hospital, academic, and university clinic. Members of the panel include generalists as well as experts in voice, cognitive communication, and speech sound disorders.**

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

**We have chosen CPT 92506 (Evaluation of speech, language, voice, communication, and/or auditory processing) as the reference code because it is the previously-reported code that will be replaced by 92521-92524.**

**Note that there are clinical labor inputs for 92506 because historically, speech-language pathology time was found under practice expense. However, we are not proposing clinical labor time for 92523 because this proposal moves speech-language pathology out of practice expense and into the work RVU column, as has been done over the past few years with the family of speech-language pathology related codes.**

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:

4. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Intra-Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor: Behavioral and qualitative analysis of voice and resonance

Global Period: XXX Meeting Date: January 24, 2013

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

**The practice expense elements were determined by a consensus panel of speech-language pathologists. The panel drew upon the current practice expense information from the RUC database for CPT code 92506. Specialists in the area of voice were also consulted.**

**The consensus panel consisted of five certified speech-language pathologists and ASHA's RUC HCPAC Advisor, all of whom are members of ASHA's Health Care Economics Committee. Geographic areas include Florida, Texas, Connecticut, Massachusetts, and Michigan. Practice settings include private practice, large group practice, hospital, academic, and university clinic. Members of the panel include generalists as well as experts in voice, cognitive communication, and speech sound disorders.**

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

**We have chosen CPT 92506 (Evaluation of speech, language, voice, communication, and/or auditory processing) as the reference code because it is the previously-reported code that will be replaced by 92521-92524.**

**Note that there are clinical labor inputs for 92506 because historically, speech-language pathology time was found under practice expense. However, we are not proposing clinical labor time for 92524 because this proposal moves speech-language pathology out of practice expense and into the work RVU column, as has been done over the past few years with the family of speech-language pathology related codes.**

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:

4. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Intra-Service Clinical Labor Activities: N/A

Post-Service Clinical Labor Activities: N/A

	A	B	C	D	E	F	G	H	I	J	K	L	M
1				REFERENCE CODE									
2	Note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.			92506		92521		92522		92523		92524	
	Meeting Date: January 2013 Tab: Specialty: Speech-Language Pathology			Evaluation of speech, language, voice, communication, and/or auditory processing		Evaluation of speech fluency (eg, stuttering, cluttering)		Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);		Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);with evaluation of language comprehension and expression (eg, receptive and expressive language)		Behavioral and qualitative analysis of voice and resonance	
3		CMS Code	Staff Type										
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			XXX		XXX		XXX		XXX		XXX	
6	TOTAL CLINICAL LABOR TIME	L055A	Speech Pathologist	156.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			15.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			108.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			33.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
10	PRE-SERVICE												
11	Start: Following visit when decision for surgery or procedure made												
12	Complete pre-service diagnostic & referral forms												
13	Coordinate pre-surgery services												
14	Schedule space and equipment in facility												
15	Provide pre-service education/obtain consent												
16	Follow-up phone calls & prescriptions												
17	Other Clinical Activity - specify:												
18	End: When patient enters office/facility for surgery/procedure												
19	SERVICE PERIOD												
20	Start: When patient enters office/facility for surgery/procedure:												
21	Greet patient, provide gowning, ensure appropriate medical records are available												
22	Obtain vital signs												
23	Provide pre-service education/obtain consent												
24	Prepare room, equipment, supplies												
25	Setup scope (non facility setting only)												
26	Prepare and position patient/ monitor patient/ set up IV												
27	Sedate/apply anesthesia												
28	Intra-service												
29	Assist physician in performing procedure												
30	Post-Service												
31	Monitor pt. following service/check tubes, monitors, drains												
32	Clean room/equipment by physician staff												
33	Clean Scope												
34	Clean Surgical Instrument Package												
35	Complete diagnostic forms, lab & X-ray requisitions												
36	Review/read X-ray, lab, and pathology reports												
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions												
38	Other Clinical Activity - specify:												
39	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			n/a		n/a		n/a		n/a		n/a	
40	Dischrg mgmt (1.0 x 99238) (enter 12 min)			n/a		n/a		n/a		n/a		n/a	
41	Dischrg mgmt (1.0 x 99239) (enter 15 min)			n/a		n/a		n/a		n/a		n/a	
42	End: Patient leaves office												
43	POST-SERVICE Period												
44	Start: Patient leaves office/facility												
45	Conduct phone calls/call in prescriptions												
46	Office visits: List Number and Level of Office Visits			# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits
47	99211 16 minutes		16										
48	99212 27 minutes		27										
49	99213 36 minutes		36										
50	99214 53 minutes		53										
51	99215 63 minutes		63										
52	Total Office Visit Time			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
53	Other Clinical Activity - specify:												
54	End: with last office visit before end of global period												
55	MEDICAL SUPPLIES			CODE	UNIT								
56	video tape, VHS	SK086	item	1									
57	patient education booklet	SK062	item	1		1		1		1		1	
58	audio cassette tape 60 min	SK007	item	1									
59	audiology scoring forms	SK008	item	4									
60	gloves, non-sterile	SB022	pair	1		1		1		1		1	
61	gauze, non-sterile 4in x 4in	SG051	item	2									
62	cup, drinking	SK018	item	1		1		1		1		1	
63	tongue depressor	SJ061	item	1		1		1		1		1	
64	drinking straw	SK020	item	1				1		1			
65	paper, laser printing (each sheet)	SK057	item			2		2		4			
66	computer media, dvd	SK013	item			1				1		1	
67	fluency assessment form, average (see attached - "New Items")	New	New			2							
68	speech assessment form, average (see attached - "New Items")	New	New					2		2			
69	language assessment form, average (see attached - "New Items")	New	New							2			
70													
71	EQUIPMENT			CODE									
72													

**AMA/Specialty Society RVS Update Committee  
Practice Expense Subcommittee  
Migration from Film to Digital Imaging Workgroup  
March 20, 2013 Conference Call  
7pm-8pm CST**

**Conference Call Report**

**Members participating on call:** *David Han, MD (Chair), Gregory Barkley, MD, James Blankenship, MD, Margaret Neal, MD, Guy Orangio, MD, Zeke Silva, MD*

The Migration from Film to Digital Imaging Workgroup met on March 20, 2013 via conference call to discuss clinical labor inputs for digital imaging, both with regards to time and equipment for these clinical labor activities. For the purposes of the discussion, the workgroup used CPT code 70450 *Computed tomography, head or brain; without contrast material* as an example.

The Workgroup reviewed potential clinical labor activities and the equipment types associated with them based on recommendations provided by The American College of Radiology (ACR). Based on the previous call, pre-service line 18 and post-service line 41 were identified as the clinical labor inputs that would be impacted by the film to digital migration. ACR suggested, and the workgroup agreed that two separate activities should be broken out from line 18 (see detail below) and three separate activities should be broken out from line 41 (see detail below). These breakdowns were necessary because the various film-related activities in the existing clinical labor activities require different equipment types in the digital practice environment. Equipment types are listed in the document attached to this report entitled *Clinical Labor Activities*. The Workgroup discussed and agreed that this example is representative of what would occur in a typical imaging service and the equipment was added to the existing set of equipment in the equipment overview document attached to this report and entitled *Digital Imaging Equipment Overview*. With regards to the supply and equipment inputs, the Workgroup discussed grouping equipment as a PACS room in the same way that a CT room is grouped but it was acknowledged that certain components of the larger PACS room may involve different times so maintaining the individual components may be preferable. The Workgroup understands that from the PACS equipment overview CMS will determine what items it deems appropriate and inappropriate to include as direct practice expense inputs for digital imaging services.

Based on the need for different equipment types, ACR identified the following two clinical labor activities to potentially replace the current one clinical activity on line 18, Pre-service activity: *Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information and confirm contrast protocol with interpreting MD* performed by a CT technologist.

1. Pre-service activity: *Availability of Prior Images Confirmed* performed by a CT technologist.
2. Pre-service activity: *Patient clinical information and questionnaire reviewed by technologist, order from physician confirmed and exam protocolled by radiologist*, performed by a CT technologist.

ACR also identified the following three clinical labor activities to potentially replace the current one clinical activity on line 41, Post-service activity: *Process films, hang films and review study with interpreting MD prior to patient discharge* performed by a CT technologist.

1. Post-service activity: *Technologist QC's images in PACS, checking for all images, reformats, and dose page.*

2. Post-service activity: *Review examination with interpreting MD.*
3. Post-service activity: *Exam documents scanned into PACS. Exam completed in RIS system to generate billing process and to populate images into Radiologist work queue.*

The Workgroup agreed that each new or reviewed code brought before the RUC in the future will have its corresponding clinical labor and equipment inputs broken down into these separate items, and staff times appropriate to each event will be assigned at the Practice Expense Subcommittee meeting as is the current practice. The Workgroup noted that pre and post clinical labor activities could blend into the intra-service time of the service period and that the specialty society will have to use their judgment on a code by code basis to determine the appropriate category for the activity.

The Workgroup then discussed the task of applying these five new line items into each code as they presently exist. Concerns were raised regarding the practicality of going through this process for each of the 604 identified codes with film related inputs. Because of the unique nature of each code, the Workgroup agreed that the only solution would be an individual code-by-code reassessment of clinical labor practice expense inputs and agreed that this would be an inappropriately onerous task. The workgroup agreed that at this point, the most appropriate solution appears to be leaving the clinical labor inputs as they exist for the identified 604 codes. This is in contradistinction to the recommendation below for the supply and equipment inputs, where the workgroup agreed that the new supply and equipment practice expense inputs should be retrofitted to the identified 604 imaging codes. The Workgroup noted that equipment time is determined by clinical staff time and will work to ensure that the clinical labor times for the existing codes will be allocated appropriately to the new digital inputs.

### Recommendations

The Workgroup makes the following recommendations for the migration of film to digital imaging:

- For existing codes:
  - Remove recommended supplies and equipment as noted on spreadsheet from 604 imaging CPT codes (see *Film to Digital Codes-Supplies-Equipment-Final* attached).
  - Replace supplies and equipment for 604 imaging CPT codes with recommended PACS equipment. Invoices will be provided by specialties (see *Digital Imaging Equipment Overview* attached).
  - No modification to clinical labor activities at this time.
- For new codes and codes undergoing review:
  - Clinical labor activities for imaging codes will be replaced with more detailed activities. These detailed activities specified below are specific to CPT code 70450, *Computed tomography, head or brain; without contrast material*. Using these as a guide, specialty societies will need to determine the allocated clinical labor equipment and time recommendations based on previous inputs and current clinical practice. These recommendations will be reviewed at the Practice Expense Subcommittee on a code by code basis.
  - For Pre-service activity: *Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information and confirm contrast protocol with interpreting MD* performed by a CT technologist, or similar list:
    - Pre-service activity: *Availability of Prior Images Confirmed* performed by a CT technologist.
    - Pre-service activity: *Patient clinical information and questionnaire reviewed by technologist, order from physician confirmed and exam protocolled by radiologist*, performed by a CT technologist.

- For Post-service activity: *Process films, hang films and review study with interpreting MD prior to patient discharge* performed by a CT technologist, or similar list:
  - Post-service activity: *Technologist QC's images in PACS, checking for all images, reformats, and dose page.*
  - Post-service activity: *Review examination with interpreting MD.*
  - Post-service activity: *Exam documents scanned into PACS. Exam completed in RIS system to generate billing process and to populate images into Radiologist work queue.*

CPT Code	Short Descriptor	Top Specialty	SK013 - computer media, dvd	SK014 - computer media, floppy disk 144mb	SK015 - computer media, optical disk 128mb	SK016 - computer media, optical disk 26gb	SK022 - film, 8inx10in (ultrasound, MRI)	SK025 - film, dry, radiographic, 8in x 10in	SK028 - film, fluoroscopic 14 x 17	SK033 - film, x-ray 10in x 12in
15732	MUSCLE-SKIN GRAFT HEAD/NECK	RECONSTRUCTIVE SURGERY								
15734	MUSCLE-SKIN GRAFT TRUNK	RECONSTRUCTIVE SURGERY								
15736	MUSCLE-SKIN GRAFT ARM	RECONSTRUCTIVE SURGERY								
15738	MUSCLE-SKIN GRAFT LEG	RECONSTRUCTIVE SURGERY								
22520	Percut vertebroplasty thor	DIAGNOSTIC RADIOLOGY								
22521	Percut vertebroplasty lumb	DIAGNOSTIC RADIOLOGY								
22523	Percut kyphoplasty thor	ORTHOPEDIC SURGERY								
22524	Percut kyphoplasty lumbar	ORTHOPEDIC SURGERY								
22526	Idet single level									
27096	INJECT SACROILIAC JOINT	ANESTHESIOLOGY						SK025		
36147	ACCESS AV DIAL GRFT FOR EVAL	DIAGNOSTIC RADIOLOGY	SK013							
36251	INS CATH REN ART 1ST UNILAT	CARDIOLOGY								
36252	INS CATH REN ART 1ST BILAT	CARDIOLOGY								
36253	INS CATH REN ART 2ND+ UNILAT	CARDIOLOGY								
36254	INS CATH REN ART 2ND+ BILAT	CARDIOLOGY								
36475	ENDOVENOUS RF 1ST VEIN	GENERAL SURGERY								
36478	ENDOVENOUS LASER 1ST VEIN	VASCULAR SURGERY								
36598	INJ W/FLUOR EVAL CV DEVICE	DIAGNOSTIC RADIOLOGY								
37184	PRIM ART MECH THROMBECTOMY	DIAGNOSTIC RADIOLOGY	SK013							
37185	PRIM ART M-THROMBECT ADD-ON	VASCULAR SURGERY								
37186	SEC ART M-THROMBECT ADD-ON	CARDIOLOGY								
37187	VENOUS MECH THROMBECTOMY	DIAGNOSTIC RADIOLOGY	SK013							
37188	VENOUS M-THROMBECTOMY ADD-ON	DIAGNOSTIC RADIOLOGY	SK013							
37191	INS ENDOVAS VENA CAVA FILTR	DIAGNOSTIC RADIOLOGY								
37192	REDO ENDOVAS VENA CAVA FILTR	DIAGNOSTIC RADIOLOGY								
37193	REM ENDOVAS VENA CAVA FILTER	DIAGNOSTIC RADIOLOGY								
37210	EMBOLIZATION UTERINE FIBROID	DIAGNOSTIC RADIOLOGY	SK013							
37220	ILIAC REVASC	VASCULAR SURGERY								
37221	ILIAC REVASC W/STENT	VASCULAR SURGERY								
37222	ILIAC REVASC ADD-ON	VASCULAR SURGERY								
37223	ILIAC REVASC W/STENT ADD-ON	VASCULAR SURGERY								
37224	FEM/POPL REVAS W/TLA	VASCULAR SURGERY								
37225	FEM/POPL REVAS W/ATHER	CARDIOLOGY								
37226	FEM/POPL REVASC W/STENT	CARDIOLOGY								
37227	FEM/POPL REVASC STNT & ATHER	CARDIOLOGY								
37228	TIB/PER REVASC W/TLA	VASCULAR SURGERY								
37229	TIB/PER REVASC W/ATHER	CARDIOLOGY								
37230	TIB/PER REVASC W/STENT	CARDIOLOGY								
37231	TIB/PER REVASC STENT & ATHER	CARDIOLOGY								
37232	TIB/PER REVASC ADD-ON	VASCULAR SURGERY								
37233	TIBPER REVASC W/ATHER ADD-ON	CARDIOLOGY								
37234	REVSC OPN/PRQ TIB/PERO STENT	CARDIOLOGY								
37235	TIB/PER REVASC STNT & ATHER	CARDIOLOGY								
38790	INJECT FOR LYMPHATIC X-RAY	GENERAL SURGERY								
43756	DX DUOD INTUB W/ASP SPEC	GASTROENTEROLOGY							SK028	
43757	DX DUOD INTUB W/ASP SPECS	GASTROENTEROLOGY							SK028	
49083	ABD PARACENTESIS W/IMAGING	DIAGNOSTIC RADIOLOGY					SK022			
49418	INSERT TUN IP CATH PERC	DIAGNOSTIC RADIOLOGY								
49440	PLACE GASTROSTOMY TUBE PERC	DIAGNOSTIC RADIOLOGY	SK013							
49441	PLACE DUOD/JEJ TUBE PERC	DIAGNOSTIC RADIOLOGY	SK013							
49442	PLACE CECOSTOMY TUBE PERC	DIAGNOSTIC RADIOLOGY	SK013							
49446	CHANGE G-TUBE TO G-J PERC	DIAGNOSTIC RADIOLOGY	SK013							
49450	REPLACE G/C TUBE PERC	DIAGNOSTIC RADIOLOGY	SK013							
49451	REPLACE DUOD/JEJ TUBE PERC	DIAGNOSTIC RADIOLOGY	SK013							
49452	REPLACE G-J TUBE PERC	DIAGNOSTIC RADIOLOGY	SK013							
49460	FIX G/COLON TUBE W/DEVICE	DIAGNOSTIC RADIOLOGY	SK013							
49465	FLUORO EXAM OF G/COLON TUBE	DIAGNOSTIC RADIOLOGY	SK013							
50382	CHANGE URETER STENT PERCUT	DIAGNOSTIC RADIOLOGY	SK013							
50384	REMOVE URETER STENT PERCUT	DIAGNOSTIC RADIOLOGY	SK013							
50385	CHANGE STENT VIA TRANSURETH	UROLOGY	SK013							
50386	REMOVE STENT VIA TRANSURETH	UROLOGY	SK013							
50387	CHANGE EXT/INT URETER STENT	DIAGNOSTIC RADIOLOGY	SK013							
50389	REMOVE RENAL TUBE W/FLUORO	DIAGNOSTIC RADIOLOGY	SK013							
51605	PREPARATION FOR BLADDER XRAY	UROLOGY								
62263	EPIDURAL LYSIS MULT SESSIONS	INTERVENTIONAL PAIN MANAGEMENT								
62264	Epidural lysis on single day	ANESTHESIOLOGY								
63661	Remove spine eltrd perq aray	MANAGEMENT								
63663	Revise spine eltrd perq aray	MANAGEMENT								
64479	INJ FORAMEN EPIDURAL C/T	MANAGEMENT						SK025		
64480	Inj foramen epidural add-on	NEUROSURGERY								
64483	INJ FORAMEN EPIDURAL L/S	MANAGEMENT						SK025		
64484	Inj foramen epidural add-on	MANAGEMENT								
64490	INJ PARAVERT F JNT C/T 1 LEV	MANAGEMENT						SK025		
64493	INJ PARAVERT F JNT L/S 1 LEV	MANAGEMENT						SK025		
64633	DESTROY CERV/THOR FACET JNT	MANAGEMENT						SK025		
64634	DESTROY C/TH FACET JNT ADDL	MANAGEMENT						SK025		

CPT Code	Short Descriptor	Top Specialty	SK013 - computer media, dvd	SK014 - computer media, floppy disk 144mb	SK015 - computer media, optical disk 128mb	SK016 - computer media, optical disk 26gb	SK022 - film, 8inx10in (ultrasound, MRI)	SK025 - film, dry, radiographic, 8in x 10in	SK028 - film, fluoroscopic 14 x 17	SK033 - film, x-ray 10in x 12in
64635	DESTROY LUMB/SAC FACET JNT	MANAGEMENT						SK025		
64636	DESTROY L/S FACET JNT ADDL	MANAGEMENT						SK025		
70010	CONTRAST X-RAY OF BRAIN	DIAGNOSTIC RADIOLOGY								SK033
70015	CONTRAST X-RAY OF BRAIN	DIAGNOSTIC RADIOLOGY								SK033
70030	X-RAY EYE FOR FOREIGN BODY	DIAGNOSTIC RADIOLOGY								
70100	X-RAY EXAM OF JAW	FAMILY PRACTICE								
70110	X-RAY EXAM OF JAW	DIAGNOSTIC RADIOLOGY								
70120	X-RAY EXAM OF MASTOIDS	DIAGNOSTIC RADIOLOGY								
70130	X-RAY EXAM OF MASTOIDS	DIAGNOSTIC RADIOLOGY								
70134	X-RAY EXAM OF MIDDLE EAR	DIAGNOSTIC RADIOLOGY								
70140	X-RAY EXAM OF FACIAL BONES	DIAGNOSTIC RADIOLOGY								
70150	X-RAY EXAM OF FACIAL BONES	DIAGNOSTIC RADIOLOGY								
70160	X-RAY EXAM OF NASAL BONES	DIAGNOSTIC RADIOLOGY								
70190	X-RAY EXAM OF EYE SOCKETS	DIAGNOSTIC RADIOLOGY								
70200	X-RAY EXAM OF EYE SOCKETS	DIAGNOSTIC RADIOLOGY								
70210	X-RAY EXAM OF SINUSES	DIAGNOSTIC RADIOLOGY								
70220	X-RAY EXAM OF SINUSES	DIAGNOSTIC RADIOLOGY								
70240	X-RAY EXAM PITUITARY SADDLE	DIAGNOSTIC RADIOLOGY								
70250	X-RAY EXAM OF SKULL	DIAGNOSTIC RADIOLOGY								SK033
70260	X-RAY EXAM OF SKULL	DIAGNOSTIC RADIOLOGY								SK033
70328	X-RAY EXAM OF JAW JOINT	DIAGNOSTIC RADIOLOGY								
70330	X-RAY EXAM OF JAW JOINTS	DIAGNOSTIC RADIOLOGY								
70336	MAGNETIC IMAGE JAW JOINT	DIAGNOSTIC RADIOLOGY								
70360	X-RAY EXAM OF NECK	DIAGNOSTIC RADIOLOGY								
70370	THROAT X-RAY & FLUOROSCOPY	FAMILY PRACTICE								SK033
70371	SPEECH EVALUATION COMPLEX	DIAGNOSTIC RADIOLOGY								
70373	CONTRAST X-RAY OF LARYNX	FAMILY PRACTICE								SK033
70390	X-RAY EXAM OF SALIVARY DUCT	DIAGNOSTIC RADIOLOGY								SK033
70450	CT HEAD/BRAIN W/O DYE	DIAGNOSTIC RADIOLOGY	SK013							
70460	CT HEAD/BRAIN W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
70470	CT HEAD/BRAIN W/O & W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
70480	CT ORBIT/EAR/FOSSA W/O DYE	DIAGNOSTIC RADIOLOGY	SK013							
70481	CT ORBIT/EAR/FOSSA W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
70482	CT ORBIT/EAR/FOSSA W/O&W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
70486	CT MAXILLOFACIAL W/O DYE	DIAGNOSTIC RADIOLOGY	SK013							
70487	CT MAXILLOFACIAL W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
70488	CT MAXILLOFACIAL W/O & W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
70490	CT SOFT TISSUE NECK W/O DYE	DIAGNOSTIC RADIOLOGY	SK013							
70491	CT SOFT TISSUE NECK W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
70492	CT SFT TSUE NCK W/O & W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
70496	CT ANGIOGRAPHY HEAD	DIAGNOSTIC RADIOLOGY								
70498	CT ANGIOGRAPHY NECK	DIAGNOSTIC RADIOLOGY								
70540	MRI ORBIT/FACE/NECK W/O DYE	DIAGNOSTIC RADIOLOGY								
70542	MRI ORBIT/FACE/NECK W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
70543	MRI ORBT/FAC/NCK W/O & W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
70544	MR ANGIOGRAPHY HEAD W/O DYE	DIAGNOSTIC RADIOLOGY				SK016				
70545	MR ANGIOGRAPHY HEAD W/DYE	DIAGNOSTIC RADIOLOGY				SK016				
70546	MR ANGIOGRAPH HEAD W/O&W/DYE	DIAGNOSTIC RADIOLOGY				SK016				
70547	MR ANGIOGRAPHY NECK W/O DYE	DIAGNOSTIC RADIOLOGY				SK016				
70548	MR ANGIOGRAPHY NECK W/DYE	DIAGNOSTIC RADIOLOGY				SK016				
70549	MR ANGIOGRAPH NECK W/O&W/DYE	DIAGNOSTIC RADIOLOGY				SK016				
70551	MRI BRAIN W/O DYE	DIAGNOSTIC RADIOLOGY								
70552	MRI BRAIN W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
70553	MRI BRAIN W/O & W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
70554	FMRI BRAIN BY TECH	DIAGNOSTIC RADIOLOGY	SK013							
71010	CHEST X-RAY	DIAGNOSTIC RADIOLOGY								
71015	CHEST X-RAY	DIAGNOSTIC RADIOLOGY								
71020	CHEST X-RAY	DIAGNOSTIC RADIOLOGY								
71021	CHEST X-RAY	DIAGNOSTIC RADIOLOGY								
71022	CHEST X-RAY	DIAGNOSTIC RADIOLOGY								
71023	CHEST X-RAY AND FLUOROSCOPY	DIAGNOSTIC RADIOLOGY								
71030	CHEST X-RAY	DIAGNOSTIC RADIOLOGY								
71034	CHEST X-RAY AND FLUOROSCOPY	CARDIOLOGY								
71035	CHEST X-RAY	DIAGNOSTIC RADIOLOGY								
71040	CONTRAST X-RAY OF BRONCHI	DIAGNOSTIC RADIOLOGY								SK033
71060	CONTRAST X-RAY OF BRONCHI	DIAGNOSTIC RADIOLOGY								SK033
71100	X-RAY EXAM OF RIBS	DIAGNOSTIC RADIOLOGY								
71101	X-RAY EXAM OF RIBS/CHEST	DIAGNOSTIC RADIOLOGY								
71110	X-RAY EXAM OF RIBS	DIAGNOSTIC RADIOLOGY								
71111	X-RAY EXAM OF RIBS/CHEST	DIAGNOSTIC RADIOLOGY								
71120	X-RAY EXAM OF BREASTBONE	DIAGNOSTIC RADIOLOGY								
71130	X-RAY EXAM OF BREASTBONE	DIAGNOSTIC RADIOLOGY								
71250	CT THORAX W/O DYE	DIAGNOSTIC RADIOLOGY	SK013							
71260	CT THORAX W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
71270	CT THORAX W/O & W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
71275	CT ANGIOGRAPHY CHEST	DIAGNOSTIC RADIOLOGY								
71550	MRI CHEST W/O DYE	DIAGNOSTIC RADIOLOGY								



CPT Code	Short Descriptor	Top Specialty	SK013 - computer media, dvd	SK014 - computer media, floppy disk 144mb	SK015 - computer media, optical disk 128mb	SK016 - computer media, optical disk 26gb	SK022 - film, 8inx10in (ultrasound, MRI)	SK025 - film, dry, radiographic, 8in x 10in	SK028 - film, fluoroscopic 14 x 17	SK033 - film, x-ray 10in x 12in
71551	MRI CHEST W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
71552	MRI CHEST W/O & W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
71555	MRI ANGIO CHEST W OR W/O DYE	DIAGNOSTIC RADIOLOGY	SK013							
72010	X-RAY EXAM OF SPINE	INTERNAL MEDICINE								SK033
72020	X-RAY EXAM OF SPINE	DIAGNOSTIC RADIOLOGY								
72040	X-RAY EXAM OF NECK SPINE	DIAGNOSTIC RADIOLOGY								SK033
72050	X-RAY EXAM OF NECK SPINE	DIAGNOSTIC RADIOLOGY								SK033
72052	X-RAY EXAM OF NECK SPINE	DIAGNOSTIC RADIOLOGY								SK033
72069	X-RAY EXAM OF TRUNK SPINE	DIAGNOSTIC RADIOLOGY								
72070	X-RAY EXAM OF THORACIC SPINE	DIAGNOSTIC RADIOLOGY								
72072	X-RAY EXAM OF THORACIC SPINE	DIAGNOSTIC RADIOLOGY								SK033
72074	X-RAY EXAM OF THORACIC SPINE	DIAGNOSTIC RADIOLOGY								
72080	X-RAY EXAM OF TRUNK SPINE	DIAGNOSTIC RADIOLOGY								
72090	X-RAY EXAM OF TRUNK SPINE	DIAGNOSTIC RADIOLOGY								
72100	X-RAY EXAM OF LOWER SPINE	DIAGNOSTIC RADIOLOGY								SK033
72110	X-RAY EXAM OF LOWER SPINE	DIAGNOSTIC RADIOLOGY								SK033
72114	X-RAY EXAM OF LOWER SPINE	DIAGNOSTIC RADIOLOGY								SK033
72120	X-RAY EXAM OF LOWER SPINE	ORTHOPEDIC SURGERY								
72125	CT NECK SPINE W/O DYE	DIAGNOSTIC RADIOLOGY	SK013							
72126	CT NECK SPINE W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
72127	CT NECK SPINE W/O & W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
72128	CT CHEST SPINE W/O DYE	DIAGNOSTIC RADIOLOGY	SK013							
72129	CT CHEST SPINE W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
72130	CT CHEST SPINE W/O & W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
72131	CT LUMBAR SPINE W/O DYE	DIAGNOSTIC RADIOLOGY	SK013							
72132	CT LUMBAR SPINE W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
72133	CT LUMBAR SPINE W/O & W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
72141	MRI NECK SPINE W/O DYE	DIAGNOSTIC RADIOLOGY								
72142	MRI NECK SPINE W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
72146	MRI CHEST SPINE W/O DYE	DIAGNOSTIC RADIOLOGY								
72147	MRI CHEST SPINE W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
72148	MRI LUMBAR SPINE W/O DYE	DIAGNOSTIC RADIOLOGY								
72149	MRI LUMBAR SPINE W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
72156	MRI NECK SPINE W/O & W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
72157	MRI CHEST SPINE W/O & W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
72158	MRI LUMBAR SPINE W/O & W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
72159	MR ANGIO SPINE W/O&W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
72170	X-RAY EXAM OF PELVIS	DIAGNOSTIC RADIOLOGY								
72190	X-RAY EXAM OF PELVIS	DIAGNOSTIC RADIOLOGY								
72191	CT ANGIOGRAPH PELV W/O&W/DYE	DIAGNOSTIC RADIOLOGY				SK016				
72192	CT PELVIS W/O DYE	DIAGNOSTIC RADIOLOGY	SK013							
72193	CT PELVIS W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
72194	CT PELVIS W/O & W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
72195	MRI PELVIS W/O DYE	DIAGNOSTIC RADIOLOGY	SK013							
72196	MRI PELVIS W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
72197	MRI PELVIS W/O & W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
72198	MR ANGIO PELVIS W/O & W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
72200	X-RAY EXAM SACROILIAC JOINTS	DIAGNOSTIC RADIOLOGY								SK033
72202	X-RAY EXAM SACROILIAC JOINTS	DIAGNOSTIC RADIOLOGY								SK033
72220	X-RAY EXAM OF TAILBONE	DIAGNOSTIC RADIOLOGY								SK033
72240	CONTRAST X-RAY OF NECK SPINE	DIAGNOSTIC RADIOLOGY								SK033
72255	CONTRAST X-RAY THORAX SPINE	DIAGNOSTIC RADIOLOGY								
72265	CONTRAST X-RAY LOWER SPINE	DIAGNOSTIC RADIOLOGY								
72270	CONTRAST X-RAY SPINE	DIAGNOSTIC RADIOLOGY								
72275	EPIDUROGRAPHY	MANAGEMENT								SK033
72285	X-RAY C/T SPINE DISK	MANAGEMENT								SK033
72295	X-RAY OF LOWER SPINE DISK	MANAGEMENT								SK033
73000	X-RAY EXAM OF COLLAR BONE	DIAGNOSTIC RADIOLOGY								SK033
73010	X-RAY EXAM OF SHOULDER BLADE	ORTHOPEDIC SURGERY								SK033
73020	X-RAY EXAM OF SHOULDER	DIAGNOSTIC RADIOLOGY								SK033
73030	X-RAY EXAM OF SHOULDER	DIAGNOSTIC RADIOLOGY								SK033
73040	CONTRAST X-RAY OF SHOULDER	DIAGNOSTIC RADIOLOGY								SK033
73050	X-RAY EXAM OF SHOULDERS	ORTHOPEDIC SURGERY								
73060	X-RAY EXAM OF HUMERUS	DIAGNOSTIC RADIOLOGY								
73070	X-RAY EXAM OF ELBOW	DIAGNOSTIC RADIOLOGY								
73080	X-RAY EXAM OF ELBOW	DIAGNOSTIC RADIOLOGY								
73085	CONTRAST X-RAY OF ELBOW	DIAGNOSTIC RADIOLOGY								
73090	X-RAY EXAM OF FOREARM	DIAGNOSTIC RADIOLOGY								
73092	X-RAY EXAM OF ARM INFANT	FAMILY PRACTICE								SK033
73100	X-RAY EXAM OF WRIST	ORTHOPEDIC SURGERY								
73110	X-RAY EXAM OF WRIST	DIAGNOSTIC RADIOLOGY								
73115	CONTRAST X-RAY OF WRIST	DIAGNOSTIC RADIOLOGY								
73120	X-RAY EXAM OF HAND	DIAGNOSTIC RADIOLOGY								SK033
73130	X-RAY EXAM OF HAND	DIAGNOSTIC RADIOLOGY								SK033
73140	X-RAY EXAM OF FINGER(S)	DIAGNOSTIC RADIOLOGY								
73200	CT UPPER EXTREMITY W/O DYE	DIAGNOSTIC RADIOLOGY	SK013							
73201	CT UPPER EXTREMITY W/DYE	DIAGNOSTIC RADIOLOGY	SK013							

CPT Code	Short Descriptor	Top Specialty	SK013 - computer media, dvd	SK014 - computer media, floppy disk 144mb	SK015 - computer media, optical disk 128mb	SK016 - computer media, optical disk 26gb	SK022 - film, 8inx10in (ultrasound, MRI)	SK025 - film, dry, radiographic, 8in x 10in	SK028 - film, fluoroscopic 14 x 17	SK033 - film, x-ray 10in x 12in
73202	CT UPPR EXTREMITY W/O&W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
73206	CT ANGIO UPR EXTRM W/O&W/DYE	DIAGNOSTIC RADIOLOGY								
73218	MRI UPPER EXTREMITY W/O DYE	DIAGNOSTIC RADIOLOGY								
73219	MRI UPPER EXTREMITY W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
73220	MRI UPPR EXTREMITY W/O&W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
73221	MRI JOINT UPR EXTREM W/O DYE	DIAGNOSTIC RADIOLOGY								
73222	MRI JOINT UPR EXTREM W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
73223	MRI JOINT UPR EXTR W/O&W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
73225	MR ANGIO UPR EXTR W/O&W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
73500	X-RAY EXAM OF HIP	DIAGNOSTIC RADIOLOGY								SK033
73510	X-RAY EXAM OF HIP	DIAGNOSTIC RADIOLOGY								SK033
73520	X-RAY EXAM OF HIPS	DIAGNOSTIC RADIOLOGY								SK033
73525	CONTRAST X-RAY OF HIP	DIAGNOSTIC RADIOLOGY								SK033
73540	X-RAY EXAM OF PELVIS & HIPS	ORTHOPEDIC SURGERY								SK033
73550	X-RAY EXAM OF THIGH	DIAGNOSTIC RADIOLOGY								SK033
73560	X-RAY EXAM OF KNEE 1 OR 2	ORTHOPEDIC SURGERY								SK033
73562	X-RAY EXAM OF KNEE 3	ORTHOPEDIC SURGERY								SK033
73564	X-RAY EXAM KNEE 4 OR MORE	DIAGNOSTIC RADIOLOGY								SK033
73565	X-RAY EXAM OF KNEES	ORTHOPEDIC SURGERY								SK033
73580	CONTRAST X-RAY OF KNEE JOINT	ORTHOPEDIC SURGERY								SK033
73590	X-RAY EXAM OF LOWER LEG	DIAGNOSTIC RADIOLOGY								SK033
73592	X-RAY EXAM OF LEG INFANT	DIAGNOSTIC RADIOLOGY								SK033
73600	X-RAY EXAM OF ANKLE	DIAGNOSTIC RADIOLOGY								SK033
73610	X-RAY EXAM OF ANKLE	DIAGNOSTIC RADIOLOGY								SK033
73615	CONTRAST X-RAY OF ANKLE	ORTHOPEDIC SURGERY								SK033
73620	X-RAY EXAM OF FOOT	PODIATRY								SK033
73630	X-RAY EXAM OF FOOT	DIAGNOSTIC RADIOLOGY								SK033
73650	X-RAY EXAM OF HEEL	DIAGNOSTIC RADIOLOGY								SK033
73660	X-RAY EXAM OF TOE(S)	DIAGNOSTIC RADIOLOGY								SK033
73700	CT LOWER EXTREMITY W/O DYE	DIAGNOSTIC RADIOLOGY	SK013							
73701	CT LOWER EXTREMITY W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
73702	CT LWR EXTREMITY W/O&W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
73706	CT ANGIO LWR EXTR W/O&W/DYE	DIAGNOSTIC RADIOLOGY								
73718	MRI LOWER EXTREMITY W/O DYE	DIAGNOSTIC RADIOLOGY								
73719	MRI LOWER EXTREMITY W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
73720	MRI LWR EXTREMITY W/O&W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
73721	MRI JNT OF LWR EXTRE W/O DYE	DIAGNOSTIC RADIOLOGY								
73722	MRI JOINT OF LWR EXTR W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
73723	MRI JOINT LWR EXTR W/O&W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
73725	MR ANG LWR EXT W OR W/O DYE	DIAGNOSTIC RADIOLOGY	SK013							
74000	X-RAY EXAM OF ABDOMEN	DIAGNOSTIC RADIOLOGY								
74010	X-RAY EXAM OF ABDOMEN	DIAGNOSTIC RADIOLOGY								
74020	X-RAY EXAM OF ABDOMEN	DIAGNOSTIC RADIOLOGY								
74022	X-RAY EXAM SERIES ABDOMEN	DIAGNOSTIC RADIOLOGY								
74150	CT ABDOMEN W/O DYE	DIAGNOSTIC RADIOLOGY	SK013							
74160	CT ABDOMEN W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
74170	CT ABDOMEN W/O & W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
74174	CT ANGIO ABD&PELV W/O&W/DYE	DIAGNOSTIC RADIOLOGY				SK016				
74175	CT ANGIO ABDOM W/O & W/DYE	DIAGNOSTIC RADIOLOGY				SK016				
74176	CT ABD & PELVIS	DIAGNOSTIC RADIOLOGY								
74177	CT ABD & PELV W/CONTRAST	DIAGNOSTIC RADIOLOGY								
74178	CT ABD & PELV 1/> REGNS	DIAGNOSTIC RADIOLOGY								
74181	MRI ABDOMEN W/O DYE	DIAGNOSTIC RADIOLOGY								
74182	MRI ABDOMEN W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
74183	MRI ABDOMEN W/O & W/DYE	DIAGNOSTIC RADIOLOGY	SK013							
74185	MRI ANGIO ABDOM W ORW/O DYE	DIAGNOSTIC RADIOLOGY	SK013							
74210	CONTRST X-RAY EXAM OF THROAT	DIAGNOSTIC RADIOLOGY								SK033
74220	CONTRAST X-RAY ESOPHAGUS	DIAGNOSTIC RADIOLOGY								
74230	CINE/VID X-RAY THROAT/ESOPH	DIAGNOSTIC RADIOLOGY								SK033
74240	X-RAY EXAM UPPER GI TRACT	DIAGNOSTIC RADIOLOGY								SK033
74241	X-RAY EXAM UPPER GI TRACT	DIAGNOSTIC RADIOLOGY								SK033
74245	X-RAY EXAM UPPER GI TRACT	DIAGNOSTIC RADIOLOGY								SK033
74246	CONTRST X-RAY UPPR GI TRACT	DIAGNOSTIC RADIOLOGY								SK033
74247	CONTRST X-RAY UPPR GI TRACT	DIAGNOSTIC RADIOLOGY								SK033
74249	CONTRST X-RAY UPPR GI TRACT	DIAGNOSTIC RADIOLOGY								SK033
74250	X-RAY EXAM OF SMALL BOWEL	DIAGNOSTIC RADIOLOGY								SK033
74251	X-RAY EXAM OF SMALL BOWEL	DIAGNOSTIC RADIOLOGY								SK033
74260	X-RAY EXAM OF SMALL BOWEL	DIAGNOSTIC RADIOLOGY								SK033
74261	Ct colonography dx	DIAGNOSTIC RADIOLOGY				SK016				
74262	Ct colonography dx w/dye	DIAGNOSTIC RADIOLOGY				SK016				
74263	Ct colonography screening					SK016				
74270	CONTRAST X-RAY EXAM OF COLON	DIAGNOSTIC RADIOLOGY								SK033
74280	CONTRAST X-RAY EXAM OF COLON	DIAGNOSTIC RADIOLOGY								SK033
74283	CONTRAST X-RAY EXAM OF COLON	DIAGNOSTIC RADIOLOGY								SK033
74290	CONTRAST X-RAY GALLBLADDER	DIAGNOSTIC RADIOLOGY								SK033
74291	CONTRAST X-RAYS GALLBLADDER	DIAGNOSTIC RADIOLOGY								SK033
74320	CONTRAST X-RAY OF BILE DUCTS	DIAGNOSTIC RADIOLOGY	SK013							

CPT Code	Short Descriptor	Top Specialty	SK013 - computer media, dvd	SK014 - computer media, floppy disk 144mb	SK015 - computer media, optical disk 128mb	SK016 - computer media, optical disk 26gb	SK022 - film, 8inx10in (ultrasound, MRI)	SK025 - film, dry, radiographic, 8in x 10in	SK028 - film, fluoroscopic 14 x 17	SK033 - film, x-ray 10in x 12in
74327	X-RAY BILE STONE REMOVAL	DIAGNOSTIC RADIOLOGY	SK013							
74400	CONTRST X-RAY URINARY TRACT	DIAGNOSTIC RADIOLOGY								SK033
74410	CONTRST X-RAY URINARY TRACT	DIAGNOSTIC RADIOLOGY								SK033
74415	CONTRST X-RAY URINARY TRACT	DIAGNOSTIC RADIOLOGY								SK033
74430	CONTRAST X-RAY BLADDER	DIAGNOSTIC RADIOLOGY								SK033
74440	X-RAY MALE GENITAL TRACT	UROLOGY								SK033
74455	X-RAY URETHRA/BLADDER	UROLOGY								SK033
74475	X-RAY CONTROL CATH INSERT	DIAGNOSTIC RADIOLOGY	SK013							
74480	X-RAY CONTROL CATH INSERT	DIAGNOSTIC RADIOLOGY	SK013							
74485	X-RAY GUIDE GU DILATION	DIAGNOSTIC RADIOLOGY	SK013							
74710	X-RAY MEASUREMENT OF PELVIS	DIAGNOSTIC RADIOLOGY								SK033
74740	X-RAY FEMALE GENITAL TRACT	DIAGNOSTIC RADIOLOGY								SK033
75557	CARDIAC MRI FOR MORPH	DIAGNOSTIC RADIOLOGY				SK016				
75559	CARDIAC MRI W/STRESS IMG	CARDIOLOGY				SK016				
75561	CARDIAC MRI FOR MORPH W/DYE	CARDIOLOGY				SK016				
75563	CARD MRI W/STRESS IMG & DYE	CARDIOLOGY				SK016				
75565	CARD MRI VELOC FLOW MAPPING	DIAGNOSTIC RADIOLOGY								
75571	CT HRT W/O DYE W/CA TEST	CARDIOLOGY				SK016				
75572	CT HRT W/3D IMAGE	CARDIOLOGY								
75573	CT HRT W/3D IMAGE CONGEN	DIAGNOSTIC RADIOLOGY				SK016				
75574	CT ANGIO HRT W/3D IMAGE	CARDIOLOGY				SK016				
75600	CONTRAST X-RAY EXAM OF AORTA	CARDIOLOGY	SK013							
75605	CONTRAST X-RAY EXAM OF AORTA	CARDIOLOGY	SK013							
75625	CONTRAST X-RAY EXAM OF AORTA	CARDIOLOGY	SK013							
75630	X-RAY AORTA LEG ARTERIES	CARDIOLOGY	SK013							
75635	CT ANGIO ABDOMINAL ARTERIES	DIAGNOSTIC RADIOLOGY								
75650	ARTERY X-RAYS HEAD & NECK	CARDIOLOGY	SK013							
75658	ARTERY X-RAYS ARM	NEPHROLOGY	SK013							
75660	ARTERY X-RAYS HEAD & NECK	DIAGNOSTIC RADIOLOGY	SK013							
75662	ARTERY X-RAYS HEAD & NECK	CARDIOLOGY	SK013							
75665	ARTERY X-RAYS HEAD & NECK	DIAGNOSTIC RADIOLOGY	SK013							
75671	ARTERY X-RAYS HEAD & NECK	DIAGNOSTIC RADIOLOGY	SK013							
75676	ARTERY X-RAYS NECK	DIAGNOSTIC RADIOLOGY	SK013							
75680	ARTERY X-RAYS NECK	CARDIOLOGY	SK013							
75685	ARTERY X-RAYS SPINE	DIAGNOSTIC RADIOLOGY	SK013							
75705	ARTERY X-RAYS SPINE	DIAGNOSTIC RADIOLOGY	SK013							
75710	ARTERY X-RAYS ARM/LEG	CARDIOLOGY	SK013							
75716	ARTERY X-RAYS ARMS/LEGS	CARDIOLOGY	SK013							
75726	ARTERY X-RAYS ABDOMEN	DIAGNOSTIC RADIOLOGY	SK013							
75731	ARTERY X-RAYS ADRENAL GLAND	CARDIOLOGY	SK013							
75733	ARTERY X-RAYS ADRENALS	CARDIOLOGY	SK013							
75736	ARTERY X-RAYS PELVIS	DIAGNOSTIC RADIOLOGY	SK013							
75741	ARTERY X-RAYS LUNG	DIAGNOSTIC RADIOLOGY	SK013							
75743	ARTERY X-RAYS LUNGS	DIAGNOSTIC RADIOLOGY	SK013							
75746	ARTERY X-RAYS LUNG	DIAGNOSTIC RADIOLOGY	SK013							
75756	ARTERY X-RAYS CHEST	CARDIOLOGY	SK013							
75774	ARTERY X-RAY EACH VESSEL	DIAGNOSTIC RADIOLOGY								
75791	AV DIALYSIS SHUNT IMAGING	NEPHROLOGY	SK013							
75809	NONVASCULAR SHUNT X-RAY	DIAGNOSTIC RADIOLOGY	SK013							
75820	VEIN X-RAY ARM/LEG	CARDIOLOGY	SK013							
75822	VEIN X-RAY ARMS/LEGS	DIAGNOSTIC RADIOLOGY	SK013							
75825	VEIN X-RAY TRUNK	DIAGNOSTIC RADIOLOGY	SK013							
75827	VEIN X-RAY CHEST	DIAGNOSTIC RADIOLOGY	SK013							
75831	VEIN X-RAY KIDNEY	DIAGNOSTIC RADIOLOGY	SK013							
75833	VEIN X-RAY KIDNEYS	DIAGNOSTIC RADIOLOGY	SK013							
75840	VEIN X-RAY ADRENAL GLAND	VASCULAR SURGERY	SK013							
75842	VEIN X-RAY ADRENAL GLANDS	DIAGNOSTIC RADIOLOGY	SK013							
75860	VEIN X-RAY NECK	CARDIOLOGY	SK013							
75870	VEIN X-RAY SKULL	DIAGNOSTIC RADIOLOGY	SK013							
75872	VEIN X-RAY SKULL	NEUROSURGERY	SK013							
75880	VEIN X-RAY EYE SOCKET	NEUROLOGY	SK013							
75885	VEIN X-RAY LIVER	DIAGNOSTIC RADIOLOGY	SK013							
75887	VEIN X-RAY LIVER	DIAGNOSTIC RADIOLOGY	SK013							
75889	VEIN X-RAY LIVER	DIAGNOSTIC RADIOLOGY	SK013							
75891	VEIN X-RAY LIVER	DIAGNOSTIC RADIOLOGY	SK013							
75893	VENOUS SAMPLING BY CATHETER	DIAGNOSTIC RADIOLOGY	SK013							
75901	REMOVE CVA DEVICE OBSTRUCT	DIAGNOSTIC RADIOLOGY								
75902	REMOVE CVA LUMEN OBSTRUCT	DIAGNOSTIC RADIOLOGY								
75960	TRANSCATH IV STENT RS&I	CARDIOLOGY								
75961	RETRIEVAL BROKEN CATHETER	DIAGNOSTIC RADIOLOGY	SK013							
75962	REPAIR ARTERIAL BLOCKAGE	CARDIOLOGY	SK013							
75964	REPAIR ARTERY BLOCKAGE EACH	VASCULAR SURGERY								
75966	REPAIR ARTERIAL BLOCKAGE	CARDIOLOGY	SK013							
75968	REPAIR ARTERY BLOCKAGE EACH	CARDIOLOGY								
75978	REPAIR VENOUS BLOCKAGE	DIAGNOSTIC RADIOLOGY	SK013							
75984	XRAY CONTROL CATHETER CHANGE	DIAGNOSTIC RADIOLOGY	SK013							
75989	ABSCCESS DRAINAGE UNDER X-RAY	DIAGNOSTIC RADIOLOGY	SK013							

CPT Code	Short Descriptor	Top Specialty	SK013 - computer media, dvd	SK014 - computer media, floppy disk 144mb	SK015 - computer media, optical disk 128mb	SK016 - computer media, optical disk 26gb	SK022 - film, 8inx10in (ultrasound, MRI)	SK025 - film, dry, radiographic, 8in x 10in	SK028 - film, fluoroscopic 14 x 17	SK033 - film, x-ray 10in x 12in
76000	FLUOROSCOPE EXAMINATION	DIAGNOSTIC RADIOLOGY							SK028	
76010	X-RAY NOSE TO RECTUM	DIAGNOSTIC RADIOLOGY								SK033
76080	X-RAY EXAM OF FISTULA	DIAGNOSTIC RADIOLOGY	SK013							
76098	X-RAY EXAM BREAST SPECIMEN	DIAGNOSTIC RADIOLOGY								
76120	CINE/VIDEO X-RAYS	IDTF								
76376	3D RENDER W/O POSTPROCESS	DIAGNOSTIC RADIOLOGY								
76377	3D RENDERING W/POSTPROCESS	DIAGNOSTIC RADIOLOGY								
76380	CAT SCAN FOLLOW-UP STUDY	DIAGNOSTIC RADIOLOGY	SK013							
76390	MR SPECTROSCOPY	DIAGNOSTIC RADIOLOGY	SK013							
76506	ECHO EXAM OF HEAD	DIAGNOSTIC RADIOLOGY					SK022			
76536	US EXAM OF HEAD AND NECK	DIAGNOSTIC RADIOLOGY					SK022			
76604	US EXAM CHEST	DIAGNOSTIC RADIOLOGY								
76645	US EXAM BREAST(S)	DIAGNOSTIC RADIOLOGY								
76700	US EXAM ABDOM COMPLETE	DIAGNOSTIC RADIOLOGY					SK022			
76705	ECHO EXAM OF ABDOMEN	DIAGNOSTIC RADIOLOGY								
76770	US EXAM ABDO BACK WALL COMP	DIAGNOSTIC RADIOLOGY					SK022			
76775	US EXAM ABDO BACK WALL LIM	DIAGNOSTIC RADIOLOGY								
76776	US EXAM K TRANSPL W/DOPPLER	DIAGNOSTIC RADIOLOGY								
76800	US EXAM SPINAL CANAL	GENERAL PRACTICE								
76801	OB US < 14 WKS SINGLE FETUS	DIAGNOSTIC RADIOLOGY					SK022			
76830	TRANSVAGINAL US NON-OB	DIAGNOSTIC RADIOLOGY					SK022			
76856	US EXAM PELVIC COMPLETE	DIAGNOSTIC RADIOLOGY					SK022			
76857	US EXAM PELVIC LIMITED	UROLOGY					SK022			
76870	US EXAM SCROTUM	DIAGNOSTIC RADIOLOGY					SK022			
76872	US TRANSRECTAL	UROLOGY					SK022			
76873	ECHOGRAP TRANS R PROS STUDY	RADIATION ONCOLOGY					SK022			
76881	US XTR NON-VASC COMPLETE	PODIATRY								
76885	US EXAM INFANT HIPS DYNAMIC	DIAGNOSTIC RADIOLOGY					SK022			
76886	US EXAM INFANT HIPS STATIC	DIAGNOSTIC RADIOLOGY								
76936	ECHO GUIDE FOR ARTERY REPAIR	DIAGNOSTIC RADIOLOGY								
76937	US GUIDE VASCULAR ACCESS	DIAGNOSTIC RADIOLOGY								
76942	ECHO GUIDE FOR BIOPSY	DIAGNOSTIC RADIOLOGY					SK022			
76970	ULTRASOUND EXAM FOLLOW-UP	GENERAL SURGERY								
77001	FLUOROGUIDE FOR VEIN DEVICE	DIAGNOSTIC RADIOLOGY								
77002	NEEDLE LOCALIZATION BY XRAY	DIAGNOSTIC RADIOLOGY	SK013						SK028	
77003	FLUOROGUIDE FOR SPINE INJECT	ANESTHESIOLOGY							SK028	
77011	CT SCAN FOR LOCALIZATION	DIAGNOSTIC RADIOLOGY	SK013							
77012	CT SCAN FOR NEEDLE BIOPSY	DIAGNOSTIC RADIOLOGY	SK013							
77014	CT SCAN FOR THERAPY GUIDE	RADIATION ONCOLOGY	SK013							
77021	MR GUIDANCE FOR NEEDLE PLACE	DIAGNOSTIC RADIOLOGY								
77031	STEREOTACT GUIDE FOR BRST BX	DIAGNOSTIC RADIOLOGY								
77032	GUIDANCE FOR NEEDLE BREAST	DIAGNOSTIC RADIOLOGY								
77051	COMPUTER DX MAMMOGRAM ADD-ON	DIAGNOSTIC RADIOLOGY								
77052	COMP SCREEN MAMMOGRAM ADD-ON	DIAGNOSTIC RADIOLOGY								
77053	X-RAY OF MAMMARY DUCT	DIAGNOSTIC RADIOLOGY								
77054	X-RAY OF MAMMARY DUCTS	DIAGNOSTIC RADIOLOGY								
77055	MAMMOGRAM ONE BREAST	DIAGNOSTIC RADIOLOGY								
77056	MAMMOGRAM BOTH BREASTS	DIAGNOSTIC RADIOLOGY								
77057	MAMMOGRAM SCREENING	DIAGNOSTIC RADIOLOGY								
77058	MRI ONE BREAST	DIAGNOSTIC RADIOLOGY	SK013							
77059	MRI BOTH BREASTS	DIAGNOSTIC RADIOLOGY	SK013							
77071	X-RAY STRESS VIEW	ORTHOPEDIC SURGERY								SK033
77072	X-RAYS FOR BONE AGE	DIAGNOSTIC RADIOLOGY								
77073	X-RAYS BONE LENGTH STUDIES	ORTHOPEDIC SURGERY								
77074	X-RAYS BONE SURVEY LIMITED	DIAGNOSTIC RADIOLOGY								SK033
77075	X-RAYS BONE SURVEY COMPLETE	DIAGNOSTIC RADIOLOGY								SK033
77076	X-RAYS BONE SURVEY INFANT	DIAGNOSTIC RADIOLOGY								SK033
77077	JOINT SURVEY SINGLE VIEW	ORTHOPEDIC SURGERY								SK033
77084	MAGNETIC IMAGE BONE MARROW	DIAGNOSTIC RADIOLOGY								
77280	SET RADIATION THERAPY FIELD	RADIATION ONCOLOGY								
77285	SET RADIATION THERAPY FIELD	RADIATION ONCOLOGY								
77290	SET RADIATION THERAPY FIELD	RADIATION ONCOLOGY								
77301	RADIOTHERAPY DOSE PLAN IMRT	RADIATION ONCOLOGY		SK014				SK025		
77336	RADIATION PHYSICS CONSULT	RADIATION ONCOLOGY								
77370	RADIATION PHYSICS CONSULT	RADIATION ONCOLOGY								
77371	SRS MULTISOURCE	NEUROSURGERY								
77372	SRS LINEAR BASED	RADIATION ONCOLOGY								
77417	RADIOLOGY PORT FILM(S)	RADIATION ONCOLOGY								
77418	RADIATION TX DELIVERY IMRT	RADIATION ONCOLOGY								
77422	NEUTRON BEAM TX SIMPLE	RADIATION ONCOLOGY								
77423	NEUTRON BEAM TX COMPLEX	RADIATION ONCOLOGY								
78006	THYROID IMAGING WITH UPTAKE	DIAGNOSTIC RADIOLOGY								
78007	THYROID IMAGE MULT UPTAKES	DIAGNOSTIC RADIOLOGY								
78010	THYROID IMAGING	DIAGNOSTIC RADIOLOGY								
78011	THYROID IMAGING WITH FLOW	DIAGNOSTIC RADIOLOGY								
78015	THYROID MET IMAGING	DIAGNOSTIC RADIOLOGY								
78016	THYROID MET IMAGING/STUDIES	NUCLEAR MEDICINE								

CPT Code	Short Descriptor	Top Specialty	SK013 - computer media, dvd	SK014 - computer media, floppy disk 144mb	SK015 - computer media, optical disk 128mb	SK016 - computer media, optical disk 26gb	SK022 - film, 8inx10in (ultrasound, MRI)	SK025 - film, dry, radiographic, 8in x 10in	SK028 - film, fluoroscopic 14 x 17	SK033 - film, x-ray 10in x 12in
78018	THYROID MET IMAGING BODY	DIAGNOSTIC RADIOLOGY								
78020	THYROID MET UPTAKE	DIAGNOSTIC RADIOLOGY								
78070	PARATHYROID NUCLEAR IMAGING	DIAGNOSTIC RADIOLOGY								
78075	ADRENAL NUCLEAR IMAGING	DIAGNOSTIC RADIOLOGY								
78102	BONE MARROW IMAGING LTD	DIAGNOSTIC RADIOLOGY								
78103	BONE MARROW IMAGING MULT	DIAGNOSTIC RADIOLOGY								
78104	BONE MARROW IMAGING BODY	DIAGNOSTIC RADIOLOGY								
78135	RED CELL SURVIVAL KINETICS	DIAGNOSTIC RADIOLOGY								
78140	RED CELL SEQUESTRATION	DIAGNOSTIC RADIOLOGY								
78185	SPLEEN IMAGING	DIAGNOSTIC RADIOLOGY								
78190	PLATELET SURVIVAL KINETICS	DIAGNOSTIC RADIOLOGY								
78195	LYMPH SYSTEM IMAGING	DIAGNOSTIC RADIOLOGY								
78201	LIVER IMAGING	DIAGNOSTIC RADIOLOGY								
78202	LIVER IMAGING WITH FLOW	DIAGNOSTIC RADIOLOGY								
78205	LIVER IMAGING (3D)	DIAGNOSTIC RADIOLOGY								
78206	LIVER IMAGE (3D) WITH FLOW	DIAGNOSTIC RADIOLOGY		SK014						
78215	LIVER AND SPLEEN IMAGING	DIAGNOSTIC RADIOLOGY								
78216	LIVER & SPLEEN IMAGE/FLOW	DIAGNOSTIC RADIOLOGY								
78226	HEPATOBIILIARY SYSTEM IMAGING	DIAGNOSTIC RADIOLOGY								
78227	HEPATOBIL SYST IMAGE W/DRUG	DIAGNOSTIC RADIOLOGY								
78230	SALIVARY GLAND IMAGING	DIAGNOSTIC RADIOLOGY								
78231	SERIAL SALIVARY IMAGING	NUCLEAR MEDICINE								
78232	SALIVARY GLAND FUNCTION EXAM	NUCLEAR MEDICINE								
78258	ESOPHAGEAL MOTILITY STUDY	DIAGNOSTIC RADIOLOGY								
78261	GASTRIC MUCOSA IMAGING	DIAGNOSTIC RADIOLOGY								
78262	GASTROESOPHAGEAL REFLUX EXAM	DIAGNOSTIC RADIOLOGY								
78264	GASTRIC EMPTYING STUDY	DIAGNOSTIC RADIOLOGY								
78278	ACUTE GI BLOOD LOSS IMAGING	DIAGNOSTIC RADIOLOGY								
78290	MECKELS DIVERT EXAM	DIAGNOSTIC RADIOLOGY								
78291	LEVEEN/SHUNT PATENCY EXAM	DIAGNOSTIC RADIOLOGY								
78300	BONE IMAGING LIMITED AREA	DIAGNOSTIC RADIOLOGY								
78305	BONE IMAGING MULTIPLE AREAS	DIAGNOSTIC RADIOLOGY								
78306	BONE IMAGING WHOLE BODY	DIAGNOSTIC RADIOLOGY								
78315	BONE IMAGING 3 PHASE	DIAGNOSTIC RADIOLOGY								
78320	BONE IMAGING (3D)	DIAGNOSTIC RADIOLOGY								
78414	NON-IMAGING HEART FUNCTION	INTERNAL MEDICINE		SK014						
78428	CARDIAC SHUNT IMAGING	CARDIOLOGY								
78445	VASCULAR FLOW IMAGING	DIAGNOSTIC RADIOLOGY								
78451	HT MUSCLE IMAGE SPECT SING	CARDIOLOGY								
78452	HT MUSCLE IMAGE SPECT MULT	CARDIOLOGY								
78453	HT MUSCLE IMAGE PLANAR SING	CARDIOLOGY								
78454	HT MUSC IMAGE PLANAR MULT	CARDIOLOGY								
78456	ACUTE VENOUS THROMBUS IMAGE	DIAGNOSTIC RADIOLOGY								
78457	VENOUS THROMBOSIS IMAGING	CARDIOLOGY								
78458	VEN THROMBOSIS IMAGES BILAT	NUCLEAR MEDICINE								
78466	HEART INFARCT IMAGE	CARDIOLOGY								
78468	HEART INFARCT IMAGE (EF)	CARDIOLOGY								
78469	HEART INFARCT IMAGE (3D)	INTERNAL MEDICINE								
78472	GATED HEART PLANAR SINGLE	DIAGNOSTIC RADIOLOGY								
78473	GATED HEART MULTIPLE	CARDIOLOGY								
78481	HEART FIRST PASS SINGLE	CARDIOLOGY								
78483	HEART FIRST PASS MULTIPLE	CARDIOLOGY								
78494	HEART IMAGE SPECT	CARDIOLOGY								
78579	LUNG VENTILATION IMAGING	DIAGNOSTIC RADIOLOGY								
78580	LUNG PERFUSION IMAGING	DIAGNOSTIC RADIOLOGY								
78582	LUNG VENTILAT&PERFUS IMAGING	DIAGNOSTIC RADIOLOGY								
78597	LUNG PERFUSION DIFFERENTIAL	DIAGNOSTIC RADIOLOGY								
78598	LUNG PERF&VENTILAT DIFERENTL	DIAGNOSTIC RADIOLOGY								
78600	BRAIN IMAGE < 4 VIEWS	DIAGNOSTIC RADIOLOGY								
78601	BRAIN IMAGE W/FLOW < 4 VIEWS	DIAGNOSTIC RADIOLOGY								
78605	BRAIN IMAGE 4+ VIEWS	DIAGNOSTIC RADIOLOGY								
78606	BRAIN IMAGE W/FLOW 4 + VIEWS	DIAGNOSTIC RADIOLOGY								
78607	BRAIN IMAGING (3D)	DIAGNOSTIC RADIOLOGY		SK014						
78610	BRAIN FLOW IMAGING ONLY	DIAGNOSTIC RADIOLOGY								
78630	CEREBROSPINAL FLUID SCAN	DIAGNOSTIC RADIOLOGY								
78635	CSF VENTRICULOGRAPHY	DIAGNOSTIC RADIOLOGY								
78645	CSF SHUNT EVALUATION	DIAGNOSTIC RADIOLOGY								
78647	CEREBROSPINAL FLUID SCAN	DIAGNOSTIC RADIOLOGY		SK014						
78650	CSF LEAKAGE IMAGING	DIAGNOSTIC RADIOLOGY								
78660	NUCLEAR EXAM OF TEAR FLOW	DIAGNOSTIC RADIOLOGY								
78700	KIDNEY IMAGING MORPHOL	DIAGNOSTIC RADIOLOGY								
78701	KIDNEY IMAGING WITH FLOW	DIAGNOSTIC RADIOLOGY								
78707	K FLOW/FUNCT IMAGE W/O DRUG	DIAGNOSTIC RADIOLOGY								
78708	K FLOW/FUNCT IMAGE W/DRUG	DIAGNOSTIC RADIOLOGY								
78709	K FLOW/FUNCT IMAGE MULTIPLE	DIAGNOSTIC RADIOLOGY								
78710	KIDNEY IMAGING (3D)	DIAGNOSTIC RADIOLOGY								
78730	Urinary bladder retention	UROLOGY								

CPT Code	Short Descriptor	Top Specialty	SK013 - computer media, dvd	SK014 - computer media, floppy disk 144mb	SK015 - computer media, optical disk 128mb	SK016 - computer media, optical disk 26gb	SK022 - film, 8inx10in (ultrasound, MRI)	SK025 - film, dry, radiographic, 8in x 10in	SK028 - film, fluoroscopic 14 x 17	SK033 - film, x-ray 10in x 12in
78740	URETERAL REFLUX STUDY	UROLOGY								
78761	TESTICULAR IMAGING W/FLOW	DIAGNOSTIC RADIOLOGY								
78800	TUMOR IMAGING LIMITED AREA	DIAGNOSTIC RADIOLOGY								
78801	TUMOR IMAGING MULT AREAS	DIAGNOSTIC RADIOLOGY								
78802	TUMOR IMAGING WHOLE BODY	DIAGNOSTIC RADIOLOGY								
78803	TUMOR IMAGING (3D)	DIAGNOSTIC RADIOLOGY		SK014						
78804	TUMOR IMAGING WHOLE BODY	DIAGNOSTIC RADIOLOGY								
78805	ABSCCESS IMAGING LTD AREA	DIAGNOSTIC RADIOLOGY								
78806	ABSCCESS IMAGING WHOLE BODY	DIAGNOSTIC RADIOLOGY								
78807	NUCLEAR LOCALIZATION/ABSCCESS	DIAGNOSTIC RADIOLOGY		SK014						
78811	PET IMAGE LTD AREA	DIAGNOSTIC RADIOLOGY								
78812	PET IMAGE SKULL-THIGH	DIAGNOSTIC RADIOLOGY								
78813	PET IMAGE FULL BODY	DIAGNOSTIC RADIOLOGY								
78814	PET IMAGE W/CT LMTD	DIAGNOSTIC RADIOLOGY								
78815	PET IMAGE W/CT SKULL-THIGH	DIAGNOSTIC RADIOLOGY								
78816	PET IMAGE W/CT FULL BODY	DIAGNOSTIC RADIOLOGY								
79440	Nuclear rx intra-articular	FAMILY PRACTICE								
93303	ECHO TRANSTHORACIC	CARDIOLOGY			SK015					
93304	ECHO TRANSTHORACIC	CARDIOLOGY			SK015					
93306	TTE W/DOPPLER COMPLETE	CARDIOLOGY			SK015					
93307	TTE W/O DOPPLER COMPLETE	CARDIOLOGY			SK015					
93308	TTE F-UP OR LMTD	CARDIOLOGY								
93312	ECHO TRANSESOPHAGEAL	CARDIOLOGY								
93314	ECHO TRANSESOPHAGEAL	CARDIOLOGY								
93350	STRESS TTE ONLY	CARDIOLOGY			SK015					
93351	Stress tte complete	CARDIOLOGY			SK015					
93451	Right heart cath	CARDIOLOGY	SK013							
93452	Left hrt cath w/ventrclgrphy	CARDIOLOGY	SK013							
93453	R&l hrt cath w/ventriclgrphy	CARDIOLOGY	SK013							
93454	Coronary artery angio s&i	CARDIOLOGY	SK013							
93455	Coronary art/grft angio s&i	CARDIOLOGY	SK013							
93456	R hrt coronary artery angio	CARDIOLOGY	SK013							
93457	R hrt art/grft angio	CARDIOLOGY	SK013							
93458	L hrt artery/ventricle angio	CARDIOLOGY	SK013							
93459	L hrt art/grft angio	CARDIOLOGY	SK013							
93460	R&l hrt art/ventricle angio	CARDIOLOGY	SK013							
93461	R&l hrt art/ventricle angio	CARDIOLOGY	SK013							
93566	INJECT R VENTR/ATRIAL ANGIO	CARDIOLOGY								
93567	INJECT SUPRVLV AORTOGRAPHY	CARDIOLOGY								
93568	INJECT PULM ART HRT CATH	CARDIOLOGY								
93880	EXTRACRANIAL STUDY	DIAGNOSTIC RADIOLOGY					SK022			
93882	EXTRACRANIAL STUDY	VASCULAR SURGERY							SK022	
93886	INTRACRANIAL STUDY	NEUROLOGY							SK022	
93888	INTRACRANIAL STUDY	NEUROLOGY							SK022	
93890	TCD VASOREACTIVITY STUDY	DIAGNOSTIC RADIOLOGY								
93892	TCD EMBOLI DETECT W/O INJ	NEUROLOGY								
93893	TCD EMBOLI DETECT W/INJ	NEUROLOGY								
93925	LOWER EXTREMITY STUDY	DIAGNOSTIC RADIOLOGY						SK022		
93926	LOWER EXTREMITY STUDY	VASCULAR SURGERY							SK022	
93930	UPPER EXTREMITY STUDY	DIAGNOSTIC RADIOLOGY							SK022	
93931	UPPER EXTREMITY STUDY	VASCULAR SURGERY							SK022	
93970	EXTREMITY STUDY	DIAGNOSTIC RADIOLOGY							SK022	
93971	EXTREMITY STUDY	DIAGNOSTIC RADIOLOGY							SK022	
93975	VASCULAR STUDY	DIAGNOSTIC RADIOLOGY							SK022	
93976	VASCULAR STUDY	DIAGNOSTIC RADIOLOGY							SK022	
93978	VASCULAR STUDY	CARDIOLOGY							SK022	
93979	VASCULAR STUDY	CARDIOLOGY							SK022	
93980	PENILE VASCULAR STUDY	UROLOGY								
93981	PENILE VASCULAR STUDY	UROLOGY								
93990	DOPPLER FLOW TESTING	VASCULAR SURGERY						SK022		
G0106	COLON CA SCREEN;BARIUM ENEMA	DIAGNOSTIC RADIOLOGY								SK033
G0120	COLON CA SCRNI; BARIUM ENEMA	DIAGNOSTIC RADIOLOGY								SK033
G0122	COLON CA SCRNI; BARIUM ENEMA	NA								SK033
G0288	RECON, CTA FOR SURG PLAN	VASCULAR SURGERY								
G0365	VESSEL MAPPING HEMO ACCESS	VASCULAR SURGERY						SK022		
G0389	ULTRASOUND EXAM AAA SCREEN	DIAGNOSTIC RADIOLOGY								

CPT Code	Short Descriptor	Top Specialty	SK034 - film, x-ray 14in x 17in	SK035 - film, x-ray 14in x 36in	SK037 - film, x-ray 8in x 10in	SK038 - film, x-ray 8in x 10in (X-omat, Radiomat)	SK086 - video tape, VHS	SK089 - x-ray developer solution	SK090 x-ray digitalization separator sheet	SK091 - x-ray envelope
15732	MUSCLE-SKIN GRAFT HEAD/NECK	RECONSTRUCTIVE SURGERY								
15734	MUSCLE-SKIN GRAFT TRUNK	RECONSTRUCTIVE SURGERY								
15736	MUSCLE-SKIN GRAFT ARM	RECONSTRUCTIVE SURGERY								
15738	MUSCLE-SKIN GRAFT LEG	RECONSTRUCTIVE SURGERY								
22520	Percut vertebroplasty thor	DIAGNOSTIC RADIOLOGY								
22521	Percut vertebroplasty lumb	DIAGNOSTIC RADIOLOGY								
22523	Percut kyphoplasty thor	ORTHOPEDIC SURGERY								
22524	Percut kyphoplasty lumbar	ORTHOPEDIC SURGERY								
22526	Idet single level									
27096	INJECT SACROILIAC JOINT	ANESTHESIOLOGY								
36147	ACCESS AV DIAL GRFT FOR EVAL	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
36251	INS CATH REN ART 1ST UNILAT	CARDIOLOGY	SK034					SK089		SK091
36252	INS CATH REN ART 1ST BILAT	CARDIOLOGY	SK034					SK089		SK091
36253	INS CATH REN ART 2ND+ UNILAT	CARDIOLOGY	SK034					SK089		SK091
36254	INS CATH REN ART 2ND+ BILAT	CARDIOLOGY	SK034					SK089		SK091
36475	ENDOVENOUS RF 1ST VEIN	GENERAL SURGERY					SK086			
36478	ENDOVENOUS LASER 1ST VEIN	VASCULAR SURGERY					SK086			
36598	INJ W/FLUOR EVAL CV DEVICE	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
37184	PRIM ART MECH THROMBECTOMY	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
37185	PRIM ART M-THROMBECT ADD-ON	VASCULAR SURGERY	SK034							
37186	SEC ART M-THROMBECT ADD-ON	CARDIOLOGY	SK034							
37187	VENOUS MECH THROMBECTOMY	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
37188	VENOUS M-THROMBECTOMY ADD-ON	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
37191	INS ENDOVAS VENA CAVA FILTR	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
37192	REDO ENDOVAS VENA CAVA FILTR	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
37193	REM ENDOVAS VENA CAVA FILTER	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
37210	EMBOLIZATION UTERINE FIBROID	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
37220	ILIAC REVASC	VASCULAR SURGERY	SK034					SK089		SK091
37221	ILIAC REVASC W/STENT	VASCULAR SURGERY	SK034					SK089		SK091
37222	ILIAC REVASC ADD-ON	VASCULAR SURGERY	SK034					SK089		
37223	ILIAC REVASC W/STENT ADD-ON	VASCULAR SURGERY	SK034					SK089		
37224	FEM/POPL REVAS W/TLA	VASCULAR SURGERY	SK034					SK089		SK091
37225	FEM/POPL REVAS W/ATHER	CARDIOLOGY	SK034					SK089		SK091
37226	FEM/POPL REVASC W/STENT	CARDIOLOGY	SK034					SK089		SK091
37227	FEM/POPL REVASC STNT & ATHER	CARDIOLOGY	SK034					SK089		SK091
37228	TIB/PER REVASC W/TLA	VASCULAR SURGERY	SK034					SK089		SK091
37229	TIB/PER REVASC W/ATHER	CARDIOLOGY	SK034					SK089		SK091
37230	TIB/PER REVASC W/STENT	CARDIOLOGY	SK034					SK089		SK091
37231	TIB/PER REVASC STENT & ATHER	CARDIOLOGY	SK034					SK089		SK091
37232	TIB/PER REVASC ADD-ON	VASCULAR SURGERY	SK034					SK089		
37233	TIBPER REVASC W/ATHER ADD-ON	CARDIOLOGY	SK034					SK089		
37234	REVSC OPN/PRQ TIB/PERO STENT	CARDIOLOGY	SK034					SK089		
37235	TIB/PER REVASC STNT & ATHER	CARDIOLOGY	SK034					SK089		
38790	INJECT FOR LYMPHATIC X-RAY	GENERAL SURGERY								
43756	DX DUOD INTUB W/ASP SPEC	GASTROENTEROLOGY								
43757	DX DUOD INTUB W/ASP SPECS	GASTROENTEROLOGY								
49083	ABD PARACENTESIS W/IMAGING	DIAGNOSTIC RADIOLOGY								
49418	INSERT TUN IP CATH PERC	DIAGNOSTIC RADIOLOGY								
49440	PLACE GASTROSTOMY TUBE PERC	DIAGNOSTIC RADIOLOGY	SK034					SK089		
49441	PLACE DUOD/JEJ TUBE PERC	DIAGNOSTIC RADIOLOGY	SK034					SK089		
49442	PLACE CECOSTOMY TUBE PERC	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
49446	CHANGE G-TUBE TO G-J PERC	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
49450	REPLACE G/C TUBE PERC	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
49451	REPLACE DUOD/JEJ TUBE PERC	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
49452	REPLACE G-J TUBE PERC	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
49460	FIX G/COLON TUBE W/DEVICE	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
49465	FLUORO EXAM OF G/COLON TUBE	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
50382	CHANGE URETER STENT PERCUT	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
50384	REMOVE URETER STENT PERCUT	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
50385	CHANGE STENT VIA TRANSURETH	UROLOGY	SK034					SK089		SK091
50386	REMOVE STENT VIA TRANSURETH	UROLOGY	SK034					SK089		SK091
50387	CHANGE EXT/INT URETER STENT	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
50389	REMOVE RENAL TUBE W/FLUORO	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
51605	PREPARATION FOR BLADDER XRAY	UROLOGY								
62263	EPIDURAL LYSIS MULT SESSIONS	INTERVENTIONAL PAIN MANAGEMENT	SK034							
62264	Epidural lysis on single day	ANESTHESIOLOGY								
63661	Remove spine eltrd perq aray	MANAGEMENT								
63663	Revise spine eltrd perq aray	MANAGEMENT								
64479	INJ FORAMEN EPIDURAL C/T	MANAGEMENT								
64480	Inj foramen epidural add-on	NEUROSURGERY								
64483	INJ FORAMEN EPIDURAL L/S	MANAGEMENT								
64484	Inj foramen epidural add-on	MANAGEMENT								
64490	INJ PARAVERT F JNT C/T 1 LEV	MANAGEMENT								
64493	INJ PARAVERT F JNT L/S 1 LEV	MANAGEMENT								
64633	DESTROY CERV/THOR FACET JNT	MANAGEMENT								
64634	DESTROY C/TH FACET JNT ADDL	MANAGEMENT								



CPT Code	Short Descriptor	Top Specialty	SK034 - film, x-ray 14in x 17in	SK035 - film, x-ray 14in x 36in	SK037 - film, x-ray 8in x 10in	SK038 - film, x-ray 8in x 10in (X-omat, Radiomat)	SK086 - video tape, VHS	SK089 - x-ray developer solution	SK090 x-ray digitalization separator sheet	SK091 - x-ray envelope
64635	DESTROY LUMB/SAC FACET JNT	MANAGEMENT								
64636	DESTROY L/S FACET JNT ADDL	MANAGEMENT								
70010	CONTRAST X-RAY OF BRAIN	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
70015	CONTRAST X-RAY OF BRAIN	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
70030	X-RAY EYE FOR FOREIGN BODY	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
70100	X-RAY EXAM OF JAW	FAMILY PRACTICE			SK037			SK089		SK091
70110	X-RAY EXAM OF JAW	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
70120	X-RAY EXAM OF MASTOIDS	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
70130	X-RAY EXAM OF MASTOIDS	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
70134	X-RAY EXAM OF MIDDLE EAR	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
70140	X-RAY EXAM OF FACIAL BONES	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
70150	X-RAY EXAM OF FACIAL BONES	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
70160	X-RAY EXAM OF NASAL BONES	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
70190	X-RAY EXAM OF EYE SOCKETS	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
70200	X-RAY EXAM OF EYE SOCKETS	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
70210	X-RAY EXAM OF SINUSES	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
70220	X-RAY EXAM OF SINUSES	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
70240	X-RAY EXAM PITUITARY SADDLE	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
70250	X-RAY EXAM OF SKULL	DIAGNOSTIC RADIOLOGY						SK089		SK091
70260	X-RAY EXAM OF SKULL	DIAGNOSTIC RADIOLOGY						SK089		SK091
70328	X-RAY EXAM OF JAW JOINT	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
70330	X-RAY EXAM OF JAW JOINTS	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
70336	MAGNETIC IMAGE JAW JOINT	DIAGNOSTIC RADIOLOGY	SK034							SK091
70360	X-RAY EXAM OF NECK	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
70370	THROAT X-RAY & FLUOROSCOPY	FAMILY PRACTICE						SK089		SK091
70371	SPEECH EVALUATION COMPLEX	DIAGNOSTIC RADIOLOGY					SK086			
70373	CONTRAST X-RAY OF LARYNX	FAMILY PRACTICE						SK089		SK091
70390	X-RAY EXAM OF SALIVARY DUCT	DIAGNOSTIC RADIOLOGY						SK089		SK091
70450	CT HEAD/BRAIN W/O DYE	DIAGNOSTIC RADIOLOGY								SK091
70460	CT HEAD/BRAIN W/DYE	DIAGNOSTIC RADIOLOGY								SK091
70470	CT HEAD/BRAIN W/O & W/DYE	DIAGNOSTIC RADIOLOGY								SK091
70480	CT ORBIT/EAR/FOSSA W/O DYE	DIAGNOSTIC RADIOLOGY								SK091
70481	CT ORBIT/EAR/FOSSA W/DYE	DIAGNOSTIC RADIOLOGY								SK091
70482	CT ORBIT/EAR/FOSSA W/O&W/DYE	DIAGNOSTIC RADIOLOGY								SK091
70486	CT MAXILLOFACIAL W/O DYE	DIAGNOSTIC RADIOLOGY								SK091
70487	CT MAXILLOFACIAL W/DYE	DIAGNOSTIC RADIOLOGY								SK091
70488	CT MAXILLOFACIAL W/O & W/DYE	DIAGNOSTIC RADIOLOGY								SK091
70490	CT SOFT TISSUE NECK W/O DYE	DIAGNOSTIC RADIOLOGY								SK091
70491	CT SOFT TISSUE NECK W/DYE	DIAGNOSTIC RADIOLOGY								SK091
70492	CT SFT TSUE NCK W/O & W/DYE	DIAGNOSTIC RADIOLOGY								SK091
70496	CT ANGIOGRAPHY HEAD	DIAGNOSTIC RADIOLOGY	SK034							SK091
70498	CT ANGIOGRAPHY NECK	DIAGNOSTIC RADIOLOGY	SK034							SK091
70540	MRI ORBIT/FACE/NECK W/O DYE	DIAGNOSTIC RADIOLOGY	SK034							SK091
70542	MRI ORBIT/FACE/NECK W/DYE	DIAGNOSTIC RADIOLOGY								SK091
70543	MRI ORBT/FAC/NCK W/O & W/DYE	DIAGNOSTIC RADIOLOGY								SK091
70544	MR ANGIOGRAPHY HEAD W/O DYE	DIAGNOSTIC RADIOLOGY	SK034							SK091
70545	MR ANGIOGRAPHY HEAD W/DYE	DIAGNOSTIC RADIOLOGY	SK034							SK091
70546	MR ANGIOGRAPH HEAD W/O&W/DYE	DIAGNOSTIC RADIOLOGY	SK034							SK091
70547	MR ANGIOGRAPHY NECK W/O DYE	DIAGNOSTIC RADIOLOGY	SK034							SK091
70548	MR ANGIOGRAPHY NECK W/DYE	DIAGNOSTIC RADIOLOGY	SK034							SK091
70549	MR ANGIOGRAPH NECK W/O&W/DYE	DIAGNOSTIC RADIOLOGY	SK034							SK091
70551	MRI BRAIN W/O DYE	DIAGNOSTIC RADIOLOGY	SK034							SK091
70552	MRI BRAIN W/DYE	DIAGNOSTIC RADIOLOGY								SK091
70553	MRI BRAIN W/O & W/DYE	DIAGNOSTIC RADIOLOGY								SK091
70554	FMRI BRAIN BY TECH	DIAGNOSTIC RADIOLOGY								SK091
71010	CHEST X-RAY	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
71015	CHEST X-RAY	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
71020	CHEST X-RAY	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
71021	CHEST X-RAY	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
71022	CHEST X-RAY	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
71023	CHEST X-RAY AND FLUOROSCOPY	DIAGNOSTIC RADIOLOGY	SK034		SK037			SK089		SK091
71030	CHEST X-RAY	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
71034	CHEST X-RAY AND FLUOROSCOPY	CARDIOLOGY	SK034		SK037			SK089		SK091
71035	CHEST X-RAY	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
71040	CONTRAST X-RAY OF BRONCHI	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
71060	CONTRAST X-RAY OF BRONCHI	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
71100	X-RAY EXAM OF RIBS	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
71101	X-RAY EXAM OF RIBS/CHEST	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
71110	X-RAY EXAM OF RIBS	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
71111	X-RAY EXAM OF RIBS/CHEST	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
71120	X-RAY EXAM OF BREASTBONE	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
71130	X-RAY EXAM OF BREASTBONE	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
71250	CT THORAX W/O DYE	DIAGNOSTIC RADIOLOGY								SK091
71260	CT THORAX W/DYE	DIAGNOSTIC RADIOLOGY								SK091
71270	CT THORAX W/O & W/DYE	DIAGNOSTIC RADIOLOGY								SK091
71275	CT ANGIOGRAPHY CHEST	DIAGNOSTIC RADIOLOGY	SK034							SK091
71550	MRI CHEST W/O DYE	DIAGNOSTIC RADIOLOGY	SK034							SK091



CPT Code	Short Descriptor	Top Specialty	SK034 - film, x-ray 14in x 17in	SK035 - film, x-ray 14in x 36in	SK037 - film, x-ray 8in x 10in	SK038 - film, x-ray 8in x 10in (X-omat, Radiomat)	SK086 - video tape, VHS	SK089 - x-ray developer solution	SK090 x-ray digitalization separator sheet	SK091 - x-ray envelope
71551	MRI CHEST W/DYE	DIAGNOSTIC RADIOLOGY								SK091
71552	MRI CHEST W/O & W/DYE	DIAGNOSTIC RADIOLOGY								SK091
71555	MRI ANGIO CHEST W OR W/O DYE	DIAGNOSTIC RADIOLOGY								SK091
72010	X-RAY EXAM OF SPINE	INTERNAL MEDICINE	SK034					SK089		SK091
72020	X-RAY EXAM OF SPINE	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
72040	X-RAY EXAM OF NECK SPINE	DIAGNOSTIC RADIOLOGY						SK089		SK091
72050	X-RAY EXAM OF NECK SPINE	DIAGNOSTIC RADIOLOGY						SK089		SK091
72052	X-RAY EXAM OF NECK SPINE	DIAGNOSTIC RADIOLOGY						SK089		SK091
72069	X-RAY EXAM OF TRUNK SPINE	DIAGNOSTIC RADIOLOGY		SK035				SK089		SK091
72070	X-RAY EXAM OF THORACIC SPINE	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
72072	X-RAY EXAM OF THORACIC SPINE	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
72074	X-RAY EXAM OF THORACIC SPINE	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
72080	X-RAY EXAM OF TRUNK SPINE	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
72090	X-RAY EXAM OF TRUNK SPINE	DIAGNOSTIC RADIOLOGY		SK035				SK089		SK091
72100	X-RAY EXAM OF LOWER SPINE	DIAGNOSTIC RADIOLOGY						SK089		
72110	X-RAY EXAM OF LOWER SPINE	DIAGNOSTIC RADIOLOGY						SK089		
72114	X-RAY EXAM OF LOWER SPINE	DIAGNOSTIC RADIOLOGY						SK089		
72120	X-RAY EXAM OF LOWER SPINE	ORTHOPEDIC SURGERY						SK089		
72125	CT NECK SPINE W/O DYE	DIAGNOSTIC RADIOLOGY								SK091
72126	CT NECK SPINE W/DYE	DIAGNOSTIC RADIOLOGY								SK091
72127	CT NECK SPINE W/O & W/DYE	DIAGNOSTIC RADIOLOGY								SK091
72128	CT CHEST SPINE W/O DYE	DIAGNOSTIC RADIOLOGY								SK091
72129	CT CHEST SPINE W/DYE	DIAGNOSTIC RADIOLOGY								SK091
72130	CT CHEST SPINE W/O & W/DYE	DIAGNOSTIC RADIOLOGY								SK091
72131	CT LUMBAR SPINE W/O DYE	DIAGNOSTIC RADIOLOGY								SK091
72132	CT LUMBAR SPINE W/DYE	DIAGNOSTIC RADIOLOGY								SK091
72133	CT LUMBAR SPINE W/O & W/DYE	DIAGNOSTIC RADIOLOGY								SK091
72141	MRI NECK SPINE W/O DYE	DIAGNOSTIC RADIOLOGY	SK034							SK091
72142	MRI NECK SPINE W/DYE	DIAGNOSTIC RADIOLOGY								SK091
72146	MRI CHEST SPINE W/O DYE	DIAGNOSTIC RADIOLOGY	SK034							SK091
72147	MRI CHEST SPINE W/DYE	DIAGNOSTIC RADIOLOGY								SK091
72148	MRI LUMBAR SPINE W/O DYE	DIAGNOSTIC RADIOLOGY	SK034							SK091
72149	MRI LUMBAR SPINE W/DYE	DIAGNOSTIC RADIOLOGY								SK091
72156	MRI NECK SPINE W/O & W/DYE	DIAGNOSTIC RADIOLOGY								SK091
72157	MRI CHEST SPINE W/O & W/DYE	DIAGNOSTIC RADIOLOGY								SK091
72158	MRI LUMBAR SPINE W/O & W/DYE	DIAGNOSTIC RADIOLOGY								SK091
72159	MR ANGIO SPINE W/O&W/DYE	DIAGNOSTIC RADIOLOGY								SK091
72170	X-RAY EXAM OF PELVIS	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
72190	X-RAY EXAM OF PELVIS	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
72191	CT ANGIOGRAPH PELV W/O&W/DYE	DIAGNOSTIC RADIOLOGY	SK034					SK089		
72192	CT PELVIS W/O DYE	DIAGNOSTIC RADIOLOGY								SK091
72193	CT PELVIS W/DYE	DIAGNOSTIC RADIOLOGY								SK091
72194	CT PELVIS W/O & W/DYE	DIAGNOSTIC RADIOLOGY								SK091
72195	MRI PELVIS W/O DYE	DIAGNOSTIC RADIOLOGY	SK034							SK091
72196	MRI PELVIS W/DYE	DIAGNOSTIC RADIOLOGY								SK091
72197	MRI PELVIS W/O & W/DYE	DIAGNOSTIC RADIOLOGY								SK091
72198	MR ANGIO PELVIS W/O & W/DYE	DIAGNOSTIC RADIOLOGY								SK091
72200	X-RAY EXAM SACROILIAC JOINTS	DIAGNOSTIC RADIOLOGY						SK089		SK091
72202	X-RAY EXAM SACROILIAC JOINTS	DIAGNOSTIC RADIOLOGY						SK089		SK091
72220	X-RAY EXAM OF TAILBONE	DIAGNOSTIC RADIOLOGY						SK089		SK091
72240	CONTRAST X-RAY OF NECK SPINE	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
72255	CONTRAST X-RAY THORAX SPINE	DIAGNOSTIC RADIOLOGY	SK034		SK037			SK089		SK091
72265	CONTRAST X-RAY LOWER SPINE	DIAGNOSTIC RADIOLOGY	SK034		SK037			SK089		SK091
72270	CONTRAST X-RAY SPINE	DIAGNOSTIC RADIOLOGY	SK034		SK037			SK089		SK091
72275	EPIDUROGRAPHY	MANAGEMENT			SK037			SK089		SK091
72285	X-RAY C/T SPINE DISK	MANAGEMENT			SK037			SK089		SK091
72295	X-RAY OF LOWER SPINE DISK	MANAGEMENT			SK037			SK089		SK091
73000	X-RAY EXAM OF COLLAR BONE	DIAGNOSTIC RADIOLOGY						SK089		SK091
73010	X-RAY EXAM OF SHOULDER BLADE	ORTHOPEDIC SURGERY						SK089		SK091
73020	X-RAY EXAM OF SHOULDER	DIAGNOSTIC RADIOLOGY						SK089		SK091
73030	X-RAY EXAM OF SHOULDER	DIAGNOSTIC RADIOLOGY						SK089		SK091
73040	CONTRAST X-RAY OF SHOULDER	DIAGNOSTIC RADIOLOGY						SK089		SK091
73050	X-RAY EXAM OF SHOULDERS	ORTHOPEDIC SURGERY	SK034					SK089		SK091
73060	X-RAY EXAM OF HUMERUS	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
73070	X-RAY EXAM OF ELBOW	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
73080	X-RAY EXAM OF ELBOW	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
73085	CONTRAST X-RAY OF ELBOW	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
73090	X-RAY EXAM OF FOREARM	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
73092	X-RAY EXAM OF ARM INFANT	FAMILY PRACTICE						SK089		SK091
73100	X-RAY EXAM OF WRIST	ORTHOPEDIC SURGERY			SK037			SK089		SK091
73110	X-RAY EXAM OF WRIST	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
73115	CONTRAST X-RAY OF WRIST	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
73120	X-RAY EXAM OF HAND	DIAGNOSTIC RADIOLOGY						SK089		SK091
73130	X-RAY EXAM OF HAND	DIAGNOSTIC RADIOLOGY						SK089		SK091
73140	X-RAY EXAM OF FINGER(S)	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
73200	CT UPPER EXTREMITY W/O DYE	DIAGNOSTIC RADIOLOGY								SK091
73201	CT UPPER EXTREMITY W/DYE	DIAGNOSTIC RADIOLOGY								SK091

CPT Code	Short Descriptor	Top Specialty	SK034 - film, x-ray 14in x 17in	SK035 - film, x-ray 14in x 36in	SK037 - film, x-ray 8in x 10in	SK038 - film, x-ray 8in x 10in (X-omat, Radiomat)	SK086 - video tape, VHS	SK089 - x-ray developer solution	SK090 x-ray digitalization separator sheet	SK091 - x-ray envelope
73202	CT UPPR EXTREMITY W/O&W/DYE	DIAGNOSTIC RADIOLOGY								SK091
73206	CT ANGIO UPR EXTRM W/O&W/DYE	DIAGNOSTIC RADIOLOGY	SK034							SK091
73218	MRI UPPER EXTREMITY W/O DYE	DIAGNOSTIC RADIOLOGY	SK034							SK091
73219	MRI UPPER EXTREMITY W/DYE	DIAGNOSTIC RADIOLOGY								SK091
73220	MRI UPPR EXTREMITY W/O&W/DYE	DIAGNOSTIC RADIOLOGY								SK091
73221	MRI JOINT UPR EXTREM W/O DYE	DIAGNOSTIC RADIOLOGY	SK034							SK091
73222	MRI JOINT UPR EXTREM W/DYE	DIAGNOSTIC RADIOLOGY								SK091
73223	MRI JOINT UPR EXTR W/O&W/DYE	DIAGNOSTIC RADIOLOGY								SK091
73225	MR ANGIO UPR EXTR W/O&W/DYE	DIAGNOSTIC RADIOLOGY								SK091
73500	X-RAY EXAM OF HIP	DIAGNOSTIC RADIOLOGY						SK089		SK091
73510	X-RAY EXAM OF HIP	DIAGNOSTIC RADIOLOGY						SK089		SK091
73520	X-RAY EXAM OF HIPS	DIAGNOSTIC RADIOLOGY						SK089		SK091
73525	CONTRAST X-RAY OF HIP	DIAGNOSTIC RADIOLOGY						SK089		SK091
73540	X-RAY EXAM OF PELVIS & HIPS	ORTHOPEDIC SURGERY						SK089		SK091
73550	X-RAY EXAM OF THIGH	DIAGNOSTIC RADIOLOGY						SK089		SK091
73560	X-RAY EXAM OF KNEE 1 OR 2	ORTHOPEDIC SURGERY						SK089		SK091
73562	X-RAY EXAM OF KNEE 3	ORTHOPEDIC SURGERY						SK089		SK091
73564	X-RAY EXAM KNEE 4 OR MORE	DIAGNOSTIC RADIOLOGY						SK089		SK091
73565	X-RAY EXAM OF KNEES	ORTHOPEDIC SURGERY						SK089		SK091
73580	CONTRAST X-RAY OF KNEE JOINT	ORTHOPEDIC SURGERY						SK089		SK091
73590	X-RAY EXAM OF LOWER LEG	DIAGNOSTIC RADIOLOGY						SK089		SK091
73592	X-RAY EXAM OF LEG INFANT	DIAGNOSTIC RADIOLOGY						SK089		SK091
73600	X-RAY EXAM OF ANKLE	DIAGNOSTIC RADIOLOGY						SK089		SK091
73610	X-RAY EXAM OF ANKLE	DIAGNOSTIC RADIOLOGY						SK089		SK091
73615	CONTRAST X-RAY OF ANKLE	ORTHOPEDIC SURGERY						SK089		SK091
73620	X-RAY EXAM OF FOOT	PODIATRY						SK089		SK091
73630	X-RAY EXAM OF FOOT	DIAGNOSTIC RADIOLOGY						SK089		SK091
73650	X-RAY EXAM OF HEEL	DIAGNOSTIC RADIOLOGY						SK089		SK091
73660	X-RAY EXAM OF TOE(S)	DIAGNOSTIC RADIOLOGY						SK089		SK091
73700	CT LOWER EXTREMITY W/O DYE	DIAGNOSTIC RADIOLOGY								SK091
73701	CT LOWER EXTREMITY W/DYE	DIAGNOSTIC RADIOLOGY								SK091
73702	CT LWR EXTREMITY W/O&W/DYE	DIAGNOSTIC RADIOLOGY								SK091
73706	CT ANGIO LWR EXTR W/O&W/DYE	DIAGNOSTIC RADIOLOGY	SK034							SK091
73718	MRI LOWER EXTREMITY W/O DYE	DIAGNOSTIC RADIOLOGY	SK034							SK091
73719	MRI LOWER EXTREMITY W/DYE	DIAGNOSTIC RADIOLOGY								SK091
73720	MRI LWR EXTREMITY W/O&W/DYE	DIAGNOSTIC RADIOLOGY								SK091
73721	MRI JNT OF LWR EXTRE W/O DYE	DIAGNOSTIC RADIOLOGY	SK034							SK091
73722	MRI JOINT OF LWR EXTR W/DYE	DIAGNOSTIC RADIOLOGY								SK091
73723	MRI JOINT LWR EXTR W/O&W/DYE	DIAGNOSTIC RADIOLOGY								SK091
73725	MR ANG LWR EXT W OR W/O DYE	DIAGNOSTIC RADIOLOGY								SK091
74000	X-RAY EXAM OF ABDOMEN	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
74010	X-RAY EXAM OF ABDOMEN	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
74020	X-RAY EXAM OF ABDOMEN	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
74022	X-RAY EXAM SERIES ABDOMEN	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
74150	CT ABDOMEN W/O DYE	DIAGNOSTIC RADIOLOGY								SK091
74160	CT ABDOMEN W/DYE	DIAGNOSTIC RADIOLOGY								SK091
74170	CT ABDOMEN W/O & W/DYE	DIAGNOSTIC RADIOLOGY								SK091
74174	CT ANGIO ABD&PELV W/O&W/DYE	DIAGNOSTIC RADIOLOGY	SK034					SK089		
74175	CT ANGIO ABDOM W/O & W/DYE	DIAGNOSTIC RADIOLOGY	SK034					SK089		
74176	CT ABD & PELVIS	DIAGNOSTIC RADIOLOGY								
74177	CT ABD & PELV W/CONTRAST	DIAGNOSTIC RADIOLOGY								
74178	CT ABD & PELV 1/> REGNS	DIAGNOSTIC RADIOLOGY								
74181	MRI ABDOMEN W/O DYE	DIAGNOSTIC RADIOLOGY	SK034							SK091
74182	MRI ABDOMEN W/DYE	DIAGNOSTIC RADIOLOGY								SK091
74183	MRI ABDOMEN W/O & W/DYE	DIAGNOSTIC RADIOLOGY								SK091
74185	MRI ANGIO ABDOM W ORW/O DYE	DIAGNOSTIC RADIOLOGY								SK091
74210	CONTRST X-RAY EXAM OF THROAT	DIAGNOSTIC RADIOLOGY						SK089		SK091
74220	CONTRAST X-RAY ESOPHAGUS	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
74230	CINE/VID X-RAY THROAT/ESOPH	DIAGNOSTIC RADIOLOGY						SK089		SK091
74240	X-RAY EXAM UPPER GI TRACT	DIAGNOSTIC RADIOLOGY						SK089		SK091
74241	X-RAY EXAM UPPER GI TRACT	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
74245	X-RAY EXAM UPPER GI TRACT	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
74246	CONTRST X-RAY UPPR GI TRACT	DIAGNOSTIC RADIOLOGY						SK089		SK091
74247	CONTRST X-RAY UPPR GI TRACT	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
74249	CONTRST X-RAY UPPR GI TRACT	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
74250	X-RAY EXAM OF SMALL BOWEL	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
74251	X-RAY EXAM OF SMALL BOWEL	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
74260	X-RAY EXAM OF SMALL BOWEL	DIAGNOSTIC RADIOLOGY						SK089		SK091
74261	Ct colonography dx	DIAGNOSTIC RADIOLOGY								
74262	Ct colonography dx w/dye	DIAGNOSTIC RADIOLOGY								
74263	Ct colonography screening									
74270	CONTRAST X-RAY EXAM OF COLON	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
74280	CONTRAST X-RAY EXAM OF COLON	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
74283	CONTRAST X-RAY EXAM OF COLON	DIAGNOSTIC RADIOLOGY						SK089		SK091
74290	CONTRAST X-RAY GALLBLADDER	DIAGNOSTIC RADIOLOGY						SK089		SK091
74291	CONTRAST X-RAYS GALLBLADDER	DIAGNOSTIC RADIOLOGY						SK089		SK091
74320	CONTRAST X-RAY OF BILE DUCTS	DIAGNOSTIC RADIOLOGY								SK091

CPT Code	Short Descriptor	Top Specialty	SK034 - film, x-ray 14in x 17in	SK035 - film, x-ray 14in x 36in	SK037 - film, x-ray 8in x 10in	SK038 - film, x-ray 8in x 10in (X-omat, Radiomat)	SK086 - video tape, VHS	SK089 - x-ray developer solution	SK090 x-ray digitalization separator sheet	SK091 - x-ray envelope
74327	X-RAY BILE STONE REMOVAL	DIAGNOSTIC RADIOLOGY								SK091
74400	CONTRST X-RAY URINARY TRACT	DIAGNOSTIC RADIOLOGY	SK034							
74410	CONTRST X-RAY URINARY TRACT	DIAGNOSTIC RADIOLOGY	SK034							
74415	CONTRST X-RAY URINARY TRACT	DIAGNOSTIC RADIOLOGY	SK034							
74430	CONTRAST X-RAY BLADDER	DIAGNOSTIC RADIOLOGY								
74440	X-RAY MALE GENITAL TRACT	UROLOGY								
74455	X-RAY URETHRA/BLADDER	UROLOGY								
74475	X-RAY CONTROL CATH INSERT	DIAGNOSTIC RADIOLOGY								SK091
74480	X-RAY CONTROL CATH INSERT	DIAGNOSTIC RADIOLOGY								SK091
74485	X-RAY GUIDE GU DILATION	DIAGNOSTIC RADIOLOGY								SK091
74710	X-RAY MEASUREMENT OF PELVIS	DIAGNOSTIC RADIOLOGY						SK089		SK091
74740	X-RAY FEMALE GENITAL TRACT	DIAGNOSTIC RADIOLOGY								
75557	CARDIAC MRI FOR MORPH	DIAGNOSTIC RADIOLOGY								
75559	CARDIAC MRI W/STRESS IMG	CARDIOLOGY								
75561	CARDIAC MRI FOR MORPH W/DYE	CARDIOLOGY								
75563	CARD MRI W/STRESS IMG & DYE	CARDIOLOGY								
75565	CARD MRI VELOC FLOW MAPPING	DIAGNOSTIC RADIOLOGY								
75571	CT HRT W/O DYE W/CA TEST	CARDIOLOGY								
75572	CT HRT W/3D IMAGE	CARDIOLOGY								
75573	CT HRT W/3D IMAGE CONGEN	DIAGNOSTIC RADIOLOGY								
75574	CT ANGIO HRT W/3D IMAGE	CARDIOLOGY								
75600	CONTRAST X-RAY EXAM OF AORTA	CARDIOLOGY			SK037					SK091
75605	CONTRAST X-RAY EXAM OF AORTA	CARDIOLOGY								SK091
75625	CONTRAST X-RAY EXAM OF AORTA	CARDIOLOGY								SK091
75630	X-RAY AORTA LEG ARTERIES	CARDIOLOGY								SK091
75635	CT ANGIO ABDOMINAL ARTERIES	DIAGNOSTIC RADIOLOGY	SK034							SK091
75650	ARTERY X-RAYS HEAD & NECK	CARDIOLOGY								SK091
75658	ARTERY X-RAYS ARM	NEPHROLOGY								SK091
75660	ARTERY X-RAYS HEAD & NECK	DIAGNOSTIC RADIOLOGY								SK091
75662	ARTERY X-RAYS HEAD & NECK	CARDIOLOGY								SK091
75665	ARTERY X-RAYS HEAD & NECK	DIAGNOSTIC RADIOLOGY								SK091
75671	ARTERY X-RAYS HEAD & NECK	DIAGNOSTIC RADIOLOGY								SK091
75676	ARTERY X-RAYS NECK	DIAGNOSTIC RADIOLOGY								SK091
75680	ARTERY X-RAYS NECK	CARDIOLOGY								SK091
75685	ARTERY X-RAYS SPINE	DIAGNOSTIC RADIOLOGY								SK091
75705	ARTERY X-RAYS SPINE	DIAGNOSTIC RADIOLOGY								SK091
75710	ARTERY X-RAYS ARM/LEG	CARDIOLOGY								SK091
75716	ARTERY X-RAYS ARMS/LEGS	CARDIOLOGY								SK091
75726	ARTERY X-RAYS ABDOMEN	DIAGNOSTIC RADIOLOGY								SK091
75731	ARTERY X-RAYS ADRENAL GLAND	CARDIOLOGY								SK091
75733	ARTERY X-RAYS ADRENALS	CARDIOLOGY								SK091
75736	ARTERY X-RAYS PELVIS	DIAGNOSTIC RADIOLOGY								SK091
75741	ARTERY X-RAYS LUNG	DIAGNOSTIC RADIOLOGY								SK091
75743	ARTERY X-RAYS LUNGS	DIAGNOSTIC RADIOLOGY								SK091
75746	ARTERY X-RAYS LUNG	DIAGNOSTIC RADIOLOGY								SK091
75756	ARTERY X-RAYS CHEST	CARDIOLOGY								SK091
75774	ARTERY X-RAY EACH VESSEL	DIAGNOSTIC RADIOLOGY								
75791	AV DIALYSIS SHUNT IMAGING	NEPHROLOGY	SK034					SK089		SK091
75809	NONVASCULAR SHUNT X-RAY	DIAGNOSTIC RADIOLOGY								SK091
75820	VEIN X-RAY ARM/LEG	CARDIOLOGY								SK091
75822	VEIN X-RAY ARMS/LEGS	DIAGNOSTIC RADIOLOGY								SK091
75825	VEIN X-RAY TRUNK	DIAGNOSTIC RADIOLOGY								SK091
75827	VEIN X-RAY CHEST	DIAGNOSTIC RADIOLOGY								SK091
75831	VEIN X-RAY KIDNEY	DIAGNOSTIC RADIOLOGY								SK091
75833	VEIN X-RAY KIDNEYS	DIAGNOSTIC RADIOLOGY								SK091
75840	VEIN X-RAY ADRENAL GLAND	VASCULAR SURGERY								SK091
75842	VEIN X-RAY ADRENAL GLANDS	DIAGNOSTIC RADIOLOGY								SK091
75860	VEIN X-RAY NECK	CARDIOLOGY								SK091
75870	VEIN X-RAY SKULL	DIAGNOSTIC RADIOLOGY								SK091
75872	VEIN X-RAY SKULL	NEUROSURGERY								SK091
75880	VEIN X-RAY EYE SOCKET	NEUROLOGY								SK091
75885	VEIN X-RAY LIVER	DIAGNOSTIC RADIOLOGY	SK034							SK091
75887	VEIN X-RAY LIVER	DIAGNOSTIC RADIOLOGY	SK034							SK091
75889	VEIN X-RAY LIVER	DIAGNOSTIC RADIOLOGY								SK091
75891	VEIN X-RAY LIVER	DIAGNOSTIC RADIOLOGY								SK091
75893	VENOUS SAMPLING BY CATHETER	DIAGNOSTIC RADIOLOGY								SK091
75901	REMOVE CVA DEVICE OBSTRUCT	DIAGNOSTIC RADIOLOGY	SK034							SK091
75902	REMOVE CVA LUMEN OBSTRUCT	DIAGNOSTIC RADIOLOGY	SK034							SK091
75960	TRANSCATH IV STENT RS&I	CARDIOLOGY	SK034					SK089		
75961	RETRIEVAL BROKEN CATHETER	DIAGNOSTIC RADIOLOGY								SK091
75962	REPAIR ARTERIAL BLOCKAGE	CARDIOLOGY								SK091
75964	REPAIR ARTERY BLOCKAGE EACH	VASCULAR SURGERY								
75966	REPAIR ARTERIAL BLOCKAGE	CARDIOLOGY								SK091
75968	REPAIR ARTERY BLOCKAGE EACH	CARDIOLOGY								
75978	REPAIR VENOUS BLOCKAGE	DIAGNOSTIC RADIOLOGY								SK091
75984	XRAY CONTROL CATHETER CHANGE	DIAGNOSTIC RADIOLOGY								SK091
75989	ABSCCESS DRAINAGE UNDER X-RAY	DIAGNOSTIC RADIOLOGY								SK091

CPT Code	Short Descriptor	Top Specialty	SK034 - film, x-ray 14in x 17in	SK035 - film, x-ray 14in x 36in	SK037 - film, x-ray 8in x 10in	SK038 - film, x-ray 8in x 10in (X-omat, Radiomat)	SK086 - video tape, VHS	SK089 - x-ray developer solution	SK090 x-ray digitalization separator sheet	SK091 - x-ray envelope
76000	FLUOROSCOPE EXAMINATION	DIAGNOSTIC RADIOLOGY						SK089		
76010	X-RAY NOSE TO RECTUM	DIAGNOSTIC RADIOLOGY						SK089		SK091
76080	X-RAY EXAM OF FISTULA	DIAGNOSTIC RADIOLOGY								SK091
76098	X-RAY EXAM BREAST SPECIMEN	DIAGNOSTIC RADIOLOGY								SK091
76120	CINE/VIDEO X-RAYS	IDTF	SK034		SK037					SK091
76376	3D RENDER W/O POSTPROCESS	DIAGNOSTIC RADIOLOGY	SK034					SK089		
76377	3D RENDERING W/POSTPROCESS	DIAGNOSTIC RADIOLOGY	SK034					SK089		
76380	CAT SCAN FOLLOW-UP STUDY	DIAGNOSTIC RADIOLOGY								SK091
76390	MR SPECTROSCOPY	DIAGNOSTIC RADIOLOGY	SK034							
76506	ECHO EXAM OF HEAD	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
76536	US EXAM OF HEAD AND NECK	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
76604	US EXAM CHEST	DIAGNOSTIC RADIOLOGY								SK091
76645	US EXAM BREAST(S)	DIAGNOSTIC RADIOLOGY								SK091
76700	US EXAM ABDOM COMPLETE	DIAGNOSTIC RADIOLOGY	SK034				SK086	SK089		SK091
76705	ECHO EXAM OF ABDOMEN	DIAGNOSTIC RADIOLOGY								SK091
76770	US EXAM ABDO BACK WALL COMP	DIAGNOSTIC RADIOLOGY	SK034				SK086	SK089		SK091
76775	US EXAM ABDO BACK WALL LIM	DIAGNOSTIC RADIOLOGY								SK091
76776	US EXAM K TRANSPL W/DOPPLER	DIAGNOSTIC RADIOLOGY								
76800	US EXAM SPINAL CANAL	GENERAL PRACTICE								SK091
76801	OB US < 14 WKS SINGLE FETUS	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
76830	TRANSVAGINAL US NON-OB	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
76856	US EXAM PELVIC COMPLETE	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
76857	US EXAM PELVIC LIMITED	UROLOGY	SK034					SK089		SK091
76870	US EXAM SCROTUM	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
76872	US TRANSRECTAL	UROLOGY	SK034					SK089		SK091
76873	ECHOGRAP TRANS R PROS STUDY	RADIATION ONCOLOGY	SK034					SK089		SK091
76881	US XTR NON-VASC COMPLETE	PODIATRY	SK034			SK038				
76885	US EXAM INFANT HIPS DYNAMIC	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
76886	US EXAM INFANT HIPS STATIC	DIAGNOSTIC RADIOLOGY								SK091
76936	ECHO GUIDE FOR ARTERY REPAIR	DIAGNOSTIC RADIOLOGY								SK091
76937	US GUIDE VASCULAR ACCESS	DIAGNOSTIC RADIOLOGY	SK034				SK086			SK091
76942	ECHO GUIDE FOR BIOPSY	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
76970	ULTRASOUND EXAM FOLLOW-UP	GENERAL SURGERY								SK091
77001	FLUOROGUIDE FOR VEIN DEVICE	DIAGNOSTIC RADIOLOGY	SK034							SK091
77002	NEEDLE LOCALIZATION BY XRAY	DIAGNOSTIC RADIOLOGY								SK091
77003	FLUOROGUIDE FOR SPINE INJECT	ANESTHESIOLOGY						SK089		
77011	CT SCAN FOR LOCALIZATION	DIAGNOSTIC RADIOLOGY								SK091
77012	CT SCAN FOR NEEDLE BIOPSY	DIAGNOSTIC RADIOLOGY								SK091
77014	CT SCAN FOR THERAPY GUIDE	RADIATION ONCOLOGY								SK091
77021	MR GUIDANCE FOR NEEDLE PLACE	DIAGNOSTIC RADIOLOGY	SK034							
77031	STEREOTACT GUIDE FOR BRST BX	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
77032	GUIDANCE FOR NEEDLE BREAST	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
77051	COMPUTER DX MAMMOGRAM ADD-ON	DIAGNOSTIC RADIOLOGY							SK090	
77052	COMP SCREEN MAMMOGRAM ADD-ON	DIAGNOSTIC RADIOLOGY							SK090	
77053	X-RAY OF MAMMARY DUCT	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
77054	X-RAY OF MAMMARY DUCTS	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
77055	MAMMOGRAM ONE BREAST	DIAGNOSTIC RADIOLOGY								SK091
77056	MAMMOGRAM BOTH BREASTS	DIAGNOSTIC RADIOLOGY								SK091
77057	MAMMOGRAM SCREENING	DIAGNOSTIC RADIOLOGY								SK091
77058	MRI ONE BREAST	DIAGNOSTIC RADIOLOGY								SK091
77059	MRI BOTH BREASTS	DIAGNOSTIC RADIOLOGY								SK091
77071	X-RAY STRESS VIEW	ORTHOPEDIC SURGERY						SK089		SK091
77072	X-RAYS FOR BONE AGE	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
77073	X-RAYS BONE LENGTH STUDIES	ORTHOPEDIC SURGERY	SK034					SK089		SK091
77074	X-RAYS BONE SURVEY LIMITED	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
77075	X-RAYS BONE SURVEY COMPLETE	DIAGNOSTIC RADIOLOGY	SK034					SK089		SK091
77076	X-RAYS BONE SURVEY INFANT	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
77077	JOINT SURVEY SINGLE VIEW	ORTHOPEDIC SURGERY						SK089		SK091
77084	MAGNETIC IMAGE BONE MARROW	DIAGNOSTIC RADIOLOGY	SK034							SK091
77280	SET RADIATION THERAPY FIELD	RADIATION ONCOLOGY	SK034					SK089		
77285	SET RADIATION THERAPY FIELD	RADIATION ONCOLOGY	SK034					SK089		
77290	SET RADIATION THERAPY FIELD	RADIATION ONCOLOGY	SK034					SK089		
77301	RADIOTHERAPY DOSE PLAN IMRT	RADIATION ONCOLOGY	SK034			SK038		SK089		
77336	RADIATION PHYSICS CONSULT	RADIATION ONCOLOGY								
77370	RADIATION PHYSICS CONSULT	RADIATION ONCOLOGY								
77371	SRS MULTISOURCE	NEUROSURGERY								
77372	SRS LINEAR BASED	RADIATION ONCOLOGY	SK034					SK089		SK091
77417	RADIOLOGY PORT FILM(S)	RADIATION ONCOLOGY	SK034					SK089		SK091
77418	RADIATION TX DELIVERY IMRT	RADIATION ONCOLOGY	SK034							
77422	NEUTRON BEAM TX SIMPLE	RADIATION ONCOLOGY								
77423	NEUTRON BEAM TX COMPLEX	RADIATION ONCOLOGY								
78006	THYROID IMAGING WITH UPTAKE	DIAGNOSTIC RADIOLOGY			SK037					SK091
78007	THYROID IMAGE MULT UPTAKES	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
78010	THYROID IMAGING	DIAGNOSTIC RADIOLOGY			SK037					SK091
78011	THYROID IMAGING WITH FLOW	DIAGNOSTIC RADIOLOGY			SK037					SK091
78015	THYROID MET IMAGING	DIAGNOSTIC RADIOLOGY			SK037					SK091
78016	THYROID MET IMAGING/STUDIES	NUCLEAR MEDICINE			SK037					SK091

CPT Code	Short Descriptor	Top Specialty	SK034 - film, x-ray 14in x 17in	SK035 - film, x-ray 14in x 36in	SK037 - film, x-ray 8in x 10in	SK038 - film, x-ray 8in x 10in (X-omat, Radiomat)	SK086 - video tape, VHS	SK089 - x-ray developer solution	SK090 x-ray digitalization separator sheet	SK091 - x-ray envelope
78018	THYROID MET IMAGING BODY	DIAGNOSTIC RADIOLOGY			SK037					SK091
78020	THYROID MET UPTAKE	DIAGNOSTIC RADIOLOGY			SK037			SK089		
78070	PARATHYROID NUCLEAR IMAGING	DIAGNOSTIC RADIOLOGY			SK037					SK091
78075	ADRENAL NUCLEAR IMAGING	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
78102	BONE MARROW IMAGING LTD	DIAGNOSTIC RADIOLOGY			SK037					SK091
78103	BONE MARROW IMAGING MULT	DIAGNOSTIC RADIOLOGY			SK037					SK091
78104	BONE MARROW IMAGING BODY	DIAGNOSTIC RADIOLOGY			SK037					SK091
78135	RED CELL SURVIVAL KINETICS	DIAGNOSTIC RADIOLOGY			SK037					SK091
78140	RED CELL SEQUESTRATION	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
78185	SPLEEN IMAGING	DIAGNOSTIC RADIOLOGY			SK037					SK091
78190	PLATELET SURVIVAL KINETICS	DIAGNOSTIC RADIOLOGY			SK037					SK091
78195	LYMPH SYSTEM IMAGING	DIAGNOSTIC RADIOLOGY			SK037					SK091
78201	LIVER IMAGING	DIAGNOSTIC RADIOLOGY			SK037					SK091
78202	LIVER IMAGING WITH FLOW	DIAGNOSTIC RADIOLOGY			SK037					SK091
78205	LIVER IMAGING (3D)	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
78206	LIVER IMAGE (3D) WITH FLOW	DIAGNOSTIC RADIOLOGY			SK037					
78215	LIVER AND SPLEEN IMAGING	DIAGNOSTIC RADIOLOGY			SK037					SK091
78216	LIVER & SPLEEN IMAGE/FLOW	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
78226	HEPATOBIILIARY SYSTEM IMAGING	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
78227	HEPATOBIL SYST IMAGE W/DRUG	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
78230	SALIVARY GLAND IMAGING	DIAGNOSTIC RADIOLOGY			SK037					SK091
78231	SERIAL SALIVARY IMAGING	NUCLEAR MEDICINE			SK037			SK089		SK091
78232	SALIVARY GLAND FUNCTION EXAM	NUCLEAR MEDICINE			SK037			SK089		SK091
78258	ESOPHAGEAL MOTILITY STUDY	DIAGNOSTIC RADIOLOGY			SK037					SK091
78261	GASTRIC MUCOSA IMAGING	DIAGNOSTIC RADIOLOGY			SK037					SK091
78262	GASTROESOPHAGEAL REFLUX EXAM	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
78264	GASTRIC EMPTYING STUDY	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
78278	ACUTE GI BLOOD LOSS IMAGING	DIAGNOSTIC RADIOLOGY			SK037					SK091
78290	MECKELS DIVERT EXAM	DIAGNOSTIC RADIOLOGY			SK037					SK091
78291	LEVEEN/SHUNT PATENCY EXAM	DIAGNOSTIC RADIOLOGY			SK037					SK091
78300	BONE IMAGING LIMITED AREA	DIAGNOSTIC RADIOLOGY			SK037					SK091
78305	BONE IMAGING MULTIPLE AREAS	DIAGNOSTIC RADIOLOGY			SK037					SK091
78306	BONE IMAGING WHOLE BODY	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
78315	BONE IMAGING 3 PHASE	DIAGNOSTIC RADIOLOGY			SK037					SK091
78320	BONE IMAGING (3D)	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
78414	NON-IMAGING HEART FUNCTION	INTERNAL MEDICINE			SK037					SK091
78428	CARDIAC SHUNT IMAGING	CARDIOLOGY			SK037					SK091
78445	VASCULAR FLOW IMAGING	DIAGNOSTIC RADIOLOGY			SK037					SK091
78451	HT MUSCLE IMAGE SPECT SING	CARDIOLOGY			SK037			SK089		SK091
78452	HT MUSCLE IMAGE SPECT MULT	CARDIOLOGY			SK037			SK089		SK091
78453	HT MUSCLE IMAGE PLANAR SING	CARDIOLOGY			SK037			SK089		SK091
78454	HT MUSC IMAGE PLANAR MULT	CARDIOLOGY			SK037			SK089		SK091
78456	ACUTE VENOUS THROMBUS IMAGE	DIAGNOSTIC RADIOLOGY			SK037					SK091
78457	VENOUS THROMBOSIS IMAGING	CARDIOLOGY			SK037					SK091
78458	VEN THROMBOSIS IMAGES BILAT	NUCLEAR MEDICINE			SK037					SK091
78466	HEART INFARCT IMAGE	CARDIOLOGY			SK037					SK091
78468	HEART INFARCT IMAGE (EF)	CARDIOLOGY			SK037					SK091
78469	HEART INFARCT IMAGE (3D)	INTERNAL MEDICINE			SK037			SK089		SK091
78472	GATED HEART PLANAR SINGLE	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
78473	GATED HEART MULTIPLE	CARDIOLOGY			SK037			SK089		SK091
78481	HEART FIRST PASS SINGLE	CARDIOLOGY			SK037			SK089		SK091
78483	HEART FIRST PASS MULTIPLE	CARDIOLOGY			SK037			SK089		SK091
78494	HEART IMAGE SPECT	CARDIOLOGY			SK037			SK089		SK091
78579	LUNG VENTILATION IMAGING	DIAGNOSTIC RADIOLOGY			SK037					SK091
78580	LUNG PERFUSION IMAGING	DIAGNOSTIC RADIOLOGY			SK037					SK091
78582	LUNG VENTILAT&PERFUS IMAGING	DIAGNOSTIC RADIOLOGY			SK037					SK091
78597	LUNG PERFUSION DIFFERENTIAL	DIAGNOSTIC RADIOLOGY			SK037					SK091
78598	LUNG PERF&VENTILAT DIFERENTL	DIAGNOSTIC RADIOLOGY			SK037					SK091
78600	BRAIN IMAGE < 4 VIEWS	DIAGNOSTIC RADIOLOGY			SK037					SK091
78601	BRAIN IMAGE W/FLOW < 4 VIEWS	DIAGNOSTIC RADIOLOGY			SK037					SK091
78605	BRAIN IMAGE 4+ VIEWS	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
78606	BRAIN IMAGE W/FLOW 4 + VIEWS	DIAGNOSTIC RADIOLOGY			SK037					SK091
78607	BRAIN IMAGING (3D)	DIAGNOSTIC RADIOLOGY			SK037					
78610	BRAIN FLOW IMAGING ONLY	DIAGNOSTIC RADIOLOGY			SK037					SK091
78630	CEREBROSPINAL FLUID SCAN	DIAGNOSTIC RADIOLOGY			SK037					SK091
78635	CSF VENTRICULOGRAPHY	DIAGNOSTIC RADIOLOGY			SK037					SK091
78645	CSF SHUNT EVALUATION	DIAGNOSTIC RADIOLOGY			SK037					SK091
78647	CEREBROSPINAL FLUID SCAN	DIAGNOSTIC RADIOLOGY			SK037					
78650	CSF LEAKAGE IMAGING	DIAGNOSTIC RADIOLOGY			SK037					SK091
78660	NUCLEAR EXAM OF TEAR FLOW	DIAGNOSTIC RADIOLOGY			SK037					SK091
78700	KIDNEY IMAGING MORPHOL	DIAGNOSTIC RADIOLOGY			SK037					SK091
78701	KIDNEY IMAGING WITH FLOW	DIAGNOSTIC RADIOLOGY			SK037					SK091
78707	K FLOW/FUNCT IMAGE W/O DRUG	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
78708	K FLOW/FUNCT IMAGE W/DRUG	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
78709	K FLOW/FUNCT IMAGE MULTIPLE	DIAGNOSTIC RADIOLOGY			SK037					SK091
78710	KIDNEY IMAGING (3D)	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
78730	Urinary bladder retention	UROLOGY								

CPT Code	Short Descriptor	Top Specialty	SK034 - film, x-ray 14in x 17in	SK035 - film, x-ray 14in x 36in	SK037 - film, x-ray 8in x 10in	SK038 - film, x-ray 8in x 10in (X-omat, Radiomat)	SK086 - video tape, VHS	SK089 - x-ray developer solution	SK090 x-ray digitalization separator sheet	SK091 - x-ray envelope
78740	URETERAL REFLUX STUDY	UROLOGY			SK037					SK091
78761	TESTICULAR IMAGING W/FLOW	DIAGNOSTIC RADIOLOGY			SK037					SK091
78800	TUMOR IMAGING LIMITED AREA	DIAGNOSTIC RADIOLOGY			SK037					SK091
78801	TUMOR IMAGING MULT AREAS	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
78802	TUMOR IMAGING WHOLE BODY	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
78803	TUMOR IMAGING (3D)	DIAGNOSTIC RADIOLOGY			SK037					
78804	TUMOR IMAGING WHOLE BODY	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
78805	ABSCCESS IMAGING LTD AREA	DIAGNOSTIC RADIOLOGY			SK037					SK091
78806	ABSCCESS IMAGING WHOLE BODY	DIAGNOSTIC RADIOLOGY			SK037			SK089		SK091
78807	NUCLEAR LOCALIZATION/ABSCCESS	DIAGNOSTIC RADIOLOGY			SK037					
78811	PET IMAGE LTD AREA	DIAGNOSTIC RADIOLOGY								SK091
78812	PET IMAGE SKULL-THIGH	DIAGNOSTIC RADIOLOGY								SK091
78813	PET IMAGE FULL BODY	DIAGNOSTIC RADIOLOGY								SK091
78814	PET IMAGE W/CT LMTD	DIAGNOSTIC RADIOLOGY								SK091
78815	PET IMAGE W/CT SKULL-THIGH	DIAGNOSTIC RADIOLOGY								SK091
78816	PET IMAGE W/CT FULL BODY	DIAGNOSTIC RADIOLOGY								SK091
79440	Nuclear rx intra-articular	FAMILY PRACTICE								
93303	ECHO TRANSTHORACIC	CARDIOLOGY					SK086			
93304	ECHO TRANSTHORACIC	CARDIOLOGY					SK086			
93306	TTE W/DOPPLER COMPLETE	CARDIOLOGY					SK086			
93307	TTE W/O DOPPLER COMPLETE	CARDIOLOGY					SK086			
93308	TTE F-UP OR LMTD	CARDIOLOGY					SK086			
93312	ECHO TRANSESOPHAGEAL	CARDIOLOGY					SK086			
93314	ECHO TRANSESOPHAGEAL	CARDIOLOGY					SK086			
93350	STRESS TTE ONLY	CARDIOLOGY					SK086			
93351	Stress tte complete	CARDIOLOGY								
93451	Right heart cath	CARDIOLOGY								
93452	Left hrt cath w/ventrclgrphy	CARDIOLOGY								
93453	R&I hrt cath w/ventrclgrphy	CARDIOLOGY								
93454	Coronary artery angio s&i	CARDIOLOGY								
93455	Coronary art/grft angio s&i	CARDIOLOGY								
93456	R hrt coronary artery angio	CARDIOLOGY								
93457	R hrt art/grft angio	CARDIOLOGY								
93458	L hrt artery/ventricle angio	CARDIOLOGY								
93459	L hrt art/grft angio	CARDIOLOGY								
93460	R&I hrt art/ventricle angio	CARDIOLOGY								
93461	R&I hrt art/ventricle angio	CARDIOLOGY								
93566	INJECT R VENTR/ATRIAL ANGIO	CARDIOLOGY	SK034							SK091
93567	INJECT SUPRVLV AORTOGRAPHY	CARDIOLOGY	SK034							SK091
93568	INJECT PULM ART HRT CATH	CARDIOLOGY	SK034							SK091
93880	EXTRACRANIAL STUDY	DIAGNOSTIC RADIOLOGY	SK034				SK086			
93882	EXTRACRANIAL STUDY	VASCULAR SURGERY	SK034				SK086			
93886	INTRACRANIAL STUDY	NEUROLOGY	SK034				SK086			
93888	INTRACRANIAL STUDY	NEUROLOGY	SK034				SK086			
93890	TCD VASOREACTIVITY STUDY	DIAGNOSTIC RADIOLOGY					SK086			
93892	TCD EMBOLI DETECT W/O INJ	NEUROLOGY					SK086			
93893	TCD EMBOLI DETECT W/INJ	NEUROLOGY					SK086			
93925	LOWER EXTREMITY STUDY	DIAGNOSTIC RADIOLOGY	SK034				SK086			
93926	LOWER EXTREMITY STUDY	VASCULAR SURGERY	SK034				SK086			
93930	UPPER EXTREMITY STUDY	DIAGNOSTIC RADIOLOGY	SK034				SK086			
93931	UPPER EXTREMITY STUDY	VASCULAR SURGERY	SK034				SK086			
93970	EXTREMITY STUDY	DIAGNOSTIC RADIOLOGY	SK034				SK086			
93971	EXTREMITY STUDY	DIAGNOSTIC RADIOLOGY	SK034				SK086			
93975	VASCULAR STUDY	DIAGNOSTIC RADIOLOGY	SK034				SK086			
93976	VASCULAR STUDY	DIAGNOSTIC RADIOLOGY	SK034				SK086			
93978	VASCULAR STUDY	CARDIOLOGY	SK034				SK086			
93979	VASCULAR STUDY	CARDIOLOGY	SK034				SK086			
93980	PENILE VASCULAR STUDY	UROLOGY	SK034							
93981	PENILE VASCULAR STUDY	UROLOGY	SK034							
93990	DOPPLER FLOW TESTING	VASCULAR SURGERY	SK034				SK086			
G0106	COLON CA SCREEN;BARIUM ENEMA	DIAGNOSTIC RADIOLOGY	SK034							
G0120	COLON CA SCRNI; BARIUM ENEMA	DIAGNOSTIC RADIOLOGY	SK034							
G0122	COLON CA SCRNI; BARIUM ENEMA	NA	SK034							
G0288	RECON, CTA FOR SURG PLAN	VASCULAR SURGERY								
G0365	VESSEL MAPPING HEMO ACCESS	VASCULAR SURGERY	SK034				SK086			
G0389	ULTRASOUND EXAM AAA SCREEN	DIAGNOSTIC RADIOLOGY								SK091



CPT Code	Short Descriptor	Top Specialty	SK092 - x-ray fixer solution	SK093 - x-ray ID card (flashcard)	SK094 - x-ray marking pencil	SK098 - film, x-ray, laser print	SM009 - cleaner, x-ray cassette-screen	ED014 - computer workstation, 3D reconstruction CT-MR	ED016 - computer workstation, MRA post processing	ED023 - film processor, PET imaging
15732	MUSCLE-SKIN GRAFT HEAD/NECK	RECONSTRUCTIVE SURGERY		SK093						
15734	MUSCLE-SKIN GRAFT TRUNK	RECONSTRUCTIVE SURGERY		SK093						
15736	MUSCLE-SKIN GRAFT ARM	RECONSTRUCTIVE SURGERY		SK093						
15738	MUSCLE-SKIN GRAFT LEG	RECONSTRUCTIVE SURGERY		SK093						
22520	Percut vertebroplasty thor	DIAGNOSTIC RADIOLOGY								
22521	Percut vertebroplasty lumb	DIAGNOSTIC RADIOLOGY								
22523	Percut kyphoplasty thor	ORTHOPEDIC SURGERY								
22524	Percut kyphoplasty lumbar	ORTHOPEDIC SURGERY								
22526	Idet single level									
27096	INJECT SACROILIAC JOINT	ANESTHESIOLOGY								
36147	ACCESS AV DIAL GRFT FOR EVAL	DIAGNOSTIC RADIOLOGY	SK092	SK093						
36251	INS CATH REN ART 1ST UNILAT	CARDIOLOGY	SK092	SK093						
36252	INS CATH REN ART 1ST BILAT	CARDIOLOGY	SK092	SK093						
36253	INS CATH REN ART 2ND+ UNILAT	CARDIOLOGY	SK092	SK093						
36254	INS CATH REN ART 2ND+ BILAT	CARDIOLOGY	SK092	SK093						
36475	ENDOVENOUS RF 1ST VEIN	GENERAL SURGERY								
36478	ENDOVENOUS LASER 1ST VEIN	VASCULAR SURGERY								
36598	INJ W/FLUOR EVAL CV DEVICE	DIAGNOSTIC RADIOLOGY	SK092							
37184	PRIM ART MECH THROMBECTOMY	DIAGNOSTIC RADIOLOGY	SK092	SK093						
37185	PRIM ART M-THROMBECT ADD-ON	VASCULAR SURGERY								
37186	SEC ART M-THROMBECT ADD-ON	CARDIOLOGY								
37187	VENOUS MECH THROMBECTOMY	DIAGNOSTIC RADIOLOGY	SK092	SK093						
37188	VENOUS M-THROMBECTOMY ADD-ON	DIAGNOSTIC RADIOLOGY	SK092	SK093						
37191	INS ENDOVAS VENA CAVA FILTR	DIAGNOSTIC RADIOLOGY	SK092	SK093						
37192	REDO ENDOVAS VENA CAVA FILTR	DIAGNOSTIC RADIOLOGY	SK092	SK093						
37193	REM ENDOVAS VENA CAVA FILTER	DIAGNOSTIC RADIOLOGY	SK092	SK093						
37210	EMBOLIZATION UTERINE FIBROID	DIAGNOSTIC RADIOLOGY	SK092							
37220	ILIAC REVASC	VASCULAR SURGERY	SK092	SK093						
37221	ILIAC REVASC W/STENT	VASCULAR SURGERY	SK092	SK093						
37222	ILIAC REVASC ADD-ON	VASCULAR SURGERY	SK092							
37223	ILIAC REVASC W/STENT ADD-ON	VASCULAR SURGERY	SK092							
37224	FEM/POPL REVAS W/TLA	VASCULAR SURGERY	SK092	SK093						
37225	FEM/POPL REVAS W/ATHER	CARDIOLOGY	SK092	SK093						
37226	FEM/POPL REVASC W/STENT	CARDIOLOGY	SK092	SK093						
37227	FEM/POPL REVASC STNT & ATHER	CARDIOLOGY	SK092	SK093						
37228	TIB/PER REVASC W/TLA	VASCULAR SURGERY	SK092	SK093						
37229	TIB/PER REVASC W/ATHER	CARDIOLOGY	SK092	SK093						
37230	TIB/PER REVASC W/STENT	CARDIOLOGY	SK092	SK093						
37231	TIB/PER REVASC STENT & ATHER	CARDIOLOGY	SK092	SK093						
37232	TIB/PER REVASC ADD-ON	VASCULAR SURGERY	SK092							
37233	TIBPER REVASC W/ATHER ADD-ON	CARDIOLOGY	SK092							
37234	REVSC OPN/PRQ TIB/PERO STENT	CARDIOLOGY	SK092							
37235	TIB/PER REVASC STNT & ATHER	CARDIOLOGY	SK092							
38790	INJECT FOR LYMPHATIC X-RAY	GENERAL SURGERY		SK093						
43756	DX DUOD INTUB W/ASP SPEC	GASTROENTEROLOGY								
43757	DX DUOD INTUB W/ASP SPECS	GASTROENTEROLOGY								
49083	ABD PARACENTESIS W/IMAGING	DIAGNOSTIC RADIOLOGY				SK098				
49418	INSERT TUN IP CATH PERC	DIAGNOSTIC RADIOLOGY				SK098				
49440	PLACE GASTROSTOMY TUBE PERC	DIAGNOSTIC RADIOLOGY	SK092							
49441	PLACE DUOD/JEJ TUBE PERC	DIAGNOSTIC RADIOLOGY	SK092							
49442	PLACE CECOSTOMY TUBE PERC	DIAGNOSTIC RADIOLOGY	SK092	SK093						
49446	CHANGE G-TUBE TO G-J PERC	DIAGNOSTIC RADIOLOGY	SK092	SK093						
49450	REPLACE G/C TUBE PERC	DIAGNOSTIC RADIOLOGY	SK092	SK093						
49451	REPLACE DUOD/JEJ TUBE PERC	DIAGNOSTIC RADIOLOGY	SK092	SK093						
49452	REPLACE G-J TUBE PERC	DIAGNOSTIC RADIOLOGY	SK092	SK093						
49460	FIX G/COLON TUBE W/DEVICE	DIAGNOSTIC RADIOLOGY	SK092	SK093						
49465	FLUORO EXAM OF G/COLON TUBE	DIAGNOSTIC RADIOLOGY	SK092	SK093						
50382	CHANGE URETER STENT PERCUT	DIAGNOSTIC RADIOLOGY	SK092							
50384	REMOVE URETER STENT PERCUT	DIAGNOSTIC RADIOLOGY	SK092							
50385	CHANGE STENT VIA TRANSURETH	UROLOGY	SK092							
50386	REMOVE STENT VIA TRANSURETH	UROLOGY	SK092							
50387	CHANGE EXT/INT URETER STENT	DIAGNOSTIC RADIOLOGY	SK092							
50389	REMOVE RENAL TUBE W/FLUORO	DIAGNOSTIC RADIOLOGY	SK092							
51605	PREPARATION FOR BLADDER XRAY	UROLOGY		SK093						
62263	EPIDURAL LYSIS MULT SESSIONS	INTERVENTIONAL PAIN MANAGEMENT								
62264	Epidural lysis on single day	ANESTHESIOLOGY								
63661	Remove spine eltrd perq aray	MANAGEMENT								
63663	Revise spine eltrd perq aray	MANAGEMENT								
64479	INJ FORAMEN EPIDURAL C/T	MANAGEMENT								
64480	Inj foramen epidural add-on	NEUROSURGERY								
64483	INJ FORAMEN EPIDURAL L/S	MANAGEMENT								
64484	Inj foramen epidural add-on	MANAGEMENT								
64490	INJ PARAVERT F JNT C/T 1 LEV	MANAGEMENT								
64493	INJ PARAVERT F JNT L/S 1 LEV	MANAGEMENT								
64633	DESTROY CERV/THOR FACET JNT	MANAGEMENT								
64634	DESTROY C/TH FACET JNT ADDL	MANAGEMENT								

CPT Code	Short Descriptor	Top Specialty	SK092 - x-ray fixer solution	SK093 - x-ray ID card (flashcard)	SK094 - x-ray marking pencil	SK098 - film, x-ray, laser print	SM009 - cleaner, x-ray cassette-screen	ED014 - computer workstation, 3D reconstruction CT-MR	ED016 - computer workstation, MRA post processing	ED023 - film processor, PET imaging
64635	DESTROY LUMB/SAC FACET JNT	MANAGEMENT								
64636	DESTROY L/S FACET JNT ADDL	MANAGEMENT								
70010	CONTRAST X-RAY OF BRAIN	DIAGNOSTIC RADIOLOGY	SK092							
70015	CONTRAST X-RAY OF BRAIN	DIAGNOSTIC RADIOLOGY	SK092							
70030	X-RAY EYE FOR FOREIGN BODY	DIAGNOSTIC RADIOLOGY	SK092							
70100	X-RAY EXAM OF JAW	FAMILY PRACTICE	SK092							
70110	X-RAY EXAM OF JAW	DIAGNOSTIC RADIOLOGY	SK092							
70120	X-RAY EXAM OF MASTOIDS	DIAGNOSTIC RADIOLOGY	SK092							
70130	X-RAY EXAM OF MASTOIDS	DIAGNOSTIC RADIOLOGY	SK092							
70134	X-RAY EXAM OF MIDDLE EAR	DIAGNOSTIC RADIOLOGY	SK092							
70140	X-RAY EXAM OF FACIAL BONES	DIAGNOSTIC RADIOLOGY	SK092							
70150	X-RAY EXAM OF FACIAL BONES	DIAGNOSTIC RADIOLOGY	SK092							
70160	X-RAY EXAM OF NASAL BONES	DIAGNOSTIC RADIOLOGY	SK092							
70190	X-RAY EXAM OF EYE SOCKETS	DIAGNOSTIC RADIOLOGY	SK092							
70200	X-RAY EXAM OF EYE SOCKETS	DIAGNOSTIC RADIOLOGY	SK092							
70210	X-RAY EXAM OF SINUSES	DIAGNOSTIC RADIOLOGY	SK092							
70220	X-RAY EXAM OF SINUSES	DIAGNOSTIC RADIOLOGY	SK092							
70240	X-RAY EXAM PITUITARY SADDLE	DIAGNOSTIC RADIOLOGY	SK092							
70250	X-RAY EXAM OF SKULL	DIAGNOSTIC RADIOLOGY	SK092							
70260	X-RAY EXAM OF SKULL	DIAGNOSTIC RADIOLOGY	SK092							
70328	X-RAY EXAM OF JAW JOINT	DIAGNOSTIC RADIOLOGY	SK092							
70330	X-RAY EXAM OF JAW JOINTS	DIAGNOSTIC RADIOLOGY	SK092							
70336	MAGNETIC IMAGE JAW JOINT	DIAGNOSTIC RADIOLOGY								
70360	X-RAY EXAM OF NECK	DIAGNOSTIC RADIOLOGY	SK092							
70370	THROAT X-RAY & FLUOROSCOPY	FAMILY PRACTICE	SK092							
70371	SPEECH EVALUATION COMPLEX	DIAGNOSTIC RADIOLOGY								
70373	CONTRAST X-RAY OF LARYNX	FAMILY PRACTICE	SK092							
70390	X-RAY EXAM OF SALIVARY DUCT	DIAGNOSTIC RADIOLOGY	SK092							
70450	CT HEAD/BRAIN W/O DYE	DIAGNOSTIC RADIOLOGY				SK098				
70460	CT HEAD/BRAIN W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
70470	CT HEAD/BRAIN W/O & W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
70480	CT ORBIT/EAR/FOSSA W/O DYE	DIAGNOSTIC RADIOLOGY				SK098				
70481	CT ORBIT/EAR/FOSSA W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
70482	CT ORBIT/EAR/FOSSA W/O&W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
70486	CT MAXILLOFACIAL W/O DYE	DIAGNOSTIC RADIOLOGY				SK098				
70487	CT MAXILLOFACIAL W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
70488	CT MAXILLOFACIAL W/O & W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
70490	CT SOFT TISSUE NECK W/O DYE	DIAGNOSTIC RADIOLOGY				SK098				
70491	CT SOFT TISSUE NECK W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
70492	CT SFT TSUE NCK W/O & W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
70496	CT ANGIOGRAPHY HEAD	DIAGNOSTIC RADIOLOGY								
70498	CT ANGIOGRAPHY NECK	DIAGNOSTIC RADIOLOGY								
70540	MRI ORBIT/FACE/NECK W/O DYE	DIAGNOSTIC RADIOLOGY								
70542	MRI ORBIT/FACE/NECK W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
70543	MRI ORBT/FAC/NCK W/O & W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
70544	MR ANGIOGRAPHY HEAD W/O DYE	DIAGNOSTIC RADIOLOGY								
70545	MR ANGIOGRAPHY HEAD W/DYE	DIAGNOSTIC RADIOLOGY								
70546	MR ANGIOGRAPH HEAD W/O&W/DYE	DIAGNOSTIC RADIOLOGY								
70547	MR ANGIOGRAPHY NECK W/O DYE	DIAGNOSTIC RADIOLOGY								
70548	MR ANGIOGRAPHY NECK W/DYE	DIAGNOSTIC RADIOLOGY								
70549	MR ANGIOGRAPH NECK W/O&W/DYE	DIAGNOSTIC RADIOLOGY								
70551	MRI BRAIN W/O DYE	DIAGNOSTIC RADIOLOGY								
70552	MRI BRAIN W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
70553	MRI BRAIN W/O & W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
70554	FMRI BRAIN BY TECH	DIAGNOSTIC RADIOLOGY				SK098		ED014		
71010	CHEST X-RAY	DIAGNOSTIC RADIOLOGY	SK092							
71015	CHEST X-RAY	DIAGNOSTIC RADIOLOGY	SK092							
71020	CHEST X-RAY	DIAGNOSTIC RADIOLOGY	SK092							
71021	CHEST X-RAY	DIAGNOSTIC RADIOLOGY	SK092							
71022	CHEST X-RAY	DIAGNOSTIC RADIOLOGY	SK092							
71023	CHEST X-RAY AND FLUOROSCOPY	DIAGNOSTIC RADIOLOGY	SK092							
71030	CHEST X-RAY	DIAGNOSTIC RADIOLOGY	SK092							
71034	CHEST X-RAY AND FLUOROSCOPY	CARDIOLOGY	SK092							
71035	CHEST X-RAY	DIAGNOSTIC RADIOLOGY	SK092							
71040	CONTRAST X-RAY OF BRONCHI	DIAGNOSTIC RADIOLOGY	SK092							
71060	CONTRAST X-RAY OF BRONCHI	DIAGNOSTIC RADIOLOGY	SK092							
71100	X-RAY EXAM OF RIBS	DIAGNOSTIC RADIOLOGY	SK092							
71101	X-RAY EXAM OF RIBS/CHEST	DIAGNOSTIC RADIOLOGY	SK092							
71110	X-RAY EXAM OF RIBS	DIAGNOSTIC RADIOLOGY	SK092							
71111	X-RAY EXAM OF RIBS/CHEST	DIAGNOSTIC RADIOLOGY	SK092							
71120	X-RAY EXAM OF BREASTBONE	DIAGNOSTIC RADIOLOGY	SK092							
71130	X-RAY EXAM OF BREASTBONE	DIAGNOSTIC RADIOLOGY	SK092							
71250	CT THORAX W/O DYE	DIAGNOSTIC RADIOLOGY				SK098				
71260	CT THORAX W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
71270	CT THORAX W/O & W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
71275	CT ANGIOGRAPHY CHEST	DIAGNOSTIC RADIOLOGY								
71550	MRI CHEST W/O DYE	DIAGNOSTIC RADIOLOGY								



CPT Code	Short Descriptor	Top Specialty	SK092 - x-ray fixer solution	SK093 - x-ray ID card (flashcard)	SK094 - x-ray marking pencil	SK098 - film, x-ray, laser print	SM009 - cleaner, x-ray cassette-screen	ED014 - computer workstation, 3D reconstruction CT-MR	ED016 - computer workstation, MRA post processing	ED023 - film processor, PET imaging
71551	MRI CHEST W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
71552	MRI CHEST W/O & W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
71555	MRI ANGIO CHEST W OR W/O DYE	DIAGNOSTIC RADIOLOGY				SK098			ED016	
72010	X-RAY EXAM OF SPINE	INTERNAL MEDICINE	SK092							
72020	X-RAY EXAM OF SPINE	DIAGNOSTIC RADIOLOGY	SK092							
72040	X-RAY EXAM OF NECK SPINE	DIAGNOSTIC RADIOLOGY	SK092							
72050	X-RAY EXAM OF NECK SPINE	DIAGNOSTIC RADIOLOGY	SK092							
72052	X-RAY EXAM OF NECK SPINE	DIAGNOSTIC RADIOLOGY	SK092							
72069	X-RAY EXAM OF TRUNK SPINE	DIAGNOSTIC RADIOLOGY	SK092							
72070	X-RAY EXAM OF THORACIC SPINE	DIAGNOSTIC RADIOLOGY	SK092							
72072	X-RAY EXAM OF THORACIC SPINE	DIAGNOSTIC RADIOLOGY	SK092							
72074	X-RAY EXAM OF THORACIC SPINE	DIAGNOSTIC RADIOLOGY	SK092							
72080	X-RAY EXAM OF TRUNK SPINE	DIAGNOSTIC RADIOLOGY	SK092							
72090	X-RAY EXAM OF TRUNK SPINE	DIAGNOSTIC RADIOLOGY	SK092							
72100	X-RAY EXAM OF LOWER SPINE	DIAGNOSTIC RADIOLOGY	SK092							
72110	X-RAY EXAM OF LOWER SPINE	DIAGNOSTIC RADIOLOGY	SK092							
72114	X-RAY EXAM OF LOWER SPINE	DIAGNOSTIC RADIOLOGY	SK092							
72120	X-RAY EXAM OF LOWER SPINE	ORTHOPEDIC SURGERY	SK092							
72125	CT NECK SPINE W/O DYE	DIAGNOSTIC RADIOLOGY				SK098				
72126	CT NECK SPINE W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
72127	CT NECK SPINE W/O & W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
72128	CT CHEST SPINE W/O DYE	DIAGNOSTIC RADIOLOGY				SK098				
72129	CT CHEST SPINE W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
72130	CT CHEST SPINE W/O & W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
72131	CT LUMBAR SPINE W/O DYE	DIAGNOSTIC RADIOLOGY				SK098				
72132	CT LUMBAR SPINE W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
72133	CT LUMBAR SPINE W/O & W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
72141	MRI NECK SPINE W/O DYE	DIAGNOSTIC RADIOLOGY								
72142	MRI NECK SPINE W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
72146	MRI CHEST SPINE W/O DYE	DIAGNOSTIC RADIOLOGY								
72147	MRI CHEST SPINE W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
72148	MRI LUMBAR SPINE W/O DYE	DIAGNOSTIC RADIOLOGY								
72149	MRI LUMBAR SPINE W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
72156	MRI NECK SPINE W/O & W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
72157	MRI CHEST SPINE W/O & W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
72158	MRI LUMBAR SPINE W/O & W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
72159	MR ANGIO SPINE W/O&W/DYE	DIAGNOSTIC RADIOLOGY				SK098			ED016	
72170	X-RAY EXAM OF PELVIS	DIAGNOSTIC RADIOLOGY	SK092							
72190	X-RAY EXAM OF PELVIS	DIAGNOSTIC RADIOLOGY	SK092							
72191	CT ANGIOGRAPH PELV W/O&W/DYE	DIAGNOSTIC RADIOLOGY	SK092			SK098		ED014		
72192	CT PELVIS W/O DYE	DIAGNOSTIC RADIOLOGY				SK098				
72193	CT PELVIS W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
72194	CT PELVIS W/O & W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
72195	MRI PELVIS W/O DYE	DIAGNOSTIC RADIOLOGY								
72196	MRI PELVIS W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
72197	MRI PELVIS W/O & W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
72198	MR ANGIO PELVIS W/O & W/DYE	DIAGNOSTIC RADIOLOGY				SK098			ED016	
72200	X-RAY EXAM SACROILIAC JOINTS	DIAGNOSTIC RADIOLOGY	SK092							
72202	X-RAY EXAM SACROILIAC JOINTS	DIAGNOSTIC RADIOLOGY	SK092							
72220	X-RAY EXAM OF TAILBONE	DIAGNOSTIC RADIOLOGY	SK092							
72240	CONTRAST X-RAY OF NECK SPINE	DIAGNOSTIC RADIOLOGY	SK092							
72255	CONTRAST X-RAY THORAX SPINE	DIAGNOSTIC RADIOLOGY	SK092							
72265	CONTRAST X-RAY LOWER SPINE	DIAGNOSTIC RADIOLOGY	SK092							
72270	CONTRAST X-RAY SPINE	DIAGNOSTIC RADIOLOGY	SK092							
72275	EPIDUROGRAPHY	MANAGEMENT	SK092							
72285	X-RAY C/T SPINE DISK	MANAGEMENT	SK092							
72295	X-RAY OF LOWER SPINE DISK	MANAGEMENT	SK092							
73000	X-RAY EXAM OF COLLAR BONE	DIAGNOSTIC RADIOLOGY	SK092							
73010	X-RAY EXAM OF SHOULDER BLADE	ORTHOPEDIC SURGERY	SK092							
73020	X-RAY EXAM OF SHOULDER	DIAGNOSTIC RADIOLOGY	SK092							
73030	X-RAY EXAM OF SHOULDER	DIAGNOSTIC RADIOLOGY	SK092							
73040	CONTRAST X-RAY OF SHOULDER	DIAGNOSTIC RADIOLOGY	SK092							
73050	X-RAY EXAM OF SHOULDERS	ORTHOPEDIC SURGERY	SK092							
73060	X-RAY EXAM OF HUMERUS	DIAGNOSTIC RADIOLOGY	SK092							
73070	X-RAY EXAM OF ELBOW	DIAGNOSTIC RADIOLOGY	SK092							
73080	X-RAY EXAM OF ELBOW	DIAGNOSTIC RADIOLOGY	SK092							
73085	CONTRAST X-RAY OF ELBOW	DIAGNOSTIC RADIOLOGY	SK092							
73090	X-RAY EXAM OF FOREARM	DIAGNOSTIC RADIOLOGY	SK092							
73092	X-RAY EXAM OF ARM INFANT	FAMILY PRACTICE	SK092							
73100	X-RAY EXAM OF WRIST	ORTHOPEDIC SURGERY	SK092							
73110	X-RAY EXAM OF WRIST	DIAGNOSTIC RADIOLOGY	SK092							
73115	CONTRAST X-RAY OF WRIST	DIAGNOSTIC RADIOLOGY	SK092							
73120	X-RAY EXAM OF HAND	DIAGNOSTIC RADIOLOGY	SK092							
73130	X-RAY EXAM OF HAND	DIAGNOSTIC RADIOLOGY	SK092							
73140	X-RAY EXAM OF FINGER(S)	DIAGNOSTIC RADIOLOGY	SK092							
73200	CT UPPER EXTREMITY W/O DYE	DIAGNOSTIC RADIOLOGY				SK098				
73201	CT UPPER EXTREMITY W/DYE	DIAGNOSTIC RADIOLOGY				SK098				

CPT Code	Short Descriptor	Top Specialty	SK092 - x-ray fixer solution	SK093 - x-ray ID card (flashcard)	SK094 - x-ray marking pencil	SK098 - film, x-ray, laser print	SM009 - cleaner, x-ray cassette-screen	ED014 - computer workstation, 3D reconstruction CT-MR	ED016 - computer workstation, MRA post processing	ED023 - film processor, PET imaging
73202	CT UPPR EXTREMITY W/O&W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
73206	CT ANGIO UPR EXTRM W/O&W/DYE	DIAGNOSTIC RADIOLOGY								
73218	MRI UPPER EXTREMITY W/O DYE	DIAGNOSTIC RADIOLOGY								
73219	MRI UPPER EXTREMITY W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
73220	MRI UPPR EXTREMITY W/O&W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
73221	MRI JOINT UPR EXTREM W/O DYE	DIAGNOSTIC RADIOLOGY								
73222	MRI JOINT UPR EXTREM W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
73223	MRI JOINT UPR EXTR W/O&W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
73225	MR ANGIO UPR EXTR W/O&W/DYE	DIAGNOSTIC RADIOLOGY				SK098			ED016	
73500	X-RAY EXAM OF HIP	DIAGNOSTIC RADIOLOGY	SK092							
73510	X-RAY EXAM OF HIP	DIAGNOSTIC RADIOLOGY	SK092							
73520	X-RAY EXAM OF HIPS	DIAGNOSTIC RADIOLOGY	SK092							
73525	CONTRAST X-RAY OF HIP	DIAGNOSTIC RADIOLOGY	SK092							
73540	X-RAY EXAM OF PELVIS & HIPS	ORTHOPEDIC SURGERY	SK092							
73550	X-RAY EXAM OF THIGH	DIAGNOSTIC RADIOLOGY	SK092							
73560	X-RAY EXAM OF KNEE 1 OR 2	ORTHOPEDIC SURGERY	SK092							
73562	X-RAY EXAM OF KNEE 3	ORTHOPEDIC SURGERY	SK092							
73564	X-RAY EXAM KNEE 4 OR MORE	DIAGNOSTIC RADIOLOGY	SK092							
73565	X-RAY EXAM OF KNEES	ORTHOPEDIC SURGERY	SK092							
73580	CONTRAST X-RAY OF KNEE JOINT	ORTHOPEDIC SURGERY	SK092							
73590	X-RAY EXAM OF LOWER LEG	DIAGNOSTIC RADIOLOGY	SK092							
73592	X-RAY EXAM OF LEG INFANT	DIAGNOSTIC RADIOLOGY	SK092							
73600	X-RAY EXAM OF ANKLE	DIAGNOSTIC RADIOLOGY	SK092							
73610	X-RAY EXAM OF ANKLE	DIAGNOSTIC RADIOLOGY	SK092							
73615	CONTRAST X-RAY OF ANKLE	ORTHOPEDIC SURGERY	SK092							
73620	X-RAY EXAM OF FOOT	PODIATRY	SK092							
73630	X-RAY EXAM OF FOOT	DIAGNOSTIC RADIOLOGY	SK092							
73650	X-RAY EXAM OF HEEL	DIAGNOSTIC RADIOLOGY	SK092							
73660	X-RAY EXAM OF TOE(S)	DIAGNOSTIC RADIOLOGY	SK092							
73700	CT LOWER EXTREMITY W/O DYE	DIAGNOSTIC RADIOLOGY				SK098				
73701	CT LOWER EXTREMITY W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
73702	CT LWR EXTREMITY W/O&W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
73706	CT ANGIO LWR EXTR W/O&W/DYE	DIAGNOSTIC RADIOLOGY								
73718	MRI LOWER EXTREMITY W/O DYE	DIAGNOSTIC RADIOLOGY								
73719	MRI LOWER EXTREMITY W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
73720	MRI LWR EXTREMITY W/O&W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
73721	MRI JNT OF LWR EXTRE W/O DYE	DIAGNOSTIC RADIOLOGY								
73722	MRI JOINT OF LWR EXTR W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
73723	MRI JOINT LWR EXTR W/O&W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
73725	MR ANG LWR EXT W OR W/O DYE	DIAGNOSTIC RADIOLOGY				SK098			ED016	
74000	X-RAY EXAM OF ABDOMEN	DIAGNOSTIC RADIOLOGY	SK092							
74010	X-RAY EXAM OF ABDOMEN	DIAGNOSTIC RADIOLOGY	SK092							
74020	X-RAY EXAM OF ABDOMEN	DIAGNOSTIC RADIOLOGY	SK092							
74022	X-RAY EXAM SERIES ABDOMEN	DIAGNOSTIC RADIOLOGY	SK092							
74150	CT ABDOMEN W/O DYE	DIAGNOSTIC RADIOLOGY				SK098				
74160	CT ABDOMEN W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
74170	CT ABDOMEN W/O & W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
74174	CT ANGIO ABD&PELV W/O&W/DYE	DIAGNOSTIC RADIOLOGY	SK092			SK098		ED014		
74175	CT ANGIO ABDOM W/O & W/DYE	DIAGNOSTIC RADIOLOGY	SK092			SK098		ED014		
74176	CT ABD & PELVIS	DIAGNOSTIC RADIOLOGY				SK098				
74177	CT ABD & PELV W/CONTRAST	DIAGNOSTIC RADIOLOGY				SK098				
74178	CT ABD & PELV 1/> REGNS	DIAGNOSTIC RADIOLOGY				SK098				
74181	MRI ABDOMEN W/O DYE	DIAGNOSTIC RADIOLOGY				SK098				
74182	MRI ABDOMEN W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
74183	MRI ABDOMEN W/O & W/DYE	DIAGNOSTIC RADIOLOGY				SK098				
74185	MRI ANGIO ABDOM W ORW/O DYE	DIAGNOSTIC RADIOLOGY				SK098			ED016	
74210	CONTRST X-RAY EXAM OF THROAT	DIAGNOSTIC RADIOLOGY	SK092							
74220	CONTRAST X-RAY ESOPHAGUS	DIAGNOSTIC RADIOLOGY	SK092							
74230	CINE/VID X-RAY THROAT/ESOPH	DIAGNOSTIC RADIOLOGY	SK092							
74240	X-RAY EXAM UPPER GI TRACT	DIAGNOSTIC RADIOLOGY	SK092							
74241	X-RAY EXAM UPPER GI TRACT	DIAGNOSTIC RADIOLOGY	SK092							
74245	X-RAY EXAM UPPER GI TRACT	DIAGNOSTIC RADIOLOGY	SK092							
74246	CONTRST X-RAY UPPR GI TRACT	DIAGNOSTIC RADIOLOGY	SK092							
74247	CONTRST X-RAY UPPR GI TRACT	DIAGNOSTIC RADIOLOGY	SK092							
74249	CONTRST X-RAY UPPR GI TRACT	DIAGNOSTIC RADIOLOGY	SK092							
74250	X-RAY EXAM OF SMALL BOWEL	DIAGNOSTIC RADIOLOGY	SK092							
74251	X-RAY EXAM OF SMALL BOWEL	DIAGNOSTIC RADIOLOGY	SK092							
74260	X-RAY EXAM OF SMALL BOWEL	DIAGNOSTIC RADIOLOGY	SK092							
74261	Ct colonography dx	DIAGNOSTIC RADIOLOGY								
74262	Ct colonography dx w/dye	DIAGNOSTIC RADIOLOGY								
74263	Ct colonography screening									
74270	CONTRAST X-RAY EXAM OF COLON	DIAGNOSTIC RADIOLOGY	SK092							
74280	CONTRAST X-RAY EXAM OF COLON	DIAGNOSTIC RADIOLOGY	SK092							
74283	CONTRAST X-RAY EXAM OF COLON	DIAGNOSTIC RADIOLOGY	SK092							
74290	CONTRAST X-RAY GALLBLADDER	DIAGNOSTIC RADIOLOGY	SK092							
74291	CONTRAST X-RAYS GALLBLADDER	DIAGNOSTIC RADIOLOGY	SK092							
74320	CONTRAST X-RAY OF BILE DUCTS	DIAGNOSTIC RADIOLOGY		SK093		SK098				

CPT Code	Short Descriptor	Top Specialty	SK092 - x-ray fixer solution	SK093 - x-ray ID card (flashcard)	SK094 - x-ray marking pencil	SK098 - film, x-ray, laser print	SM009 - cleaner, x-ray cassette-screen	ED014 - computer workstation, 3D reconstruction CT-MR	ED016 - computer workstation, MRA post processing	ED023 - film processor, PET imaging
74327	X-RAY BILE STONE REMOVAL	DIAGNOSTIC RADIOLOGY		SK093		SK098				
74400	CONTRST X-RAY URINARY TRACT	DIAGNOSTIC RADIOLOGY		SK093						
74410	CONTRST X-RAY URINARY TRACT	DIAGNOSTIC RADIOLOGY		SK093						
74415	CONTRST X-RAY URINARY TRACT	DIAGNOSTIC RADIOLOGY		SK093						
74430	CONTRAST X-RAY BLADDER	DIAGNOSTIC RADIOLOGY		SK093						
74440	X-RAY MALE GENITAL TRACT	UROLOGY								
74455	X-RAY URETHRA/BLADDER	UROLOGY		SK093						
74475	X-RAY CONTROL CATH INSERT	DIAGNOSTIC RADIOLOGY				SK098				
74480	X-RAY CONTROL CATH INSERT	DIAGNOSTIC RADIOLOGY				SK098				
74485	X-RAY GUIDE GU DILATION	DIAGNOSTIC RADIOLOGY				SK098				
74710	X-RAY MEASUREMENT OF PELVIS	DIAGNOSTIC RADIOLOGY	SK092							
74740	X-RAY FEMALE GENITAL TRACT	DIAGNOSTIC RADIOLOGY		SK093						
75557	CARDIAC MRI FOR MORPH	DIAGNOSTIC RADIOLOGY						ED014		
75559	CARDIAC MRI W/STRESS IMG	CARDIOLOGY						ED014		
75561	CARDIAC MRI FOR MORPH W/DYE	CARDIOLOGY						ED014		
75563	CARD MRI W/STRESS IMG & DYE	CARDIOLOGY						ED014		
75565	CARD MRI VELOC FLOW MAPPING	DIAGNOSTIC RADIOLOGY						ED014		
75571	CT HRT W/O DYE W/CA TEST	CARDIOLOGY						ED014		
75572	CT HRT W/3D IMAGE	CARDIOLOGY						ED014		
75573	CT HRT W/3D IMAGE CONGEN	DIAGNOSTIC RADIOLOGY						ED014		
75574	CT ANGIO HRT W/3D IMAGE	CARDIOLOGY						ED014		
75600	CONTRAST X-RAY EXAM OF AORTA	CARDIOLOGY	SK092	SK093		SK098				
75605	CONTRAST X-RAY EXAM OF AORTA	CARDIOLOGY		SK093		SK098				
75625	CONTRAST X-RAY EXAM OF AORTA	CARDIOLOGY		SK093		SK098				
75630	X-RAY AORTA LEG ARTERIES	CARDIOLOGY		SK093		SK098				
75635	CT ANGIO ABDOMINAL ARTERIES	DIAGNOSTIC RADIOLOGY								
75650	ARTERY X-RAYS HEAD & NECK	CARDIOLOGY		SK093		SK098				
75658	ARTERY X-RAYS ARM	NEPHROLOGY		SK093		SK098				
75660	ARTERY X-RAYS HEAD & NECK	DIAGNOSTIC RADIOLOGY		SK093		SK098				
75662	ARTERY X-RAYS HEAD & NECK	CARDIOLOGY		SK093		SK098				
75665	ARTERY X-RAYS HEAD & NECK	DIAGNOSTIC RADIOLOGY		SK093		SK098				
75671	ARTERY X-RAYS HEAD & NECK	DIAGNOSTIC RADIOLOGY		SK093		SK098				
75676	ARTERY X-RAYS NECK	DIAGNOSTIC RADIOLOGY		SK093		SK098				
75680	ARTERY X-RAYS NECK	CARDIOLOGY		SK093		SK098				
75685	ARTERY X-RAYS SPINE	DIAGNOSTIC RADIOLOGY		SK093		SK098				
75705	ARTERY X-RAYS SPINE	DIAGNOSTIC RADIOLOGY		SK093		SK098				
75710	ARTERY X-RAYS ARM/LEG	CARDIOLOGY		SK093		SK098				
75716	ARTERY X-RAYS ARMS/LEGS	CARDIOLOGY		SK093		SK098				
75726	ARTERY X-RAYS ABDOMEN	DIAGNOSTIC RADIOLOGY		SK093		SK098				
75731	ARTERY X-RAYS ADRENAL GLAND	CARDIOLOGY		SK093		SK098				
75733	ARTERY X-RAYS ADRENALS	CARDIOLOGY		SK093		SK098				
75736	ARTERY X-RAYS PELVIS	DIAGNOSTIC RADIOLOGY		SK093		SK098				
75741	ARTERY X-RAYS LUNG	DIAGNOSTIC RADIOLOGY		SK093		SK098				
75743	ARTERY X-RAYS LUNGS	DIAGNOSTIC RADIOLOGY		SK093		SK098				
75746	ARTERY X-RAYS LUNG	DIAGNOSTIC RADIOLOGY		SK093		SK098				
75756	ARTERY X-RAYS CHEST	CARDIOLOGY		SK093		SK098				
75774	ARTERY X-RAY EACH VESSEL	DIAGNOSTIC RADIOLOGY				SK098				
75791	AV DIALYSIS SHUNT IMAGING	NEPHROLOGY	SK092							
75809	NONVASCULAR SHUNT X-RAY	DIAGNOSTIC RADIOLOGY				SK098				
75820	VEIN X-RAY ARM/LEG	CARDIOLOGY		SK093		SK098				
75822	VEIN X-RAY ARMS/LEGS	DIAGNOSTIC RADIOLOGY		SK093		SK098				
75825	VEIN X-RAY TRUNK	DIAGNOSTIC RADIOLOGY		SK093		SK098				
75827	VEIN X-RAY CHEST	DIAGNOSTIC RADIOLOGY		SK093		SK098				
75831	VEIN X-RAY KIDNEY	DIAGNOSTIC RADIOLOGY		SK093		SK098				
75833	VEIN X-RAY KIDNEYS	DIAGNOSTIC RADIOLOGY		SK093		SK098				
75840	VEIN X-RAY ADRENAL GLAND	VASCULAR SURGERY		SK093		SK098				
75842	VEIN X-RAY ADRENAL GLANDS	DIAGNOSTIC RADIOLOGY		SK093		SK098				
75860	VEIN X-RAY NECK	CARDIOLOGY		SK093		SK098				
75870	VEIN X-RAY SKULL	DIAGNOSTIC RADIOLOGY		SK093		SK098				
75872	VEIN X-RAY SKULL	NEUROSURGERY		SK093		SK098				
75880	VEIN X-RAY EYE SOCKET	NEUROLOGY		SK093		SK098				
75885	VEIN X-RAY LIVER	DIAGNOSTIC RADIOLOGY		SK093						
75887	VEIN X-RAY LIVER	DIAGNOSTIC RADIOLOGY		SK093						
75889	VEIN X-RAY LIVER	DIAGNOSTIC RADIOLOGY		SK093		SK098				
75891	VEIN X-RAY LIVER	DIAGNOSTIC RADIOLOGY		SK093		SK098				
75893	VENOUS SAMPLING BY CATHETER	DIAGNOSTIC RADIOLOGY		SK093		SK098				
75901	REMOVE CVA DEVICE OBSTRUCT	DIAGNOSTIC RADIOLOGY								
75902	REMOVE CVA LUMEN OBSTRUCT	DIAGNOSTIC RADIOLOGY								
75960	TRANSCATH IV STENT RS&I	CARDIOLOGY	SK092							
75961	RETRIEVAL BROKEN CATHETER	DIAGNOSTIC RADIOLOGY		SK093		SK098				
75962	REPAIR ARTERIAL BLOCKAGE	CARDIOLOGY		SK093		SK098				
75964	REPAIR ARTERY BLOCKAGE EACH	VASCULAR SURGERY				SK098				
75966	REPAIR ARTERIAL BLOCKAGE	CARDIOLOGY		SK093		SK098				
75968	REPAIR ARTERY BLOCKAGE EACH	CARDIOLOGY				SK098				
75978	REPAIR VENOUS BLOCKAGE	DIAGNOSTIC RADIOLOGY		SK093		SK098				
75984	XRAY CONTROL CATHETER CHANGE	DIAGNOSTIC RADIOLOGY				SK098				
75989	ABSCCESS DRAINAGE UNDER X-RAY	DIAGNOSTIC RADIOLOGY		SK093		SK098				

CPT Code	Short Descriptor	Top Specialty	SK092 - x-ray fixer solution	SK093 - x-ray ID card (flashcard)	SK094 - x-ray marking pencil	SK098 - film, x-ray, laser print	SM009 - cleaner, x-ray cassette-screen	ED014 - computer workstation, 3D reconstruction CT-MR	ED016 - computer workstation, MRA post processing	ED023 - film processor, PET imaging
76000	FLUOROSCOPE EXAMINATION	DIAGNOSTIC RADIOLOGY								
76010	X-RAY NOSE TO RECTUM	DIAGNOSTIC RADIOLOGY	SK092							
76080	X-RAY EXAM OF FISTULA	DIAGNOSTIC RADIOLOGY				SK098				
76098	X-RAY EXAM BREAST SPECIMEN	DIAGNOSTIC RADIOLOGY		SK093		SK098	SM009			
76120	CINE/VIDEO X-RAYS	IDTF								
76376	3D RENDER W/O POSTPROCESS	DIAGNOSTIC RADIOLOGY	SK092							
76377	3D RENDERING W/POSTPROCESS	DIAGNOSTIC RADIOLOGY	SK092					ED014		
76380	CAT SCAN FOLLOW-UP STUDY	DIAGNOSTIC RADIOLOGY				SK098				
76390	MR SPECTROSCOPY	DIAGNOSTIC RADIOLOGY								
76506	ECHO EXAM OF HEAD	DIAGNOSTIC RADIOLOGY								
76536	US EXAM OF HEAD AND NECK	DIAGNOSTIC RADIOLOGY								
76604	US EXAM CHEST	DIAGNOSTIC RADIOLOGY				SK098				
76645	US EXAM BREAST(S)	DIAGNOSTIC RADIOLOGY				SK098				
76700	US EXAM ABDOM COMPLETE	DIAGNOSTIC RADIOLOGY								
76705	ECHO EXAM OF ABDOMEN	DIAGNOSTIC RADIOLOGY				SK098				
76770	US EXAM ABDO BACK WALL COMP	DIAGNOSTIC RADIOLOGY								
76775	US EXAM ABDO BACK WALL LIM	DIAGNOSTIC RADIOLOGY				SK098				
76776	US EXAM K TRANSPL W/DOPPLER	DIAGNOSTIC RADIOLOGY				SK098				
76800	US EXAM SPINAL CANAL	GENERAL PRACTICE				SK098				
76801	OB US < 14 WKS SINGLE FETUS	DIAGNOSTIC RADIOLOGY								
76830	TRANSVAGINAL US NON-OB	DIAGNOSTIC RADIOLOGY								
76856	US EXAM PELVIC COMPLETE	DIAGNOSTIC RADIOLOGY								
76857	US EXAM PELVIC LIMITED	UROLOGY								
76870	US EXAM SCROTUM	DIAGNOSTIC RADIOLOGY								
76872	US TRANSRECTAL	UROLOGY								
76873	ECHOGRAP TRANS R PROS STUDY	RADIATION ONCOLOGY								
76881	US XTR NON-VASC COMPLETE	PODIATRY								
76885	US EXAM INFANT HIPS DYNAMIC	DIAGNOSTIC RADIOLOGY								
76886	US EXAM INFANT HIPS STATIC	DIAGNOSTIC RADIOLOGY				SK098				
76936	ECHO GUIDE FOR ARTERY REPAIR	DIAGNOSTIC RADIOLOGY				SK098				
76937	US GUIDE VASCULAR ACCESS	DIAGNOSTIC RADIOLOGY								
76942	ECHO GUIDE FOR BIOPSY	DIAGNOSTIC RADIOLOGY								
76970	ULTRASOUND EXAM FOLLOW-UP	GENERAL SURGERY								
77001	FLUOROGUIDE FOR VEIN DEVICE	DIAGNOSTIC RADIOLOGY								
77002	NEEDLE LOCALIZATION BY XRAY	DIAGNOSTIC RADIOLOGY		SK093						
77003	FLUOROGUIDE FOR SPINE INJECT	ANESTHESIOLOGY	SK092							
77011	CT SCAN FOR LOCALIZATION	DIAGNOSTIC RADIOLOGY				SK098				
77012	CT SCAN FOR NEEDLE BIOPSY	DIAGNOSTIC RADIOLOGY				SK098				
77014	CT SCAN FOR THERAPY GUIDE	RADIATION ONCOLOGY				SK098				
77021	MR GUIDANCE FOR NEEDLE PLACE	DIAGNOSTIC RADIOLOGY								
77031	STEREOTACT GUIDE FOR BRST BX	DIAGNOSTIC RADIOLOGY	SK092							
77032	GUIDANCE FOR NEEDLE BREAST	DIAGNOSTIC RADIOLOGY	SK092							
77051	COMPUTER DX MAMMOGRAM ADD-ON	DIAGNOSTIC RADIOLOGY								
77052	COMP SCREEN MAMMOGRAM ADD-ON	DIAGNOSTIC RADIOLOGY								
77053	X-RAY OF MAMMARY DUCT	DIAGNOSTIC RADIOLOGY	SK092							
77054	X-RAY OF MAMMARY DUCTS	DIAGNOSTIC RADIOLOGY	SK092							
77055	MAMMOGRAM ONE BREAST	DIAGNOSTIC RADIOLOGY		SK093		SK098	SM009			
77056	MAMMOGRAM BOTH BREASTS	DIAGNOSTIC RADIOLOGY		SK093		SK098	SM009			
77057	MAMMOGRAM SCREENING	DIAGNOSTIC RADIOLOGY		SK093		SK098	SM009			
77058	MRI ONE BREAST	DIAGNOSTIC RADIOLOGY				SK098				
77059	MRI BOTH BREASTS	DIAGNOSTIC RADIOLOGY				SK098				
77071	X-RAY STRESS VIEW	ORTHOPEDIC SURGERY	SK092							
77072	X-RAYS FOR BONE AGE	DIAGNOSTIC RADIOLOGY	SK092							
77073	X-RAYS BONE LENGTH STUDIES	ORTHOPEDIC SURGERY	SK092							
77074	X-RAYS BONE SURVEY LIMITED	DIAGNOSTIC RADIOLOGY	SK092							
77075	X-RAYS BONE SURVEY COMPLETE	DIAGNOSTIC RADIOLOGY	SK092							
77076	X-RAYS BONE SURVEY INFANT	DIAGNOSTIC RADIOLOGY	SK092							
77077	JOINT SURVEY SINGLE VIEW	ORTHOPEDIC SURGERY	SK092							
77084	MAGNETIC IMAGE BONE MARROW	DIAGNOSTIC RADIOLOGY								
77280	SET RADIATION THERAPY FIELD	RADIATION ONCOLOGY	SK092							
77285	SET RADIATION THERAPY FIELD	RADIATION ONCOLOGY	SK092							
77290	SET RADIATION THERAPY FIELD	RADIATION ONCOLOGY	SK092							
77301	RADIOTHERAPY DOSE PLAN IMRT	RADIATION ONCOLOGY								
77336	RADIATION PHYSICS CONSULT	RADIATION ONCOLOGY								
77370	RADIATION PHYSICS CONSULT	RADIATION ONCOLOGY								
77371	SRS MULTISOURCE	NEUROSURGERY								
77372	SRS LINEAR BASED	RADIATION ONCOLOGY		SK093	SK094					
77417	RADIOLOGY PORT FILM(S)	RADIATION ONCOLOGY	SK092	SK093	SK094					
77418	RADIATION TX DELIVERY IMRT	RADIATION ONCOLOGY		SK093						
77422	NEUTRON BEAM TX SIMPLE	RADIATION ONCOLOGY								
77423	NEUTRON BEAM TX COMPLEX	RADIATION ONCOLOGY								
78006	THYROID IMAGING WITH UPTAKE	DIAGNOSTIC RADIOLOGY	SK092							
78007	THYROID IMAGE MULT UPTAKES	DIAGNOSTIC RADIOLOGY	SK092							
78010	THYROID IMAGING	DIAGNOSTIC RADIOLOGY	SK092							
78011	THYROID IMAGING WITH FLOW	DIAGNOSTIC RADIOLOGY	SK092							
78015	THYROID MET IMAGING	DIAGNOSTIC RADIOLOGY	SK092							
78016	THYROID MET IMAGING/STUDIES	NUCLEAR MEDICINE	SK092							

CPT Code	Short Descriptor	Top Specialty	SK092 - x-ray fixer solution	SK093 - x-ray ID card (flashcard)	SK094 - x-ray marking pencil	SK098 - film, x-ray, laser print	SM009 - cleaner, x-ray cassette-screen	ED014 - computer workstation, 3D reconstruction CT-MR	ED016 - computer workstation, MRA post processing	ED023 - film processor, PET imaging
78018	THYROID MET IMAGING BODY	DIAGNOSTIC RADIOLOGY	SK092							
78020	THYROID MET UPTAKE	DIAGNOSTIC RADIOLOGY	SK092							
78070	PARATHYROID NUCLEAR IMAGING	DIAGNOSTIC RADIOLOGY	SK092							
78075	ADRENAL NUCLEAR IMAGING	DIAGNOSTIC RADIOLOGY	SK092							
78102	BONE MARROW IMAGING LTD	DIAGNOSTIC RADIOLOGY	SK092							
78103	BONE MARROW IMAGING MULT	DIAGNOSTIC RADIOLOGY	SK092							
78104	BONE MARROW IMAGING BODY	DIAGNOSTIC RADIOLOGY	SK092							
78135	RED CELL SURVIVAL KINETICS	DIAGNOSTIC RADIOLOGY	SK092							
78140	RED CELL SEQUESTRATION	DIAGNOSTIC RADIOLOGY	SK092							
78185	SPLEEN IMAGING	DIAGNOSTIC RADIOLOGY	SK092							
78190	PLATELET SURVIVAL KINETICS	DIAGNOSTIC RADIOLOGY	SK092							
78195	LYMPH SYSTEM IMAGING	DIAGNOSTIC RADIOLOGY	SK092							
78201	LIVER IMAGING	DIAGNOSTIC RADIOLOGY	SK092							
78202	LIVER IMAGING WITH FLOW	DIAGNOSTIC RADIOLOGY	SK092							
78205	LIVER IMAGING (3D)	DIAGNOSTIC RADIOLOGY	SK092							
78206	LIVER IMAGE (3D) WITH FLOW	DIAGNOSTIC RADIOLOGY								
78215	LIVER AND SPLEEN IMAGING	DIAGNOSTIC RADIOLOGY	SK092							
78216	LIVER & SPLEEN IMAGE/FLOW	DIAGNOSTIC RADIOLOGY	SK092							
78226	HEPATOBIILIARY SYSTEM IMAGING	DIAGNOSTIC RADIOLOGY	SK092							
78227	HEPATOBIL SYST IMAGE W/DRUG	DIAGNOSTIC RADIOLOGY	SK092							
78230	SALIVARY GLAND IMAGING	DIAGNOSTIC RADIOLOGY	SK092							
78231	SERIAL SALIVARY IMAGING	NUCLEAR MEDICINE	SK092							
78232	SALIVARY GLAND FUNCTION EXAM	NUCLEAR MEDICINE	SK092							
78258	ESOPHAGEAL MOTILITY STUDY	DIAGNOSTIC RADIOLOGY	SK092							
78261	GASTRIC MUCOSA IMAGING	DIAGNOSTIC RADIOLOGY	SK092							
78262	GASTROESOPHAGEAL REFLUX EXAM	DIAGNOSTIC RADIOLOGY	SK092							
78264	GASTRIC EMPTYING STUDY	DIAGNOSTIC RADIOLOGY	SK092							
78278	ACUTE GI BLOOD LOSS IMAGING	DIAGNOSTIC RADIOLOGY	SK092							
78290	MECKELS DIVERT EXAM	DIAGNOSTIC RADIOLOGY	SK092							
78291	LEVEEN/SHUNT PATENCY EXAM	DIAGNOSTIC RADIOLOGY	SK092							
78300	BONE IMAGING LIMITED AREA	DIAGNOSTIC RADIOLOGY	SK092							
78305	BONE IMAGING MULTIPLE AREAS	DIAGNOSTIC RADIOLOGY	SK092							
78306	BONE IMAGING WHOLE BODY	DIAGNOSTIC RADIOLOGY	SK092							
78315	BONE IMAGING 3 PHASE	DIAGNOSTIC RADIOLOGY	SK092							
78320	BONE IMAGING (3D)	DIAGNOSTIC RADIOLOGY	SK092							
78414	NON-IMAGING HEART FUNCTION	INTERNAL MEDICINE								
78428	CARDIAC SHUNT IMAGING	CARDIOLOGY	SK092							
78445	VASCULAR FLOW IMAGING	DIAGNOSTIC RADIOLOGY	SK092							
78451	HT MUSCLE IMAGE SPECT SING	CARDIOLOGY	SK092							
78452	HT MUSCLE IMAGE SPECT MULT	CARDIOLOGY	SK092							
78453	HT MUSCLE IMAGE PLANAR SING	CARDIOLOGY	SK092							
78454	HT MUSC IMAGE PLANAR MULT	CARDIOLOGY	SK092							
78456	ACUTE VENOUS THROMBUS IMAGE	DIAGNOSTIC RADIOLOGY	SK092							
78457	VENOUS THROMBOSIS IMAGING	CARDIOLOGY	SK092							
78458	VEN THROMBOSIS IMAGES BILAT	NUCLEAR MEDICINE	SK092							
78466	HEART INFARCT IMAGE	CARDIOLOGY	SK092							
78468	HEART INFARCT IMAGE (EF)	CARDIOLOGY	SK092							
78469	HEART INFARCT IMAGE (3D)	INTERNAL MEDICINE	SK092							
78472	GATED HEART PLANAR SINGLE	DIAGNOSTIC RADIOLOGY	SK092							
78473	GATED HEART MULTIPLE	CARDIOLOGY	SK092							
78481	HEART FIRST PASS SINGLE	CARDIOLOGY	SK092							
78483	HEART FIRST PASS MULTIPLE	CARDIOLOGY	SK092							
78494	HEART IMAGE SPECT	CARDIOLOGY	SK092							
78579	LUNG VENTILATION IMAGING	DIAGNOSTIC RADIOLOGY	SK092							
78580	LUNG PERFUSION IMAGING	DIAGNOSTIC RADIOLOGY	SK092							
78582	LUNG VENTILAT&PERFUS IMAGING	DIAGNOSTIC RADIOLOGY	SK092							
78597	LUNG PERFUSION DIFFERENTIAL	DIAGNOSTIC RADIOLOGY	SK092							
78598	LUNG PERF&VENTILAT DIFERENTL	DIAGNOSTIC RADIOLOGY	SK092							
78600	BRAIN IMAGE < 4 VIEWS	DIAGNOSTIC RADIOLOGY	SK092							
78601	BRAIN IMAGE W/FLOW < 4 VIEWS	DIAGNOSTIC RADIOLOGY	SK092							
78605	BRAIN IMAGE 4+ VIEWS	DIAGNOSTIC RADIOLOGY	SK092							
78606	BRAIN IMAGE W/FLOW 4 + VIEWS	DIAGNOSTIC RADIOLOGY	SK092							
78607	BRAIN IMAGING (3D)	DIAGNOSTIC RADIOLOGY								
78610	BRAIN FLOW IMAGING ONLY	DIAGNOSTIC RADIOLOGY	SK092							
78630	CEREBROSPINAL FLUID SCAN	DIAGNOSTIC RADIOLOGY	SK092							
78635	CSF VENTRICULOGRAPHY	DIAGNOSTIC RADIOLOGY	SK092							
78645	CSF SHUNT EVALUATION	DIAGNOSTIC RADIOLOGY	SK092							
78647	CEREBROSPINAL FLUID SCAN	DIAGNOSTIC RADIOLOGY								
78650	CSF LEAKAGE IMAGING	DIAGNOSTIC RADIOLOGY	SK092							
78660	NUCLEAR EXAM OF TEAR FLOW	DIAGNOSTIC RADIOLOGY	SK092							
78700	KIDNEY IMAGING MORPHOL	DIAGNOSTIC RADIOLOGY	SK092							
78701	KIDNEY IMAGING WITH FLOW	DIAGNOSTIC RADIOLOGY	SK092							
78707	K FLOW/FUNCT IMAGE W/O DRUG	DIAGNOSTIC RADIOLOGY	SK092							
78708	K FLOW/FUNCT IMAGE W/DRUG	DIAGNOSTIC RADIOLOGY	SK092							
78709	K FLOW/FUNCT IMAGE MULTIPLE	DIAGNOSTIC RADIOLOGY	SK092							
78710	KIDNEY IMAGING (3D)	DIAGNOSTIC RADIOLOGY	SK092							
78730	Urinary bladder retention	UROLOGY								

CPT Code	Short Descriptor	Top Specialty	SK092 - x-ray fixer solution	SK093 - x-ray ID card (flashcard)	SK094 - x-ray marking pencil	SK098 - film, x-ray, laser print	SM009 - cleaner, x-ray cassette-screen	ED014 - computer workstation, 3D reconstruction CT-MR	ED016 - computer workstation, MRA post processing	ED023 - film processor, PET imaging
78740	URETERAL REFLEX STUDY	UROLOGY	SK092							
78761	TESTICULAR IMAGING W/FLOW	DIAGNOSTIC RADIOLOGY	SK092							
78800	TUMOR IMAGING LIMITED AREA	DIAGNOSTIC RADIOLOGY	SK092							
78801	TUMOR IMAGING MULT AREAS	DIAGNOSTIC RADIOLOGY	SK092							
78802	TUMOR IMAGING WHOLE BODY	DIAGNOSTIC RADIOLOGY	SK092							
78803	TUMOR IMAGING (3D)	DIAGNOSTIC RADIOLOGY								
78804	TUMOR IMAGING WHOLE BODY	DIAGNOSTIC RADIOLOGY	SK092							
78805	ABSCCESS IMAGING LTD AREA	DIAGNOSTIC RADIOLOGY	SK092							
78806	ABSCCESS IMAGING WHOLE BODY	DIAGNOSTIC RADIOLOGY	SK092							
78807	NUCLEAR LOCALIZATION/ABSCCESS	DIAGNOSTIC RADIOLOGY								
78811	PET IMAGE LTD AREA	DIAGNOSTIC RADIOLOGY				SK098				
78812	PET IMAGE SKULL-THIGH	DIAGNOSTIC RADIOLOGY				SK098				ED023
78813	PET IMAGE FULL BODY	DIAGNOSTIC RADIOLOGY				SK098				ED023
78814	PET IMAGE W/CT LMTD	DIAGNOSTIC RADIOLOGY				SK098				ED023
78815	PET IMAGE W/CT SKULL-THIGH	DIAGNOSTIC RADIOLOGY				SK098				ED023
78816	PET IMAGE W/CT FULL BODY	DIAGNOSTIC RADIOLOGY				SK098				ED023
79440	Nuclear rx intra-articular	FAMILY PRACTICE								
93303	ECHO TRANSTHORACIC	CARDIOLOGY								
93304	ECHO TRANSTHORACIC	CARDIOLOGY								
93306	TTE W/DOPPLER COMPLETE	CARDIOLOGY								
93307	TTE W/O DOPPLER COMPLETE	CARDIOLOGY								
93308	TTE F-UP OR LMTD	CARDIOLOGY								
93312	ECHO TRANSESOPHAGEAL	CARDIOLOGY								
93314	ECHO TRANSESOPHAGEAL	CARDIOLOGY								
93350	STRESS TTE ONLY	CARDIOLOGY								
93351	Stress tte complete	CARDIOLOGY								
93451	Right heart cath	CARDIOLOGY								
93452	Left hrt cath w/ventrclgrphy	CARDIOLOGY								
93453	R&l hrt cath w/ventrclgrphy	CARDIOLOGY								
93454	Coronary artery angio s&i	CARDIOLOGY								
93455	Coronary art/grft angio s&i	CARDIOLOGY								
93456	R hrt coronary artery angio	CARDIOLOGY								
93457	R hrt art/grft angio	CARDIOLOGY								
93458	L hrt artery/ventricle angio	CARDIOLOGY								
93459	L hrt art/grft angio	CARDIOLOGY								
93460	R&l hrt art/ventricle angio	CARDIOLOGY								
93461	R&l hrt art/ventricle angio	CARDIOLOGY								
93566	INJECT R VENTR/ATRIAL ANGIO	CARDIOLOGY		SK093						
93567	INJECT SUPRVLV AORTOGRAPHY	CARDIOLOGY		SK093						
93568	INJECT PULM ART HRT CATH	CARDIOLOGY		SK093						
93880	EXTRACRANIAL STUDY	DIAGNOSTIC RADIOLOGY								
93882	EXTRACRANIAL STUDY	VASCULAR SURGERY								
93886	INTRACRANIAL STUDY	NEUROLOGY								
93888	INTRACRANIAL STUDY	NEUROLOGY								
93890	TCD VASOREACTIVITY STUDY	DIAGNOSTIC RADIOLOGY								
93892	TCD EMBOLI DETECT W/O INJ	NEUROLOGY								
93893	TCD EMBOLI DETECT W/INJ	NEUROLOGY								
93925	LOWER EXTREMITY STUDY	DIAGNOSTIC RADIOLOGY								
93926	LOWER EXTREMITY STUDY	VASCULAR SURGERY								
93930	UPPER EXTREMITY STUDY	DIAGNOSTIC RADIOLOGY								
93931	UPPER EXTREMITY STUDY	VASCULAR SURGERY								
93970	EXTREMITY STUDY	DIAGNOSTIC RADIOLOGY								
93971	EXTREMITY STUDY	DIAGNOSTIC RADIOLOGY								
93975	VASCULAR STUDY	DIAGNOSTIC RADIOLOGY								
93976	VASCULAR STUDY	DIAGNOSTIC RADIOLOGY								
93978	VASCULAR STUDY	CARDIOLOGY								
93979	VASCULAR STUDY	CARDIOLOGY								
93980	PENILE VASCULAR STUDY	UROLOGY								
93981	PENILE VASCULAR STUDY	UROLOGY								
93990	DOPPLER FLOW TESTING	VASCULAR SURGERY								
G0106	COLON CA SCREEN;BARIUM ENEMA	DIAGNOSTIC RADIOLOGY		SK093						
G0120	COLON CA SCRNI; BARIUM ENEMA	DIAGNOSTIC RADIOLOGY		SK093						
G0122	COLON CA SCRNI; BARIUM ENEMA	NA		SK093						
G0288	RECON, CTA FOR SURG PLAN	VASCULAR SURGERY						ED014		
G0365	VESSEL MAPPING HEMO ACCESS	VASCULAR SURGERY								
G0389	ULTRASOUND EXAM AAA SCREEN	DIAGNOSTIC RADIOLOGY				SK098				



CPT Code	Short Descriptor	Top Specialty	ED024 - film processor, dry, laser	ED025 - film processor, wet	ED027 - film processor, x-omat (M6B)	ER018 - densitometer, film	ER029 - film alternator (motorized film viewbox)	ER067 - x-ray view box, 4 panel
15732	MUSCLE-SKIN GRAFT HEAD/NECK	RECONSTRUCTIVE SURGERY						
15734	MUSCLE-SKIN GRAFT TRUNK	RECONSTRUCTIVE SURGERY						
15736	MUSCLE-SKIN GRAFT ARM	RECONSTRUCTIVE SURGERY						
15738	MUSCLE-SKIN GRAFT LEG	RECONSTRUCTIVE SURGERY						
22520	Percut vertebroplasty thor	DIAGNOSTIC RADIOLOGY						ER067
22521	Percut vertebroplasty lumb	DIAGNOSTIC RADIOLOGY						ER067
22523	Percut kyphoplasty thor	ORTHOPEDIC SURGERY						ER067
22524	Percut kyphoplasty lumbar	ORTHOPEDIC SURGERY						ER067
22526	Idet single level							ER067
27096	INJECT SACROILIAC JOINT	ANESTHESIOLOGY						ER067
36147	ACCESS AV DIAL GRFT FOR EVAL	DIAGNOSTIC RADIOLOGY					ER029	
36251	INS CATH REN ART 1ST UNILAT	CARDIOLOGY					ER029	
36252	INS CATH REN ART 1ST BILAT	CARDIOLOGY					ER029	
36253	INS CATH REN ART 2ND+ UNILAT	CARDIOLOGY					ER029	
36254	INS CATH REN ART 2ND+ BILAT	CARDIOLOGY					ER029	
36475	ENDOVENOUS RF 1ST VEIN	GENERAL SURGERY						
36478	ENDOVENOUS LASER 1ST VEIN	VASCULAR SURGERY						
36598	INJ W/FLUOR EVAL CV DEVICE	DIAGNOSTIC RADIOLOGY					ER029	
37184	PRIM ART MECH THROMBECTOMY	DIAGNOSTIC RADIOLOGY		ED025			ER029	
37185	PRIM ART M-THROMBECT ADD-ON	VASCULAR SURGERY		ED025			ER029	
37186	SEC ART M-THROMBECT ADD-ON	CARDIOLOGY		ED025			ER029	
37187	VENOUS MECH THROMBECTOMY	DIAGNOSTIC RADIOLOGY		ED025			ER029	
37188	VENOUS M-THROMBECTOMY ADD-ON	DIAGNOSTIC RADIOLOGY		ED025			ER029	
37191	INS ENDOVAS VENA CAVA FILTR	DIAGNOSTIC RADIOLOGY					ER029	
37192	REDO ENDOVAS VENA CAVA FILTR	DIAGNOSTIC RADIOLOGY					ER029	
37193	REM ENDOVAS VENA CAVA FILTER	DIAGNOSTIC RADIOLOGY					ER029	
37210	EMBOLIZATION UTERINE FIBROID	DIAGNOSTIC RADIOLOGY					ER029	
37220	ILIAC REVASC	VASCULAR SURGERY					ER029	
37221	ILIAC REVASC W/STENT	VASCULAR SURGERY					ER029	
37222	ILIAC REVASC ADD-ON	VASCULAR SURGERY					ER029	
37223	ILIAC REVASC W/STENT ADD-ON	VASCULAR SURGERY					ER029	
37224	FEM/POPL REVAS W/TLA	VASCULAR SURGERY					ER029	
37225	FEM/POPL REVAS W/ATHER	CARDIOLOGY					ER029	
37226	FEM/POPL REVASC W/STENT	CARDIOLOGY					ER029	
37227	FEM/POPL REVASC STNT & ATHER	CARDIOLOGY					ER029	
37228	TIB/PER REVASC W/TLA	VASCULAR SURGERY					ER029	
37229	TIB/PER REVASC W/ATHER	CARDIOLOGY					ER029	
37230	TIB/PER REVASC W/STENT	CARDIOLOGY					ER029	
37231	TIB/PER REVASC STENT & ATHER	CARDIOLOGY					ER029	
37232	TIB/PER REVASC ADD-ON	VASCULAR SURGERY					ER029	
37233	TIBPER REVASC W/ATHER ADD-ON	CARDIOLOGY					ER029	
37234	REVSC OPN/PRQ TIB/PERO STENT	CARDIOLOGY					ER029	
37235	TIB/PER REVASC STNT & ATHER	CARDIOLOGY					ER029	
38790	INJECT FOR LYMPHATIC X-RAY	GENERAL SURGERY						
43756	DX DUOD INTUB W/ASP SPEC	GASTROENTEROLOGY						
43757	DX DUOD INTUB W/ASP SPECS	GASTROENTEROLOGY						
49083	ABD PARACENTESIS W/IMAGING	DIAGNOSTIC RADIOLOGY					ER029	
49418	INSERT TUN IP CATH PERC	DIAGNOSTIC RADIOLOGY	ED024				ER029	
49440	PLACE GASTROSTOMY TUBE PERC	DIAGNOSTIC RADIOLOGY					ER029	
49441	PLACE DUOD/JEJ TUBE PERC	DIAGNOSTIC RADIOLOGY					ER029	
49442	PLACE CECOSTOMY TUBE PERC	DIAGNOSTIC RADIOLOGY					ER029	
49446	CHANGE G-TUBE TO G-J PERC	DIAGNOSTIC RADIOLOGY					ER029	
49450	REPLACE G/C TUBE PERC	DIAGNOSTIC RADIOLOGY					ER029	
49451	REPLACE DUOD/JEJ TUBE PERC	DIAGNOSTIC RADIOLOGY					ER029	
49452	REPLACE G-J TUBE PERC	DIAGNOSTIC RADIOLOGY					ER029	
49460	FIX G/COLON TUBE W/DEVICE	DIAGNOSTIC RADIOLOGY					ER029	
49465	FLUORO EXAM OF G/COLON TUBE	DIAGNOSTIC RADIOLOGY					ER029	
50382	CHANGE URETER STENT PERCUT	DIAGNOSTIC RADIOLOGY	ED024				ER029	
50384	REMOVE URETER STENT PERCUT	DIAGNOSTIC RADIOLOGY	ED024				ER029	
50385	CHANGE STENT VIA TRANSURETH	UROLOGY	ED024				ER029	
50386	REMOVE STENT VIA TRANSURETH	UROLOGY	ED024				ER029	
50387	CHANGE EXT/INT URETER STENT	DIAGNOSTIC RADIOLOGY	ED024				ER029	
50389	REMOVE RENAL TUBE W/FLUORO	DIAGNOSTIC RADIOLOGY	ED024				ER029	
51605	PREPARATION FOR BLADDER XRAY	UROLOGY						
62263	EPIDURAL LYSIS MULT SESSIONS	INTERVENTIONAL PAIN MANAGEMENT						
62264	Epidural lysis on single day	ANESTHESIOLOGY						ER067
63661	Remove spine eltrd perq aray	MANAGEMENT						ER067
63663	Revise spine eltrd perq aray	MANAGEMENT						ER067
64479	INJ FORAMEN EPIDURAL C/T	MANAGEMENT						ER067
64480	Inj foramen epidural add-on	NEUROSURGERY						ER067
64483	INJ FORAMEN EPIDURAL L/S	MANAGEMENT						ER067
64484	Inj foramen epidural add-on	MANAGEMENT						ER067
64490	INJ PARAVERT F JNT C/T 1 LEV	MANAGEMENT						ER067
64493	INJ PARAVERT F JNT L/S 1 LEV	MANAGEMENT						ER067
64633	DESTROY CERV/THOR FACET JNT	MANAGEMENT		ED025			ER029	ER067
64634	DESTROY C/TH FACET JNT ADDL	MANAGEMENT		ED025			ER029	ER067

CPT Code	Short Descriptor	Top Specialty	ED024 - film processor, dry, laser	ED025 - film processor, wet	ED027 - film processor, x-omat (M6B)	ER018 - densitometer, film	ER029 - film alternator (motorized film viewbox)	ER067 - x-ray view box, 4 panel
64635	DESTROY LUMB/SAC FACET JNT	MANAGEMENT		ED025			ER029	ER067
64636	DESTROY L/S FACET JNT ADDL	MANAGEMENT		ED025			ER029	ER067
70010	CONTRAST X-RAY OF BRAIN	DIAGNOSTIC RADIOLOGY						
70015	CONTRAST X-RAY OF BRAIN	DIAGNOSTIC RADIOLOGY		ED025			ER029	
70030	X-RAY EYE FOR FOREIGN BODY	DIAGNOSTIC RADIOLOGY		ED025			ER029	
70100	X-RAY EXAM OF JAW	FAMILY PRACTICE		ED025			ER029	
70110	X-RAY EXAM OF JAW	DIAGNOSTIC RADIOLOGY		ED025			ER029	
70120	X-RAY EXAM OF MASTOIDS	DIAGNOSTIC RADIOLOGY		ED025			ER029	
70130	X-RAY EXAM OF MASTOIDS	DIAGNOSTIC RADIOLOGY		ED025			ER029	
70134	X-RAY EXAM OF MIDDLE EAR	DIAGNOSTIC RADIOLOGY		ED025			ER029	
70140	X-RAY EXAM OF FACIAL BONES	DIAGNOSTIC RADIOLOGY		ED025			ER029	
70150	X-RAY EXAM OF FACIAL BONES	DIAGNOSTIC RADIOLOGY		ED025			ER029	
70160	X-RAY EXAM OF NASAL BONES	DIAGNOSTIC RADIOLOGY		ED025			ER029	
70190	X-RAY EXAM OF EYE SOCKETS	DIAGNOSTIC RADIOLOGY		ED025			ER029	
70200	X-RAY EXAM OF EYE SOCKETS	DIAGNOSTIC RADIOLOGY		ED025			ER029	
70210	X-RAY EXAM OF SINUSES	DIAGNOSTIC RADIOLOGY		ED025			ER029	
70220	X-RAY EXAM OF SINUSES	DIAGNOSTIC RADIOLOGY		ED025			ER029	
70240	X-RAY EXAM PITUITARY SADDLE	DIAGNOSTIC RADIOLOGY		ED025			ER029	
70250	X-RAY EXAM OF SKULL	DIAGNOSTIC RADIOLOGY		ED025			ER029	
70260	X-RAY EXAM OF SKULL	DIAGNOSTIC RADIOLOGY		ED025			ER029	
70328	X-RAY EXAM OF JAW JOINT	DIAGNOSTIC RADIOLOGY		ED025			ER029	
70330	X-RAY EXAM OF JAW JOINTS	DIAGNOSTIC RADIOLOGY		ED025			ER029	
70336	MAGNETIC IMAGE JAW JOINT	DIAGNOSTIC RADIOLOGY						
70360	X-RAY EXAM OF NECK	DIAGNOSTIC RADIOLOGY		ED025			ER029	
70370	THROAT X-RAY & FLUOROSCOPY	FAMILY PRACTICE		ED025			ER029	
70371	SPEECH EVALUATION COMPLEX	DIAGNOSTIC RADIOLOGY						
70373	CONTRAST X-RAY OF LARYNX	FAMILY PRACTICE		ED025			ER029	
70390	X-RAY EXAM OF SALIVARY DUCT	DIAGNOSTIC RADIOLOGY		ED025			ER029	
70450	CT HEAD/BRAIN W/O DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
70460	CT HEAD/BRAIN W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
70470	CT HEAD/BRAIN W/O & W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
70480	CT ORBIT/EAR/FOSSA W/O DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
70481	CT ORBIT/EAR/FOSSA W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
70482	CT ORBIT/EAR/FOSSA W/O&W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
70486	CT MAXILLOFACIAL W/O DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
70487	CT MAXILLOFACIAL W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
70488	CT MAXILLOFACIAL W/O & W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
70490	CT SOFT TISSUE NECK W/O DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
70491	CT SOFT TISSUE NECK W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
70492	CT SFT TSUE NCK W/O & W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
70496	CT ANGIOGRAPHY HEAD	DIAGNOSTIC RADIOLOGY					ER029	
70498	CT ANGIOGRAPHY NECK	DIAGNOSTIC RADIOLOGY	ED024				ER029	
70540	MRI ORBIT/FACE/NECK W/O DYE	DIAGNOSTIC RADIOLOGY						
70542	MRI ORBIT/FACE/NECK W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
70543	MRI ORBT/FAC/NCK W/O & W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
70544	MR ANGIOGRAPHY HEAD W/O DYE	DIAGNOSTIC RADIOLOGY					ER029	
70545	MR ANGIOGRAPHY HEAD W/DYE	DIAGNOSTIC RADIOLOGY					ER029	
70546	MR ANGIOGRAPH HEAD W/O&W/DYE	DIAGNOSTIC RADIOLOGY					ER029	
70547	MR ANGIOGRAPHY NECK W/O DYE	DIAGNOSTIC RADIOLOGY					ER029	
70548	MR ANGIOGRAPHY NECK W/DYE	DIAGNOSTIC RADIOLOGY					ER029	
70549	MR ANGIOGRAPH NECK W/O&W/DYE	DIAGNOSTIC RADIOLOGY					ER029	
70551	MRI BRAIN W/O DYE	DIAGNOSTIC RADIOLOGY						
70552	MRI BRAIN W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
70553	MRI BRAIN W/O & W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
70554	FMRI BRAIN BY TECH	DIAGNOSTIC RADIOLOGY	ED024					
71010	CHEST X-RAY	DIAGNOSTIC RADIOLOGY		ED025			ER029	
71015	CHEST X-RAY	DIAGNOSTIC RADIOLOGY		ED025			ER029	
71020	CHEST X-RAY	DIAGNOSTIC RADIOLOGY		ED025			ER029	
71021	CHEST X-RAY	DIAGNOSTIC RADIOLOGY		ED025			ER029	
71022	CHEST X-RAY	DIAGNOSTIC RADIOLOGY		ED025			ER029	
71023	CHEST X-RAY AND FLUOROSCOPY	DIAGNOSTIC RADIOLOGY		ED025			ER029	
71030	CHEST X-RAY	DIAGNOSTIC RADIOLOGY		ED025			ER029	
71034	CHEST X-RAY AND FLUOROSCOPY	CARDIOLOGY		ED025			ER029	
71035	CHEST X-RAY	DIAGNOSTIC RADIOLOGY		ED025			ER029	
71040	CONTRAST X-RAY OF BRONCHI	DIAGNOSTIC RADIOLOGY		ED025			ER029	
71060	CONTRAST X-RAY OF BRONCHI	DIAGNOSTIC RADIOLOGY		ED025			ER029	
71100	X-RAY EXAM OF RIBS	DIAGNOSTIC RADIOLOGY		ED025			ER029	
71101	X-RAY EXAM OF RIBS/CHEST	DIAGNOSTIC RADIOLOGY		ED025			ER029	
71110	X-RAY EXAM OF RIBS	DIAGNOSTIC RADIOLOGY		ED025			ER029	
71111	X-RAY EXAM OF RIBS/CHEST	DIAGNOSTIC RADIOLOGY		ED025			ER029	
71120	X-RAY EXAM OF BREASTBONE	DIAGNOSTIC RADIOLOGY		ED025			ER029	
71130	X-RAY EXAM OF BREASTBONE	DIAGNOSTIC RADIOLOGY		ED025			ER029	
71250	CT THORAX W/O DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
71260	CT THORAX W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
71270	CT THORAX W/O & W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
71275	CT ANGIOGRAPHY CHEST	DIAGNOSTIC RADIOLOGY	ED024					
71550	MRI CHEST W/O DYE	DIAGNOSTIC RADIOLOGY						



CPT Code	Short Descriptor	Top Specialty	ED024 - film processor, dry, laser	ED025 - film processor, wet	ED027 - film processor, x-omat (M6B)	ER018 - densitometer, film	ER029 - film alternator (motorized film viewbox)	ER067 - x-ray view box, 4 panel
71551	MRI CHEST W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
71552	MRI CHEST W/O & W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
71555	MRI ANGIO CHEST W OR W/O DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
72010	X-RAY EXAM OF SPINE	INTERNAL MEDICINE		ED025			ER029	
72020	X-RAY EXAM OF SPINE	DIAGNOSTIC RADIOLOGY		ED025			ER029	
72040	X-RAY EXAM OF NECK SPINE	DIAGNOSTIC RADIOLOGY		ED025			ER029	
72050	X-RAY EXAM OF NECK SPINE	DIAGNOSTIC RADIOLOGY		ED025			ER029	
72052	X-RAY EXAM OF NECK SPINE	DIAGNOSTIC RADIOLOGY		ED025			ER029	
72069	X-RAY EXAM OF TRUNK SPINE	DIAGNOSTIC RADIOLOGY		ED025			ER029	
72070	X-RAY EXAM OF THORACIC SPINE	DIAGNOSTIC RADIOLOGY		ED025			ER029	
72072	X-RAY EXAM OF THORACIC SPINE	DIAGNOSTIC RADIOLOGY		ED025			ER029	
72074	X-RAY EXAM OF THORACIC SPINE	DIAGNOSTIC RADIOLOGY		ED025			ER029	
72080	X-RAY EXAM OF TRUNK SPINE	DIAGNOSTIC RADIOLOGY		ED025			ER029	
72090	X-RAY EXAM OF TRUNK SPINE	DIAGNOSTIC RADIOLOGY		ED025			ER029	
72100	X-RAY EXAM OF LOWER SPINE	DIAGNOSTIC RADIOLOGY		ED025			ER029	
72110	X-RAY EXAM OF LOWER SPINE	DIAGNOSTIC RADIOLOGY		ED025			ER029	
72114	X-RAY EXAM OF LOWER SPINE	DIAGNOSTIC RADIOLOGY		ED025			ER029	
72120	X-RAY EXAM OF LOWER SPINE	ORTHOPEDIC SURGERY		ED025			ER029	
72125	CT NECK SPINE W/O DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
72126	CT NECK SPINE W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
72127	CT NECK SPINE W/O & W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
72128	CT CHEST SPINE W/O DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
72129	CT CHEST SPINE W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
72130	CT CHEST SPINE W/O & W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
72131	CT LUMBAR SPINE W/O DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
72132	CT LUMBAR SPINE W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
72133	CT LUMBAR SPINE W/O & W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
72141	MRI NECK SPINE W/O DYE	DIAGNOSTIC RADIOLOGY						
72142	MRI NECK SPINE W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
72146	MRI CHEST SPINE W/O DYE	DIAGNOSTIC RADIOLOGY						
72147	MRI CHEST SPINE W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
72148	MRI LUMBAR SPINE W/O DYE	DIAGNOSTIC RADIOLOGY						
72149	MRI LUMBAR SPINE W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
72156	MRI NECK SPINE W/O & W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
72157	MRI CHEST SPINE W/O & W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
72158	MRI LUMBAR SPINE W/O & W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
72159	MR ANGIO SPINE W/O&W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
72170	X-RAY EXAM OF PELVIS	DIAGNOSTIC RADIOLOGY		ED025			ER029	
72190	X-RAY EXAM OF PELVIS	DIAGNOSTIC RADIOLOGY		ED025			ER029	
72191	CT ANGIOGRAPH PELV W/O&W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
72192	CT PELVIS W/O DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
72193	CT PELVIS W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
72194	CT PELVIS W/O & W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
72195	MRI PELVIS W/O DYE	DIAGNOSTIC RADIOLOGY						
72196	MRI PELVIS W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
72197	MRI PELVIS W/O & W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
72198	MR ANGIO PELVIS W/O & W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
72200	X-RAY EXAM SACROILIAC JOINTS	DIAGNOSTIC RADIOLOGY		ED025			ER029	
72202	X-RAY EXAM SACROILIAC JOINTS	DIAGNOSTIC RADIOLOGY		ED025			ER029	
72220	X-RAY EXAM OF TAILBONE	DIAGNOSTIC RADIOLOGY		ED025			ER029	
72240	CONTRAST X-RAY OF NECK SPINE	DIAGNOSTIC RADIOLOGY		ED025			ER029	
72255	CONTRAST X-RAY THORAX SPINE	DIAGNOSTIC RADIOLOGY		ED025			ER029	
72265	CONTRAST X-RAY LOWER SPINE	DIAGNOSTIC RADIOLOGY		ED025			ER029	
72270	CONTRAST X-RAY SPINE	DIAGNOSTIC RADIOLOGY		ED025			ER029	
72275	EPIDUROGRAPHY	MANAGEMENT		ED025			ER029	
72285	X-RAY C/T SPINE DISK	MANAGEMENT		ED025			ER029	
72295	X-RAY OF LOWER SPINE DISK	MANAGEMENT		ED025			ER029	
73000	X-RAY EXAM OF COLLAR BONE	DIAGNOSTIC RADIOLOGY		ED025			ER029	
73010	X-RAY EXAM OF SHOULDER BLADE	ORTHOPEDIC SURGERY		ED025			ER029	
73020	X-RAY EXAM OF SHOULDER	DIAGNOSTIC RADIOLOGY		ED025			ER029	
73030	X-RAY EXAM OF SHOULDER	DIAGNOSTIC RADIOLOGY		ED025			ER029	
73040	CONTRAST X-RAY OF SHOULDER	DIAGNOSTIC RADIOLOGY		ED025			ER029	
73050	X-RAY EXAM OF SHOULDERS	ORTHOPEDIC SURGERY		ED025			ER029	
73060	X-RAY EXAM OF HUMERUS	DIAGNOSTIC RADIOLOGY		ED025			ER029	
73070	X-RAY EXAM OF ELBOW	DIAGNOSTIC RADIOLOGY		ED025			ER029	
73080	X-RAY EXAM OF ELBOW	DIAGNOSTIC RADIOLOGY		ED025			ER029	
73085	CONTRAST X-RAY OF ELBOW	DIAGNOSTIC RADIOLOGY		ED025			ER029	
73090	X-RAY EXAM OF FOREARM	DIAGNOSTIC RADIOLOGY		ED025			ER029	
73092	X-RAY EXAM OF ARM INFANT	FAMILY PRACTICE		ED025			ER029	
73100	X-RAY EXAM OF WRIST	ORTHOPEDIC SURGERY		ED025			ER029	
73110	X-RAY EXAM OF WRIST	DIAGNOSTIC RADIOLOGY		ED025			ER029	
73115	CONTRAST X-RAY OF WRIST	DIAGNOSTIC RADIOLOGY		ED025			ER029	
73120	X-RAY EXAM OF HAND	DIAGNOSTIC RADIOLOGY		ED025			ER029	
73130	X-RAY EXAM OF HAND	DIAGNOSTIC RADIOLOGY		ED025			ER029	
73140	X-RAY EXAM OF FINGER(S)	DIAGNOSTIC RADIOLOGY		ED025			ER029	
73200	CT UPPER EXTREMITY W/O DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
73201	CT UPPER EXTREMITY W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	

CPT Code	Short Descriptor	Top Specialty	ED024 - film processor, dry, laser	ED025 - film processor, wet	ED027 - film processor, x-omat (M6B)	ER018 - densitometer, film	ER029 - film alternator (motorized film viewbox)	ER067 - x-ray view box, 4 panel
73202	CT UPPR EXTREMITY W/O&W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
73206	CT ANGIO UPR EXTRM W/O&W/DYE	DIAGNOSTIC RADIOLOGY	ED024					
73218	MRI UPPER EXTREMITY W/O DYE	DIAGNOSTIC RADIOLOGY						
73219	MRI UPPER EXTREMITY W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
73220	MRI UPPR EXTREMITY W/O&W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
73221	MRI JOINT UPR EXTREM W/O DYE	DIAGNOSTIC RADIOLOGY						
73222	MRI JOINT UPR EXTREM W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
73223	MRI JOINT UPR EXTR W/O&W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
73225	MR ANGIO UPR EXTR W/O&W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
73500	X-RAY EXAM OF HIP	DIAGNOSTIC RADIOLOGY		ED025			ER029	
73510	X-RAY EXAM OF HIP	DIAGNOSTIC RADIOLOGY		ED025			ER029	
73520	X-RAY EXAM OF HIPS	DIAGNOSTIC RADIOLOGY		ED025			ER029	
73525	CONTRAST X-RAY OF HIP	DIAGNOSTIC RADIOLOGY		ED025			ER029	
73540	X-RAY EXAM OF PELVIS & HIPS	ORTHOPEDIC SURGERY		ED025			ER029	
73550	X-RAY EXAM OF THIGH	DIAGNOSTIC RADIOLOGY		ED025			ER029	
73560	X-RAY EXAM OF KNEE 1 OR 2	ORTHOPEDIC SURGERY		ED025			ER029	
73562	X-RAY EXAM OF KNEE 3	ORTHOPEDIC SURGERY		ED025			ER029	
73564	X-RAY EXAM KNEE 4 OR MORE	DIAGNOSTIC RADIOLOGY		ED025			ER029	
73565	X-RAY EXAM OF KNEES	ORTHOPEDIC SURGERY		ED025			ER029	
73580	CONTRAST X-RAY OF KNEE JOINT	ORTHOPEDIC SURGERY		ED025			ER029	
73590	X-RAY EXAM OF LOWER LEG	DIAGNOSTIC RADIOLOGY		ED025			ER029	
73592	X-RAY EXAM OF LEG INFANT	DIAGNOSTIC RADIOLOGY		ED025			ER029	
73600	X-RAY EXAM OF ANKLE	DIAGNOSTIC RADIOLOGY		ED025			ER029	
73610	X-RAY EXAM OF ANKLE	DIAGNOSTIC RADIOLOGY		ED025			ER029	
73615	CONTRAST X-RAY OF ANKLE	ORTHOPEDIC SURGERY		ED025			ER029	
73620	X-RAY EXAM OF FOOT	PODIATRY		ED025			ER029	
73630	X-RAY EXAM OF FOOT	DIAGNOSTIC RADIOLOGY		ED025			ER029	
73650	X-RAY EXAM OF HEEL	DIAGNOSTIC RADIOLOGY		ED025			ER029	
73660	X-RAY EXAM OF TOE(S)	DIAGNOSTIC RADIOLOGY		ED025			ER029	
73700	CT LOWER EXTREMITY W/O DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
73701	CT LOWER EXTREMITY W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
73702	CT LWR EXTREMITY W/O&W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
73706	CT ANGIO LWR EXTR W/O&W/DYE	DIAGNOSTIC RADIOLOGY	ED024					
73718	MRI LOWER EXTREMITY W/O DYE	DIAGNOSTIC RADIOLOGY						
73719	MRI LOWER EXTREMITY W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
73720	MRI LWR EXTREMITY W/O&W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
73721	MRI JNT OF LWR EXTRE W/O DYE	DIAGNOSTIC RADIOLOGY						
73722	MRI JOINT OF LWR EXTR W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
73723	MRI JOINT LWR EXTR W/O&W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
73725	MR ANG LWR EXT W OR W/O DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
74000	X-RAY EXAM OF ABDOMEN	DIAGNOSTIC RADIOLOGY		ED025			ER029	
74010	X-RAY EXAM OF ABDOMEN	DIAGNOSTIC RADIOLOGY		ED025			ER029	
74020	X-RAY EXAM OF ABDOMEN	DIAGNOSTIC RADIOLOGY		ED025			ER029	
74022	X-RAY EXAM SERIES ABDOMEN	DIAGNOSTIC RADIOLOGY		ED025			ER029	
74150	CT ABDOMEN W/O DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
74160	CT ABDOMEN W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
74170	CT ABDOMEN W/O & W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
74174	CT ANGIO ABD&PELV W/O&W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
74175	CT ANGIO ABDOM W/O & W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
74176	CT ABD & PELVIS	DIAGNOSTIC RADIOLOGY					ER029	
74177	CT ABD & PELV W/CONTRAST	DIAGNOSTIC RADIOLOGY					ER029	
74178	CT ABD & PELV 1/> REGNS	DIAGNOSTIC RADIOLOGY					ER029	
74181	MRI ABDOMEN W/O DYE	DIAGNOSTIC RADIOLOGY						
74182	MRI ABDOMEN W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
74183	MRI ABDOMEN W/O & W/DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
74185	MRI ANGIO ABDOM W ORW/O DYE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
74210	CONTRST X-RAY EXAM OF THROAT	DIAGNOSTIC RADIOLOGY		ED025			ER029	
74220	CONTRAST X-RAY ESOPHAGUS	DIAGNOSTIC RADIOLOGY		ED025			ER029	
74230	CINE/VID X-RAY THROAT/ESOPH	DIAGNOSTIC RADIOLOGY		ED025			ER029	
74240	X-RAY EXAM UPPER GI TRACT	DIAGNOSTIC RADIOLOGY		ED025			ER029	
74241	X-RAY EXAM UPPER GI TRACT	DIAGNOSTIC RADIOLOGY		ED025			ER029	
74245	X-RAY EXAM UPPER GI TRACT	DIAGNOSTIC RADIOLOGY		ED025			ER029	
74246	CONTRST X-RAY UPPR GI TRACT	DIAGNOSTIC RADIOLOGY		ED025			ER029	
74247	CONTRST X-RAY UPPR GI TRACT	DIAGNOSTIC RADIOLOGY		ED025			ER029	
74249	CONTRST X-RAY UPPR GI TRACT	DIAGNOSTIC RADIOLOGY		ED025			ER029	
74250	X-RAY EXAM OF SMALL BOWEL	DIAGNOSTIC RADIOLOGY		ED025			ER029	
74251	X-RAY EXAM OF SMALL BOWEL	DIAGNOSTIC RADIOLOGY		ED025			ER029	
74260	X-RAY EXAM OF SMALL BOWEL	DIAGNOSTIC RADIOLOGY		ED025			ER029	
74261	Ct colonography dx	DIAGNOSTIC RADIOLOGY						
74262	Ct colonography dx w/dye	DIAGNOSTIC RADIOLOGY						
74263	Ct colonography screening							
74270	CONTRAST X-RAY EXAM OF COLON	DIAGNOSTIC RADIOLOGY		ED025			ER029	
74280	CONTRAST X-RAY EXAM OF COLON	DIAGNOSTIC RADIOLOGY		ED025			ER029	
74283	CONTRAST X-RAY EXAM OF COLON	DIAGNOSTIC RADIOLOGY		ED025			ER029	
74290	CONTRAST X-RAY GALLBLADDER	DIAGNOSTIC RADIOLOGY		ED025			ER029	
74291	CONTRAST X-RAYS GALLBLADDER	DIAGNOSTIC RADIOLOGY		ED025			ER029	
74320	CONTRAST X-RAY OF BILE DUCTS	DIAGNOSTIC RADIOLOGY	ED024				ER029	

XXX code - look into carrier priced

XXX code - look into carrier priced

XXX code - look into carrier priced

CPT Code	Short Descriptor	Top Specialty	ED024 - film processor, dry, laser	ED025 - film processor, wet	ED027 - film processor, x-omat (M6B)	ER018 - densitometer, film	ER029 - film alternator (motorized film viewbox)	ER067 - x-ray view box, 4 panel
74327	X-RAY BILE STONE REMOVAL	DIAGNOSTIC RADIOLOGY	ED024				ER029	
74400	CONTRST X-RAY URINARY TRACT	DIAGNOSTIC RADIOLOGY						
74410	CONTRST X-RAY URINARY TRACT	DIAGNOSTIC RADIOLOGY						
74415	CONTRST X-RAY URINARY TRACT	DIAGNOSTIC RADIOLOGY						
74430	CONTRAST X-RAY BLADDER	DIAGNOSTIC RADIOLOGY						
74440	X-RAY MALE GENITAL TRACT	UROLOGY		ED025				
74455	X-RAY URETHRA/BLADDER	UROLOGY						
74475	X-RAY CONTROL CATH INSERT	DIAGNOSTIC RADIOLOGY	ED024				ER029	
74480	X-RAY CONTROL CATH INSERT	DIAGNOSTIC RADIOLOGY	ED024				ER029	
74485	X-RAY GUIDE GU DILATION	DIAGNOSTIC RADIOLOGY	ED024				ER029	
74710	X-RAY MEASUREMENT OF PELVIS	DIAGNOSTIC RADIOLOGY		ED025			ER029	
74740	X-RAY FEMALE GENITAL TRACT	DIAGNOSTIC RADIOLOGY						
75557	CARDIAC MRI FOR MORPH	DIAGNOSTIC RADIOLOGY						
75559	CARDIAC MRI W/STRESS IMG	CARDIOLOGY						
75561	CARDIAC MRI FOR MORPH W/DYE	CARDIOLOGY						
75563	CARD MRI W/STRESS IMG & DYE	CARDIOLOGY						
75565	CARD MRI VELOC FLOW MAPPING	DIAGNOSTIC RADIOLOGY						
75571	CT HRT W/O DYE W/CA TEST	CARDIOLOGY						
75572	CT HRT W/3D IMAGE	CARDIOLOGY						
75573	CT HRT W/3D IMAGE CONGEN	DIAGNOSTIC RADIOLOGY						
75574	CT ANGIO HRT W/3D IMAGE	CARDIOLOGY						
75600	CONTRAST X-RAY EXAM OF AORTA	CARDIOLOGY	ED024	ED025			ER029	ER067
75605	CONTRAST X-RAY EXAM OF AORTA	CARDIOLOGY	ED024				ER029	
75625	CONTRAST X-RAY EXAM OF AORTA	CARDIOLOGY	ED024				ER029	
75630	X-RAY AORTA LEG ARTERIES	CARDIOLOGY	ED024				ER029	
75635	CT ANGIO ABDOMINAL ARTERIES	DIAGNOSTIC RADIOLOGY	ED024					
75650	ARTERY X-RAYS HEAD & NECK	CARDIOLOGY	ED024				ER029	
75658	ARTERY X-RAYS ARM	NEPHROLOGY	ED024				ER029	
75660	ARTERY X-RAYS HEAD & NECK	DIAGNOSTIC RADIOLOGY	ED024				ER029	
75662	ARTERY X-RAYS HEAD & NECK	CARDIOLOGY	ED024				ER029	
75665	ARTERY X-RAYS HEAD & NECK	DIAGNOSTIC RADIOLOGY	ED024				ER029	
75671	ARTERY X-RAYS HEAD & NECK	DIAGNOSTIC RADIOLOGY	ED024				ER029	
75676	ARTERY X-RAYS NECK	DIAGNOSTIC RADIOLOGY	ED024				ER029	
75680	ARTERY X-RAYS NECK	CARDIOLOGY	ED024				ER029	
75685	ARTERY X-RAYS SPINE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
75705	ARTERY X-RAYS SPINE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
75710	ARTERY X-RAYS ARM/LEG	CARDIOLOGY	ED024				ER029	
75716	ARTERY X-RAYS ARMS/LEGS	CARDIOLOGY	ED024				ER029	
75726	ARTERY X-RAYS ABDOMEN	DIAGNOSTIC RADIOLOGY	ED024				ER029	
75731	ARTERY X-RAYS ADRENAL GLAND	CARDIOLOGY	ED024				ER029	
75733	ARTERY X-RAYS ADRENALS	CARDIOLOGY	ED024				ER029	
75736	ARTERY X-RAYS PELVIS	DIAGNOSTIC RADIOLOGY	ED024				ER029	
75741	ARTERY X-RAYS LUNG	DIAGNOSTIC RADIOLOGY	ED024				ER029	
75743	ARTERY X-RAYS LUNGS	DIAGNOSTIC RADIOLOGY	ED024				ER029	
75746	ARTERY X-RAYS LUNG	DIAGNOSTIC RADIOLOGY	ED024				ER029	
75756	ARTERY X-RAYS CHEST	CARDIOLOGY	ED024				ER029	
75774	ARTERY X-RAY EACH VESSEL	DIAGNOSTIC RADIOLOGY	ED024				ER029	
75791	AV DIALYSIS SHUNT IMAGING	NEPHROLOGY					ER029	
75809	NONVASCULAR SHUNT X-RAY	DIAGNOSTIC RADIOLOGY	ED024				ER029	
75820	VEIN X-RAY ARM/LEG	CARDIOLOGY	ED024				ER029	
75822	VEIN X-RAY ARMS/LEGS	DIAGNOSTIC RADIOLOGY	ED024				ER029	
75825	VEIN X-RAY TRUNK	DIAGNOSTIC RADIOLOGY	ED024				ER029	
75827	VEIN X-RAY CHEST	DIAGNOSTIC RADIOLOGY	ED024				ER029	
75831	VEIN X-RAY KIDNEY	DIAGNOSTIC RADIOLOGY	ED024				ER029	
75833	VEIN X-RAY KIDNEYS	DIAGNOSTIC RADIOLOGY	ED024				ER029	
75840	VEIN X-RAY ADRENAL GLAND	VASCULAR SURGERY	ED024				ER029	
75842	VEIN X-RAY ADRENAL GLANDS	DIAGNOSTIC RADIOLOGY	ED024				ER029	
75860	VEIN X-RAY NECK	CARDIOLOGY	ED024				ER029	
75870	VEIN X-RAY SKULL	DIAGNOSTIC RADIOLOGY	ED024				ER029	
75872	VEIN X-RAY SKULL	NEUROSURGERY	ED024				ER029	
75880	VEIN X-RAY EYE SOCKET	NEUROLOGY	ED024				ER029	
75885	VEIN X-RAY LIVER	DIAGNOSTIC RADIOLOGY	ED024				ER029	
75887	VEIN X-RAY LIVER	DIAGNOSTIC RADIOLOGY	ED024				ER029	
75889	VEIN X-RAY LIVER	DIAGNOSTIC RADIOLOGY	ED024				ER029	
75891	VEIN X-RAY LIVER	DIAGNOSTIC RADIOLOGY	ED024				ER029	
75893	VENOUS SAMPLING BY CATHETER	DIAGNOSTIC RADIOLOGY	ED024				ER029	
75901	REMOVE CVA DEVICE OBSTRUCT	DIAGNOSTIC RADIOLOGY						
75902	REMOVE CVA LUMEN OBSTRUCT	DIAGNOSTIC RADIOLOGY						
75960	TRANSCATH IV STENT RS&I	CARDIOLOGY					ER029	
75961	RETRIEVAL BROKEN CATHETER	DIAGNOSTIC RADIOLOGY	ED024				ER029	
75962	REPAIR ARTERIAL BLOCKAGE	CARDIOLOGY	ED024				ER029	
75964	REPAIR ARTERY BLOCKAGE EACH	VASCULAR SURGERY	ED024				ER029	
75966	REPAIR ARTERIAL BLOCKAGE	CARDIOLOGY	ED024				ER029	
75968	REPAIR ARTERY BLOCKAGE EACH	CARDIOLOGY	ED024				ER029	
75978	REPAIR VENOUS BLOCKAGE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
75984	XRAY CONTROL CATHETER CHANGE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
75989	ABSCCESS DRAINAGE UNDER X-RAY	DIAGNOSTIC RADIOLOGY	ED024				ER029	

CPT Code	Short Descriptor	Top Specialty	ED024 - film processor, dry, laser	ED025 - film processor, wet	ED027 - film processor, x-omat (M6B)	ER018 - densitometer, film	ER029 - film alternator (motorized film viewbox)	ER067 - x-ray view box, 4 panel
76000	FLUOROSCOPE EXAMINATION	DIAGNOSTIC RADIOLOGY		ED025			ER029	
76010	X-RAY NOSE TO RECTUM	DIAGNOSTIC RADIOLOGY		ED025			ER029	
76080	X-RAY EXAM OF FISTULA	DIAGNOSTIC RADIOLOGY	ED024				ER029	
76098	X-RAY EXAM BREAST SPECIMEN	DIAGNOSTIC RADIOLOGY	ED024				ER029	
76120	CINE/VIDEO X-RAYS	IDTF	ED024				ER029	
76376	3D RENDER W/O POSTPROCESS	DIAGNOSTIC RADIOLOGY		ED025			ER029	
76377	3D RENDERING W/POSTPROCESS	DIAGNOSTIC RADIOLOGY		ED025			ER029	
76380	CAT SCAN FOLLOW-UP STUDY	DIAGNOSTIC RADIOLOGY	ED024				ER029	
76390	MR SPECTROSCOPY	DIAGNOSTIC RADIOLOGY	ED024				ER029	
76506	ECHO EXAM OF HEAD	DIAGNOSTIC RADIOLOGY	ED024				ER029	
76536	US EXAM OF HEAD AND NECK	DIAGNOSTIC RADIOLOGY	ED024				ER029	
76604	US EXAM CHEST	DIAGNOSTIC RADIOLOGY	ED024				ER029	
76645	US EXAM BREAST(S)	DIAGNOSTIC RADIOLOGY	ED024				ER029	
76700	US EXAM ABDOM COMPLETE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
76705	ECHO EXAM OF ABDOMEN	DIAGNOSTIC RADIOLOGY	ED024				ER029	
76770	US EXAM ABDO BACK WALL COMP	DIAGNOSTIC RADIOLOGY	ED024				ER029	
76775	US EXAM ABDO BACK WALL LIM	DIAGNOSTIC RADIOLOGY	ED024				ER029	
76776	US EXAM K TRANSPL W/DOPPLER	DIAGNOSTIC RADIOLOGY					ER029	
76800	US EXAM SPINAL CANAL	GENERAL PRACTICE	ED024				ER029	
76801	OB US < 14 WKS SINGLE FETUS	DIAGNOSTIC RADIOLOGY	ED024				ER029	
76830	TRANSVAGINAL US NON-OB	DIAGNOSTIC RADIOLOGY	ED024				ER029	
76856	US EXAM PELVIC COMPLETE	DIAGNOSTIC RADIOLOGY	ED024				ER029	
76857	US EXAM PELVIC LIMITED	UROLOGY	ED024				ER029	
76870	US EXAM SCROTUM	DIAGNOSTIC RADIOLOGY	ED024				ER029	
76872	US TRANSRECTAL	UROLOGY	ED024				ER029	
76873	ECHOGRAP TRANS R PROS STUDY	RADIATION ONCOLOGY	ED024				ER029	
76881	US XTR NON-VASC COMPLETE	PODIATRY					ER029	
76885	US EXAM INFANT HIPS DYNAMIC	DIAGNOSTIC RADIOLOGY	ED024				ER029	
76886	US EXAM INFANT HIPS STATIC	DIAGNOSTIC RADIOLOGY	ED024				ER029	
76936	ECHO GUIDE FOR ARTERY REPAIR	DIAGNOSTIC RADIOLOGY	ED024				ER029	
76937	US GUIDE VASCULAR ACCESS	DIAGNOSTIC RADIOLOGY		ED025				
76942	ECHO GUIDE FOR BIOPSY	DIAGNOSTIC RADIOLOGY	ED024				ER029	
76970	ULTRASOUND EXAM FOLLOW-UP	GENERAL SURGERY						
77001	FLUOROGUIDE FOR VEIN DEVICE	DIAGNOSTIC RADIOLOGY		ED025				
77002	NEEDLE LOCALIZATION BY XRAY	DIAGNOSTIC RADIOLOGY	ED024				ER029	
77003	FLUOROGUIDE FOR SPINE INJECT	ANESTHESIOLOGY		ED025			ER029	
77011	CT SCAN FOR LOCALIZATION	DIAGNOSTIC RADIOLOGY	ED024				ER029	
77012	CT SCAN FOR NEEDLE BIOPSY	DIAGNOSTIC RADIOLOGY	ED024				ER029	
77014	CT SCAN FOR THERAPY GUIDE	RADIATION ONCOLOGY	ED024				ER029	
77021	MR GUIDANCE FOR NEEDLE PLACE	DIAGNOSTIC RADIOLOGY						
77031	STEREOTACT GUIDE FOR BRST BX	DIAGNOSTIC RADIOLOGY						
77032	GUIDANCE FOR NEEDLE BREAST	DIAGNOSTIC RADIOLOGY		ED025			ER029	
77051	COMPUTER DX MAMMOGRAM ADD-ON	DIAGNOSTIC RADIOLOGY						
77052	COMP SCREEN MAMMOGRAM ADD-ON	DIAGNOSTIC RADIOLOGY						
77053	X-RAY OF MAMMARY DUCT	DIAGNOSTIC RADIOLOGY		ED025				ER067
77054	X-RAY OF MAMMARY DUCTS	DIAGNOSTIC RADIOLOGY		ED025				ER067
77055	MAMMOGRAM ONE BREAST	DIAGNOSTIC RADIOLOGY					ER029	
77056	MAMMOGRAM BOTH BREASTS	DIAGNOSTIC RADIOLOGY					ER029	
77057	MAMMOGRAM SCREENING	DIAGNOSTIC RADIOLOGY					ER029	
77058	MRI ONE BREAST	DIAGNOSTIC RADIOLOGY	ED024				ER029	
77059	MRI BOTH BREASTS	DIAGNOSTIC RADIOLOGY	ED024				ER029	
77071	X-RAY STRESS VIEW	ORTHOPEDIC SURGERY		ED025			ER029	
77072	X-RAYS FOR BONE AGE	DIAGNOSTIC RADIOLOGY		ED025			ER029	
77073	X-RAYS BONE LENGTH STUDIES	ORTHOPEDIC SURGERY		ED025			ER029	
77074	X-RAYS BONE SURVEY LIMITED	DIAGNOSTIC RADIOLOGY		ED025			ER029	
77075	X-RAYS BONE SURVEY COMPLETE	DIAGNOSTIC RADIOLOGY		ED025			ER029	
77076	X-RAYS BONE SURVEY INFANT	DIAGNOSTIC RADIOLOGY		ED025			ER029	
77077	JOINT SURVEY SINGLE VIEW	ORTHOPEDIC SURGERY		ED025			ER029	
77084	MAGNETIC IMAGE BONE MARROW	DIAGNOSTIC RADIOLOGY						
77280	SET RADIATION THERAPY FIELD	RADIATION ONCOLOGY		ED025			ER029	
77285	SET RADIATION THERAPY FIELD	RADIATION ONCOLOGY		ED025			ER029	
77290	SET RADIATION THERAPY FIELD	RADIATION ONCOLOGY		ED025			ER029	
77301	RADIOTHERAPY DOSE PLAN IMRT	RADIATION ONCOLOGY	ED024	ED025				
77336	RADIATION PHYSICS CONSULT	RADIATION ONCOLOGY				ER018		
77370	RADIATION PHYSICS CONSULT	RADIATION ONCOLOGY				ER018		
77371	SRS MULTISOURCE	NEUROSURGERY			ED027			ER067
77372	SRS LINEAR BASED	RADIATION ONCOLOGY			ED027			ER067
77417	RADIOLOGY PORT FILM(S)	RADIATION ONCOLOGY			ED027			
77418	RADIATION TX DELIVERY IMRT	RADIATION ONCOLOGY						
77422	NEUTRON BEAM TX SIMPLE	RADIATION ONCOLOGY			ED027			ER067
77423	NEUTRON BEAM TX COMPLEX	RADIATION ONCOLOGY			ED027			ER067
78006	THYROID IMAGING WITH UPTAKE	DIAGNOSTIC RADIOLOGY		ED025				ER067
78007	THYROID IMAGE MULT UPTAKES	DIAGNOSTIC RADIOLOGY		ED025				ER067
78010	THYROID IMAGING	DIAGNOSTIC RADIOLOGY		ED025				ER067
78011	THYROID IMAGING WITH FLOW	DIAGNOSTIC RADIOLOGY		ED025				ER067
78015	THYROID MET IMAGING	DIAGNOSTIC RADIOLOGY		ED025				ER067
78016	THYROID MET IMAGING/STUDIES	NUCLEAR MEDICINE		ED025				ER067

CPT Code	Short Descriptor	Top Specialty	ED024 - film processor, dry, laser	ED025 - film processor, wet	ED027 - film processor, x-omat (M6B)	ER018 - densitometer, film	ER029 - film alternator (motorized film viewbox)	ER067 - x-ray view box, 4 panel
78018	THYROID MET IMAGING BODY	DIAGNOSTIC RADIOLOGY		ED025				ER067
78020	THYROID MET UPTAKE	DIAGNOSTIC RADIOLOGY						
78070	PARATHYROID NUCLEAR IMAGING	DIAGNOSTIC RADIOLOGY						
78075	ADRENAL NUCLEAR IMAGING	DIAGNOSTIC RADIOLOGY		ED025				ER067
78102	BONE MARROW IMAGING LTD	DIAGNOSTIC RADIOLOGY		ED025				ER067
78103	BONE MARROW IMAGING MULT	DIAGNOSTIC RADIOLOGY		ED025				ER067
78104	BONE MARROW IMAGING BODY	DIAGNOSTIC RADIOLOGY		ED025				ER067
78135	RED CELL SURVIVAL KINETICS	DIAGNOSTIC RADIOLOGY		ED025				ER067
78140	RED CELL SEQUESTRATION	DIAGNOSTIC RADIOLOGY						
78185	SPLEEN IMAGING	DIAGNOSTIC RADIOLOGY		ED025				ER067
78190	PLATELET SURVIVAL KINETICS	DIAGNOSTIC RADIOLOGY		ED025				ER067
78195	LYMPH SYSTEM IMAGING	DIAGNOSTIC RADIOLOGY		ED025				ER067
78201	LIVER IMAGING	DIAGNOSTIC RADIOLOGY		ED025				ER067
78202	LIVER IMAGING WITH FLOW	DIAGNOSTIC RADIOLOGY		ED025				ER067
78205	LIVER IMAGING (3D)	DIAGNOSTIC RADIOLOGY		ED025				ER067
78206	LIVER IMAGE (3D) WITH FLOW	DIAGNOSTIC RADIOLOGY		ED025				ER067
78215	LIVER AND SPLEEN IMAGING	DIAGNOSTIC RADIOLOGY		ED025				ER067
78216	LIVER & SPLEEN IMAGE/FLOW	DIAGNOSTIC RADIOLOGY						
78226	HEPATOBILIARY SYSTEM IMAGING	DIAGNOSTIC RADIOLOGY		ED025				ER067
78227	HEPATOBIL SYST IMAGE W/DRUG	DIAGNOSTIC RADIOLOGY		ED025				ER067
78230	SALIVARY GLAND IMAGING	DIAGNOSTIC RADIOLOGY		ED025				ER067
78231	SERIAL SALIVARY IMAGING	NUCLEAR MEDICINE						
78232	SALIVARY GLAND FUNCTION EXAM	NUCLEAR MEDICINE						
78258	ESOPHAGEAL MOTILITY STUDY	DIAGNOSTIC RADIOLOGY		ED025				ER067
78261	GASTRIC MUCOSA IMAGING	DIAGNOSTIC RADIOLOGY		ED025				ER067
78262	GASTROESOPHAGEAL REFLUX EXAM	DIAGNOSTIC RADIOLOGY		ED025				ER067
78264	GASTRIC EMPTYING STUDY	DIAGNOSTIC RADIOLOGY		ED025				ER067
78278	ACUTE GI BLOOD LOSS IMAGING	DIAGNOSTIC RADIOLOGY		ED025				ER067
78290	MECKELS DIVERT EXAM	DIAGNOSTIC RADIOLOGY		ED025				ER067
78291	LEVEEN/SHUNT PATENCY EXAM	DIAGNOSTIC RADIOLOGY		ED025				ER067
78300	BONE IMAGING LIMITED AREA	DIAGNOSTIC RADIOLOGY		ED025				ER067
78305	BONE IMAGING MULTIPLE AREAS	DIAGNOSTIC RADIOLOGY		ED025				ER067
78306	BONE IMAGING WHOLE BODY	DIAGNOSTIC RADIOLOGY		ED025				ER067
78315	BONE IMAGING 3 PHASE	DIAGNOSTIC RADIOLOGY		ED025				ER067
78320	BONE IMAGING (3D)	DIAGNOSTIC RADIOLOGY		ED025				ER067
78414	NON-IMAGING HEART FUNCTION	INTERNAL MEDICINE						
78428	CARDIAC SHUNT IMAGING	CARDIOLOGY		ED025				ER067
78445	VASCULAR FLOW IMAGING	DIAGNOSTIC RADIOLOGY		ED025				ER067
78451	HT MUSCLE IMAGE SPECT SING	CARDIOLOGY			ED027			ER067
78452	HT MUSCLE IMAGE SPECT MULT	CARDIOLOGY			ED027			ER067
78453	HT MUSCLE IMAGE PLANAR SING	CARDIOLOGY			ED027			ER067
78454	HT MUSC IMAGE PLANAR MULT	CARDIOLOGY			ED027			ER067
78456	ACUTE VENOUS THROMBUS IMAGE	DIAGNOSTIC RADIOLOGY		ED025				ER067
78457	VENOUS THROMBOSIS IMAGING	CARDIOLOGY		ED025				ER067
78458	VEN THROMBOSIS IMAGES BILAT	NUCLEAR MEDICINE		ED025				ER067
78466	HEART INFARCT IMAGE	CARDIOLOGY		ED025				ER067
78468	HEART INFARCT IMAGE (EF)	CARDIOLOGY		ED025				ER067
78469	HEART INFARCT IMAGE (3D)	INTERNAL MEDICINE		ED025				ER067
78472	GATED HEART PLANAR SINGLE	DIAGNOSTIC RADIOLOGY		ED025				ER067
78473	GATED HEART MULTIPLE	CARDIOLOGY						
78481	HEART FIRST PASS SINGLE	CARDIOLOGY		ED025				ER067
78483	HEART FIRST PASS MULTIPLE	CARDIOLOGY		ED025				ER067
78494	HEART IMAGE SPECT	CARDIOLOGY		ED025				ER067
78579	LUNG VENTILATION IMAGING	DIAGNOSTIC RADIOLOGY		ED025				ER067
78580	LUNG PERFUSION IMAGING	DIAGNOSTIC RADIOLOGY		ED025				ER067
78582	LUNG VENTILAT&PERFUS IMAGING	DIAGNOSTIC RADIOLOGY		ED025				ER067
78597	LUNG PERFUSION DIFFERENTIAL	DIAGNOSTIC RADIOLOGY		ED025				ER067
78598	LUNG PERF&VENTILAT DIFERENTL	DIAGNOSTIC RADIOLOGY		ED025				ER067
78600	BRAIN IMAGE < 4 VIEWS	DIAGNOSTIC RADIOLOGY		ED025				ER067
78601	BRAIN IMAGE W/FLOW < 4 VIEWS	DIAGNOSTIC RADIOLOGY		ED025				ER067
78605	BRAIN IMAGE 4+ VIEWS	DIAGNOSTIC RADIOLOGY		ED025				ER067
78606	BRAIN IMAGE W/FLOW 4 + VIEWS	DIAGNOSTIC RADIOLOGY		ED025				ER067
78607	BRAIN IMAGING (3D)	DIAGNOSTIC RADIOLOGY		ED025				ER067
78610	BRAIN FLOW IMAGING ONLY	DIAGNOSTIC RADIOLOGY		ED025				ER067
78630	CEREBROSPINAL FLUID SCAN	DIAGNOSTIC RADIOLOGY		ED025				ER067
78635	CSF VENTRICULOGRAPHY	DIAGNOSTIC RADIOLOGY		ED025				ER067
78645	CSF SHUNT EVALUATION	DIAGNOSTIC RADIOLOGY		ED025				ER067
78647	CEREBROSPINAL FLUID SCAN	DIAGNOSTIC RADIOLOGY		ED025				ER067
78650	CSF LEAKAGE IMAGING	DIAGNOSTIC RADIOLOGY		ED025				ER067
78660	NUCLEAR EXAM OF TEAR FLOW	DIAGNOSTIC RADIOLOGY		ED025				ER067
78700	KIDNEY IMAGING MORPHOL	DIAGNOSTIC RADIOLOGY		ED025				ER067
78701	KIDNEY IMAGING WITH FLOW	DIAGNOSTIC RADIOLOGY		ED025				ER067
78707	K FLOW/FUNCT IMAGE W/O DRUG	DIAGNOSTIC RADIOLOGY		ED025				ER067
78708	K FLOW/FUNCT IMAGE W/DRUG	DIAGNOSTIC RADIOLOGY						
78709	K FLOW/FUNCT IMAGE MULTIPLE	DIAGNOSTIC RADIOLOGY		ED025				ER067
78710	KIDNEY IMAGING (3D)	DIAGNOSTIC RADIOLOGY		ED025				ER067
78730	Urinary bladder retention	UROLOGY						ER067

CPT Code	Short Descriptor	Top Specialty	ED024 - film processor, dry, laser	ED025 - film processor, wet	ED027 - film processor, x-omat (M6B)	ER018 - densitometer, film	ER029 - film alternator (motorized film viewbox)	ER067 - x-ray view box, 4 panel
78740	URETERAL REFLUX STUDY	UROLOGY		ED025				ER067
78761	TESTICULAR IMAGING W/FLOW	DIAGNOSTIC RADIOLOGY		ED025				ER067
78800	TUMOR IMAGING LIMITED AREA	DIAGNOSTIC RADIOLOGY		ED025				ER067
78801	TUMOR IMAGING MULT AREAS	DIAGNOSTIC RADIOLOGY		ED025				ER067
78802	TUMOR IMAGING WHOLE BODY	DIAGNOSTIC RADIOLOGY		ED025				ER067
78803	TUMOR IMAGING (3D)	DIAGNOSTIC RADIOLOGY		ED025				ER067
78804	TUMOR IMAGING WHOLE BODY	DIAGNOSTIC RADIOLOGY		ED025				ER067
78805	ABSCCESS IMAGING LTD AREA	DIAGNOSTIC RADIOLOGY		ED025				ER067
78806	ABSCCESS IMAGING WHOLE BODY	DIAGNOSTIC RADIOLOGY		ED025				ER067
78807	NUCLEAR LOCALIZATION/ABSCCESS	DIAGNOSTIC RADIOLOGY		ED025				ER067
78811	PET IMAGE LTD AREA	DIAGNOSTIC RADIOLOGY						ER067
78812	PET IMAGE SKULL-THIGH	DIAGNOSTIC RADIOLOGY						ER067
78813	PET IMAGE FULL BODY	DIAGNOSTIC RADIOLOGY						ER067
78814	PET IMAGE W/CT LMTD	DIAGNOSTIC RADIOLOGY						ER067
78815	PET IMAGE W/CT SKULL-THIGH	DIAGNOSTIC RADIOLOGY						ER067
78816	PET IMAGE W/CT FULL BODY	DIAGNOSTIC RADIOLOGY						ER067
79440	Nuclear rx intra-articular	FAMILY PRACTICE						ER067
93303	ECHO TRANSTHORACIC	CARDIOLOGY						
93304	ECHO TRANSTHORACIC	CARDIOLOGY						
93306	TTE W/DOPPLER COMPLETE	CARDIOLOGY						
93307	TTE W/O DOPPLER COMPLETE	CARDIOLOGY						
93308	TTE F-UP OR LMTD	CARDIOLOGY						
93312	ECHO TRANSESOPHAGEAL	CARDIOLOGY						
93314	ECHO TRANSESOPHAGEAL	CARDIOLOGY						
93350	STRESS TTE ONLY	CARDIOLOGY						
93351	Stress tte complete	CARDIOLOGY						
93451	Right heart cath	CARDIOLOGY						
93452	Left hrt cath w/ventrclgrphy	CARDIOLOGY						
93453	R&l hrt cath w/ventriclgrphy	CARDIOLOGY						
93454	Coronary artery angio s&i	CARDIOLOGY						
93455	Coronary art/grft angio s&i	CARDIOLOGY						
93456	R hrt coronary artery angio	CARDIOLOGY						
93457	R hrt art/grft angio	CARDIOLOGY						
93458	L hrt artery/ventricle angio	CARDIOLOGY						
93459	L hrt art/grft angio	CARDIOLOGY						
93460	R&l hrt art/ventricle angio	CARDIOLOGY						
93461	R&l hrt art/ventricle angio	CARDIOLOGY						
93566	INJECT R VENTR/ATRIAL ANGIO	CARDIOLOGY						
93567	INJECT SUPRVLV AORTOGRAPHY	CARDIOLOGY						
93568	INJECT PULM ART HRT CATH	CARDIOLOGY						
93880	EXTRACRANIAL STUDY	DIAGNOSTIC RADIOLOGY		ED025				ER067
93882	EXTRACRANIAL STUDY	VASCULAR SURGERY		ED025				ER067
93886	INTRACRANIAL STUDY	NEUROLOGY		ED025				ER067
93888	INTRACRANIAL STUDY	NEUROLOGY		ED025				ER067
93890	TCD VASOREACTIVITY STUDY	DIAGNOSTIC RADIOLOGY						
93892	TCD EMBOLI DETECT W/O INJ	NEUROLOGY						
93893	TCD EMBOLI DETECT W/INJ	NEUROLOGY						
93925	LOWER EXTREMITY STUDY	DIAGNOSTIC RADIOLOGY		ED025				ER067
93926	LOWER EXTREMITY STUDY	VASCULAR SURGERY		ED025				ER067
93930	UPPER EXTREMITY STUDY	DIAGNOSTIC RADIOLOGY		ED025				ER067
93931	UPPER EXTREMITY STUDY	VASCULAR SURGERY		ED025				ER067
93970	EXTREMITY STUDY	DIAGNOSTIC RADIOLOGY		ED025				ER067
93971	EXTREMITY STUDY	DIAGNOSTIC RADIOLOGY		ED025				ER067
93975	VASCULAR STUDY	DIAGNOSTIC RADIOLOGY		ED025				ER067
93976	VASCULAR STUDY	DIAGNOSTIC RADIOLOGY		ED025				ER067
93978	VASCULAR STUDY	CARDIOLOGY		ED025				ER067
93979	VASCULAR STUDY	CARDIOLOGY		ED025				ER067
93980	PENILE VASCULAR STUDY	UROLOGY						
93981	PENILE VASCULAR STUDY	UROLOGY						
93990	DOPPLER FLOW TESTING	VASCULAR SURGERY		ED025				ER067
G0106	COLON CA SCREEN;BARIUM ENEMA	DIAGNOSTIC RADIOLOGY						
G0120	COLON CA SCRNI; BARIUM ENEMA	DIAGNOSTIC RADIOLOGY						
G0122	COLON CA SCRNI; BARIUM ENEMA	NA						
G0288	RECON, CTA FOR SURG PLAN	VASCULAR SURGERY		ED025			ER029	
G0365	VESSEL MAPPING HEMO ACCESS	VASCULAR SURGERY		ED025				ER067
G0389	ULTRASOUND EXAM AAA SCREEN	DIAGNOSTIC RADIOLOGY	ED024				ER029	

## Digital Imaging Equipment Overview

- PACS Network (Modality to PACS)
  - Jack on wall
  - Cable from jack to closet
  - Crossconnect twisted pairs from closet panel to port on network switch
  - Fiber to switch in data center
  - Connection from data center switch to DICOM server
  - Q/A station
    - In technologist areas to check imaging studies for completeness, accuracy and adequate image quality prior to completing the study in Radiology Information System (RIS) and making it available for radiologist to interpret
  - Tech Interface Hardware
    - PC
    - RIS Computer and Software
    - Document Scanner
- PACS infrastructure
  - Servers
    - DICOM server(s)
    - Database server(s)
    - Web Server(s)
    - File server(s)
    - Load Balancer or Content Switch to distribute the load evenly across all the DICOM / Web servers.
  - Storage
    - Online Storage (approximately 185TB of fast hard drives)
    - Nearline Storage (tape or other backup for disaster recovery)
  - CD/DVD Burner and Software
    - For creation of tangible image media for imaging exchange (capability required by MQSA for Mammography)
  - Digital Film Scanner
  - PACS Software
    - RIS (to index storage of films)
    - HL7 Interfaces providing HL7 feeds between RIS and PAC
    - Connectivity to HIS for patient data etc.
- PACS Network (PACS to workstation)
  - Jack on wall
  - Cable from jack to closet
  - Crossconnect twisted pairs from closet panel to port on network switch
  - Fiber to switch in data center
  - Connection from data center switch to DICOM server
  - Q/A station
    - In technologist areas to check imaging studies for completeness, accuracy and adequate image quality prior to completing the study in RIS and making it available for radiologist to interpret
- PACS workstation
  - CPU
  - 2-4 DICOM calibrated diagnostic display
  - 1 General purpose display
  - 2-3 high end graphics cards
  - Input Devices (Mouse, keyboard, microphone, headset, foot switch, etc.)
  - PACS workstation software (Win OS, Antivirus, PACS application)
  - Other software as applicable (Dictation, 3D, CAD, Office, Screen Capture, Macro Player, etc.)



## CT Brain w/o contrast

### 70450

#### Pre-Service

Clinical Activity	Staff Type	Time	Equipment Type	Comments
Availability of Prior Images Confirmed	CT Technologist(L046A)		PC ED021 Digital Film Scanner	Line 18 in existing PE spreadsheet split into 2 lines
Patient clinical information and questionnaire reviewed by technologist, order from physician confirmed and exam protocolled by radiologist .	CT Technologist(L046A)		RIS Computer and Software	Currently pre-service (ie.. Following visit when decision for procedure made) but could be considered service period (when patient enters office for procedure)

#### Post-Service

Clinical Activity	Staff Type	Time	Equipment Type	Comment
Technologist QC's images in PACS, checking for all images, reformats, and dose page.	CT Technologist(L046A)		PC - ED021 Q/C Station and PACS Software	Line 41 in previous PE spreadsheet divided into several lines
Review examination with interpreting MD	CT Technologist(L046A)		PACS Viewing Station and PACS software	
Exam documents scanned into PACS. Exam completed in RIS system to generate billing process and to populate images into Radiologist work queue.	CT Technologist(L046A)		Document Scanner(connected to PACS) PC (ED021) RIS Computer and Software	



AMA/Specialty Society RVS Update Committee Summary of Recommendations  
*July 19<sup>th</sup> NPRM Screen*

January 2012

**Pathology Consultations-PE Only**

In the CY 2012 proposed rule CMS requested a review of both the direct PE inputs and work values of CPT code 88305 in accordance with the consolidated approach to reviewing potentially misvalued codes. It was determined that a review of the work was not necessary because the most recent extensive review of the professional component was conducted by the RUC in April of 2010, and that a review of the direct PE inputs alone is appropriate.

The RUC reviewed the direct PE inputs for CPT code 88300 *Level I - Surgical pathology, gross examination only* (work RVU=0.08); CPT code 88302 *Level II - Surgical pathology, gross and microscopic examination* (work RVU=0.13); CPT code 88304 *Level III - Surgical pathology, gross and microscopic examination* (work RVU=0.22); CPT code 88305 *Level IV - Surgical pathology, gross and microscopic examination* (work RVU=0.75); CPT code 88307 *Level V - Surgical pathology, gross and microscopic examination* (work RVU=1.59) and CPT code 88309 *Level VI - Surgical pathology, gross and microscopic examination* (work RVU=2.80). **The PE Subcommittee carefully reviewed the supply inputs to ensure there is no overlap with the indirect expenses and made necessary adjustments. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
88300		<b>Level I</b> - Surgical pathology, gross examination only	XXX	0.08 (No Change)

88302		<b>Level II</b> - Surgical pathology, gross and microscopic examination	XXX	0.13 (No Change)
88304		<b>Level III</b> - Surgical pathology, gross and microscopic examination	XXX	0.22 (No Change)
88305		<b>Level IV</b> - Surgical pathology, gross and microscopic examination	XXX	0.75 (No Change)
88307		<b>Level V</b> - Surgical pathology, gross and microscopic examination	XXX	1.59 (No Change)
88309		<b>Level VI</b> - Surgical pathology, gross and microscopic examination	XXX	2.80 (No Change)

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

Global Period: \_XXX Meeting Date: \_ February 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The College of American Pathologists contacted interested specialties (American Academy of Dermatology, American Society for Gastrointestinal Endoscopy, American Gastroenterological Association, and the American Urological Association) for their recommendations and comments regarding the direct practice inputs for codes 88300 – 88309. A conference call was convened and the practice expense recommendations were reviewed and agreed upon by all specialties.

If you have provided any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:

No good comparison code is available; the entire family of services is under review.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities - where applicable.

Order, fill, label, restock and distribute specimen containers.

Intra-Service Clinical Labor Activities:

Accession specimen in lab computer system including the following: Unwrap and/or remove specimen bottle and requisition slip from plastic bag. Check demographics to ensure they are correct and to ensure proper billing. Check requisition slip against bottle to see if the patient's name and/or specimen location (s) match each other. Distribute requisition form and specimen to grossing station.

Prepare tissue cassettes. When appropriate, photograph gross specimen, download file into lab computer system (88307-9 only)

Obtain and display applicable specimen radiographs.

Assist pathologist with gross specimen examination, cleaning grossing area between specimens.

Load solutions into tissue processor. Load and sort cassettes into tissue processor includes drain cassette basket, place basket in processor, put lid on basket, close lid, set processor. Confirm settings. Take requisitions to administrative staff.

Confirm specimen ID. Embed tissue in paraffin includes: Review applicable gross information (number of fragments, orientation, size) Take cassette out of embedding chamber, open cassette, put paraffin in bottom of embedding mold, embed tissue, put cassette on top of mold and fill mold with paraffin. Put mold on cold plate. Take

**Anatomic Pathology Services 88300 – 88309**  
**Specialty Society – Pathology**

embedded specimen out of mold, transfer to cutting cold plate. Add paraffin to embedding melting pot and clean embedding center.

Retrieve paraffin block from freezer and place on ice tray at microtome. Place paraffin block in microtome. Change and insert knife. Rough-cut block. Place block on ice. Retrieve block and section. Place section on water bath. Confirm specimen ID. Label microscopic slides with slide labeler and place section on microscopic slide from water bath. Put on drain tray. Put in staining basket and put staining basket in oven. Remove from oven, set clock for cool time, and put handle on basket.

Prepare automated stainer with solutions and load microscopic slides. Set and confirm stainer program.

Prepare automated coverslipper, remove slides from stainer and place on coverslipper. Complete workload recording logs. Collate slides and paperwork. Deliver to pathologist.

Clean grossing station; includes Load dirty cutting board, knives, forceps, etc. (instrument pack) in dishwasher, clean counter, clean sink, dispose of and package trash, restock, set up gross area for next day. Pack specimens for short term storage prior to disposal.

Post-Service Clinical Labor Activities: where applicable.

Thoroughly clean all of the equipment, tissue processor, and embedding and staining areas. Recycle the xylene and dispose of chemicals, specific specimens after designated period and the case is signed out. File the blocks, slides and requisitions.

	A	B	C	D	E	F	G	H	I
1	88300 - 88309 Direct Practice Expense Recommendation			88300	88302	88304	88305	88307	88309
	Meeting Date: January 2012 Specialty: Pathology, Dermatology, Urology, Gastroenterology TAB 24 - REVISED			Level I - Surgical pathology, gross examination only	Level II - Surgical pathology, gross and microscopic examination Appendix, incidental...	Level III - Surgical pathology, gross and microscopic examination ...	Level IV - Surgical pathology, gross and microscopic examination ...	Level V - Surgical pathology, gross and microscopic examination ...	Level VI - Surgical pathology, gross and microscopic examination ...
2		CMS	Staff						
3	LOCATION	Code	Type	Non Facility	Non Facility	Non Facility	Non Facility	Non Facility	Non Facility
4									
6									
7	GLOBAL PERIOD								
8	TOTAL CLINICAL LABOR TIME			13.00	23.50	29.50	29.50	111.00	139.00
9	TOTAL HISTOTECHNOLOGIST	L037B	Histotech	5.00	10.00	14.00	16.00	82.00	111.00
10	TOTAL LAB TECHNICIAN	L033A	Lab Tech	8.00	13.50	15.50	13.50	29.00	28.00
11	TOTAL PRE-SERV CLINICAL LABOR TIME			-	0.50	0.50	0.50	1.00	1.00
12	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			12.00	19.00	24.00	25.00	97.00	125.00
13	TOTAL POST-SERV CLINICAL LABOR TIME			1.00	4.00	5.00	4.00	13.00	13.00
14	PRE-SERVICE	Blocks 0 1 2 2 12 18							
15	Start: When containers/requisitions prepared for physician								
16	Order, fill, label, restock and distribute specimen containers .	L033A	Lab Tech	-	0.50	0.50	0.50	1.00	1.00
17	End:When specimen is ready for examination by pathologist								
18	SERVICE PERIOD								
19	Start: When specimen is ready for examination by pathologist								
20	Accession specimen in lab computer system including the following: Unwrap and/or remove specimen bottle and requisition slip from plastic bag. Check demographics to ensure they are correct and to ensure proper billing. Check requisition slip against bottle to see If patient name and/or specimen location (s) match each other. Distribute requisition form and specimen to grossing station.	L033A	Lab Tech	6	6	6	6	6	6
21	Prepare tissue cassettes	L037B	Histotech		1	1	1	2	3
22	Photograph gross specimen, download file into lab computer system (88307-9 only)	L037B	Histotech					5	5
23	Obtain and display applicable specimen radiographs.	L033A	Lab Tech					1	
24	Assist pathologist with gross specimen examination	L037B	Histotech	5	1	2	3	15	20
25	Clean grossing area between specimens	L033A	Lab Tech	1	1	1	1	2	2
26	Load solutions into tissue processor. Load and sort cassettes into tissue processor includes drain cassette basket, place basket in processor, put lid on basket, close lid, set processor. Confirm settings. Take requisitions to secretary.	L037B	Histotech		1	1	1	5	5
27	Confirm specimen ID. Embed tissue in paraffin includes: Review applicable gross information (number of fragments, orientation, size) Take cassette out of embedding chamber, open cassette, put paraffin in bottom of embedding mold, embed tissue, put cassette on top of mold and fill mold with paraffin. Put mold on cold plate. Take embedded specimen out of mold, transfer to cutting cold plate. Add paraffin to embedding melting pot and clean embedding center.	L037B	Histotech		2	2	3	15	20
28	Retrieve paraffin block from freezer and place on ice tray at microtome. Place paraffin block in microtome. Change and insert knife. Rough-cut block. Place block on ice. Retrieve block and section. Place section on water bath. Confirm specimen ID. Label microscopic slides with slide labeler and place section on microscopic slide from water bath. Put on drain tray. Put in staining basket and put staining basket in oven. Remove from oven, set clock for cool time, and put handle on basket.	L037B	Histotech		3	6	6	36	54
29	Prepare automated stainer with solutions and load microscopic slides. Set and confirm stainer program.	L037B	Histotech		1	1	1	2	2
30	Prepare automated coverslipper, remove slides from stainer and place on coverslipper	L037B	Histotech		1	1	1	2	2
31	Complete workload recording logs. Collate slides and paperwork. Deliver to pathologist.	L033A	Lab Tech		1	1	1	3	3
32	Clean grossing station includes; Load dirty cutting board, knives, forceps, etc. (instrument pack) in dishwasher, clean counter, clean sink, dispose of and package trash, restock, set up gross area for next day	L033A	Lab Tech		1	1	1	1	1
33	Pack specimens for short term storage prior to disposal	L033A	Lab Tech			1		2	2
34	Other Clinical Activity (please specify)								
35	End: When specimen examination by pathologist is complete								
36	POST SERVICE - PERIOD								
37	Start: When specimen examination by pathologist is complete								
38	Clean tissue processor, embedding and staining area	L033A	Lab Tech		1	1	1	5	5
39	Recycle xylene from tissue processor and stainer	L033A	Lab Tech		1	1	1	2	2
40	Dispose of remaining chemicals	L033A	Lab Tech		1	1	1	2	2
41	Discard remaining specimen after designated period following case sign out	L033A	Lab Tech	1		1		2	2
42	File blocks, slides, and requisitions	L033A	Lab Tech		1	1	1	2	2
43	End: When specimen, chemical waste and record handling is complete								

	A	B	C	D	E	F	G	H	I
1	<b>88300 - 88309 Direct Practice Expense Recommendation</b>			<b>88300</b>	<b>88302</b>	<b>88304</b>	<b>88305</b>	<b>88307</b>	<b>88309</b>
2	Meeting Date: January 2012 Specialty: Pathology, Dermatology, Urology, Gastroenterology TAB 24 - REVISED			Level I - Surgical pathology, gross examination only	Level II - Surgical pathology, gross and microscopic examination Appendix, incidental...	Level III - Surgical pathology, gross and microscopic examination ...	Level IV - Surgical pathology, gross and microscopic examination ...	Level V - Surgical pathology, gross and microscopic examination ...	Level VI - Surgical pathology, gross and microscopic examination ...
		<b>CMS</b>	<b>Staff</b>						
3	<b>LOCATION</b>	<b>Code</b>	<b>Type</b>	Non Facility	Non Facility	Non Facility	Non Facility	Non Facility	Non Facility
44	<b>MEDICAL SUPPLIES</b>		<b>Unit</b>						
45	gloves, non-sterile, nitrile	SB023	pair	1	2	2	2	2	2
46	gown, staff, impervious	SB027	item	0.1	0.1	0.1	0.1	0.1	0.1
47	mask, surgical	SB033	item	0.1	0.1	0.1	0.1	0.1	0.1
48	biopsy sponge (Histo-Prep)	SD005	item		-	-	2		
49	blade, microtome	SF004	item		0.10	0.20	0.20	1.20	1.80
50	scalpel with blade, surgical (#10-20)	SF033	item		1	1	1	2	3
51	eye shield, non-fog	SG049	item	0.1	0.1	0.1	0.1	0.1	0.1
52	bleach	SL020	ml	10	10	10	10	10	10
53	cover slip, glass	SL030	item		1	2	6	12	18
54	specimen container 86 oz	SL034	item	1				1	
55	specimen container 163 oz	see invoices 1a #1	item						1
56	cup, biopsy-specimen non-sterile 4oz	SL035	item		1	1	1		
57	embedding cassette	SL058	item		1	2	2	12	18
58	embedding mold	SL060	item		1	2	2	12	18
59	embedding paraffin	SL061	kg		0.008	0.016	0.005	0.096	0.144
60	eosin solution	SL063	ml		4.00	8	8	48	72
61	fixative (for tissue specimen)	SL068	ml		50	100	50	500	750
62	fixative processing (buffered formalin)	SL070	ml		14	28	28	170	252
63	histology freezing spray (Freeze-It)	SL078	oz		0.10	0.10	0.20	0.20	0.20
64	label for microscope slides	SL085	item		1	2	6	12	18
65	mold release agent, liquid	SL093	ml		0.10	0.20	0.20	1.20	1.80
66	mounting media (Histomount)	SL095	ml		1	1	2	4	6
67	slide, microscope	SL122	item		1	2	6	12	18
68	stain, hematoxylin	SL135	ml		16	32	32	192	288
69	xylenes solvent	SL151	ml		30	60	60	360	540
70	formaldehyde spill control	SM017	grams		5	10	5	15	15
71	wipes, lens cleaning (per wipe) (Kimwipe)	SM027	item		1	1	2	15	20
72									
		see invoices 2a/ cost calc/ specimen disp. Invoices							
73	specimen, solvent, and formalin disposal cost		dollars		0.18	0.35	0.35	1.85	1.85
74	marking dyes	see invoices 1a #4	ml				3	5	3
75	acetic acid 5%	SH001	ml			2	1	5	3
76	paraffin repel	see invoices 1a #5	ml		1	1	1	2	2
77									
78	clarifier	see invoices 1a #7	ml		2	4	4	24	36
79	Q-tips	see invoices 1a #8	item				3	3	1
80	towel, paper (Bounty) (per sheet)	SK082	item	2	2	2	2	8	10
81	gauze, non-sterile 4in x 4in	SG051	item		2	4	4	8	10
		see invoices 2a/ cost calc							
82	Courier transportation costs		dollars	2.02	2.02	2.02	2.02	2.02	2.02
83	100% alcohol	SL189	ml		30	60	60	360	540
84	95% alcohol	SL248	ml		18	36	36	216	324
85	70% alcohol	SL190	ml		4	8	8	48	72

	A	B	C	D	E	F	G	H	I
1	<b>88300 - 88309 Direct Practice Expense Recommendation</b>			<b>88300</b>	<b>88302</b>	<b>88304</b>	<b>88305</b>	<b>88307</b>	<b>88309</b>
2	Meeting Date: January 2012 Specialty: Pathology, Dermatology, Urology, Gastroenterology TAB 24 - REVISED			Level I - Surgical pathology, gross examination only	Level II - Surgical pathology, gross and microscopic examination Appendix, incidental...	Level III - Surgical pathology, gross and microscopic examination ...	Level IV - Surgical pathology, gross and microscopic examination ...	Level V - Surgical pathology, gross and microscopic examination ...	Level VI - Surgical pathology, gross and microscopic examination ...
		<b>CMS</b>	<b>Staff</b>						
3	<b>LOCATION</b>	<b>Code</b>	<b>Type</b>	Non Facility	Non Facility	Non Facility	Non Facility	Non Facility	Non Facility
86	<b>Equipment</b>								
87	balance, scale	EP005	minutes			1		2	3
88	grossing station w-heavy duty disposal	EP015	minutes	6	2	5	2	16	30
89	microscope, compound	EP024	minutes		5	10	20	24	60
90	paraffin dispenser (two-gallon)	EP032	minutes		1	2	2	12	18
91	slide coverslipper, robotic	EP033	minutes		1	2	6	12	18
92	tissue embedding center	EP039	minutes		1	2	2	12	18
93	water bath, general purpose (lab)	EP043	minutes		3	6	6	36	54
94	instrument pack, basic (\$500-\$1499)	EQ137	minutes		5	10	10	40	50
95	equipment maintance cost	see invoices 2a/ invoice #9	dollars		0.61	0.61	0.61	0.61	0.61
96	microtome	ER041	minutes		3	6	6	36	54
97	slide dryer	EP034	minutes		1	1	1	1	1
98	slide stainer, automated high-volume throughput	EP036	minutes		2	4	12	24	36
99	tissue processor	EP040	minutes		5	10	10	234	351
100	solvent recycling system	EP038	minutes		2	4	4	24	36
101	Freezer	see invoice #10	minutes		1	1	1	2	2
102	automated cassette labeler	see invoice #11	minutes		1	1	1	2	2
103	camera, digital system, 12 megapixel (medical grade)	ED005	minutes					5	5
104	hood, fume	EP017	minutes		1	1	1	2	2
105	Copath System with maintenance contract	see invoices #12- 14/LabInfoSys	minutes	3	3	5	4	10	12
106	Copath software	see invoices #12- 14/LabInfoSys	minutes	3	3	5	4	10	12
107	loupes, standard, up to 3.5x	EQ176	minutes				1		
108	slide labeler	see invoices 2a	minutes		1	1	1	5	5

# Multispecialty AP Block Study Results - Specialty Data Breakdown

## Totals

# LABS Reporting	Cases Reviewed
90	1,214

CPT CODE	# LABS Reporting	Cases Reviewed	Median from Study	CMS/RUC Assumptions – January 2012
88302	33	140	1	1
88304	83	370	3	2
88305	83	408	4	2
88307	35	161	13	12
88309	31	135	21	18

## CAP Data

CPT CODE	CASES REVIEWED	MEDIAN
88302	33	1
88304	34	3
88305	31	3
88307	33	11
88309	30	19
	161	

## APC Data

CPT CODE	CASES REVIEWED	MEDIAN
88302	102	1
88304	108	3
88305	103	5
88307	117	15
88309	103	22
	533	

## ACLA Data

CPT CODE	CASES REVIEWED	MEDIAN
88302	5	1
88304	6	1
88305	11	3
88307	11	14
88309	2	14
	35	

## AAD Data

CPT CODE	CASES REVIEWED	MEDIAN
88304	152	3
88305	178	4
	330	

## ASDP Data

	CASES REVIEWED	MEDIAN
88304	70	3
88305	85	4
	155	





January 4, 2013

Scott Collins, MD Chair  
Research Subcommittee  
RVS Update Committee  
American Medical Association  
515 North State Street  
Chicago, IL 60654

RE: Multispecialty Anatomic Pathology Block Study

Dear Doctor Collins;

As requested by CMS, the College of American Pathologists, and other stakeholders, conducted a national anatomic pathology study of the number of blocks typically produced for CPT codes 88302-88309 during the months of November and December 2012. The methodology and the results of this study are summarized below and were included in the CAP's comment letter to CMS regarding their Final Rule on the Payment Policies Under the Physician Fee Schedule, CMS – 1590-FC, November 16, 2012. In that rule, CMS asked for comment and data on the number of blocks assumed in the determination of practice expense recommendations for those codes. As part of that process, the RUC has been asked to review the number of blocks assumed in the evaluation of practice expense recommendations for those codes.

#### **Typical Number of Blocks Assumption for Anatomic Pathology Services**

CMS stated in its final ruling that the "number of blocks used has a significant impact on the quantity of other supplies and the number of clinical labor and equipment minutes assigned as direct PE inputs." ... CMS is concerned that the number of blocks assumed for each code may be inaccurate." CMS therefore requested public comment regarding "the appropriate number of blocks and urges the AMA RUC and interested medical specialty societies to provide corroborating, independent evidence that the number of blocks assumed in the current direct PE input recommendations is typical."

In response to CMS' request, the College of American Pathologists joined with the following stakeholders and medical specialties in a data collection effort:

1. American Academy of Dermatology (AAD)
2. American Clinical Laboratory Association (ACLA)
3. Association of Pathology Chairs (APC)
4. American Society of Dermatopathology (ASDP)

Over 1,000 laboratories of various sizes and locations were asked to review number of blocks typically used for the CPT codes 88302-88309 using RUC approved vignettes. AAD, ACLA, APC, and ASDP provided assistance in obtaining laboratory participants for the study. The patient age and gender did not need to be matched exactly, but the specimens had to be otherwise strictly comparable to those described in the vignette. CAP asked that participants review their service logs from the last month to provide data. Each case was examined for the number of blocks created. Each lab was asked to

# College of American Pathologists

provide the vignette specific data on a minimum of five cases.

## Clinical Vignettes:

Current Medicare ICD9 data were a major factor employed in developing the vignettes for each of the five services. The vignettes represent the typical specimen type associated with each of these codes. The vignettes for 88304 and 88305 were developed in conjunction with the dermatology specialty societies. Through the RUC process, the vignettes for this family of codes were reviewed and approved by the RUC's Research Subcommittee and the full RUC prior to surveying these services for physician work. The RUC and the specialties involved agreed that the vignettes were correct for valuing these services. In addition, when CAP surveyed the codes using the RUC approved survey instrument, over 90% of the respondents for each vignette indicated that the vignette was typical for the service. Below are the respondent percentages of those who indicated the chosen vignette was typical.

CPT Code	Percent indicating typicality of Vignette
88302	92%
88304	97%
88305	92%
88307	99%
88309	96%

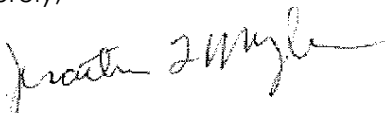
Subsequent to the RUC survey and the 2013 final rule, the CAP and other specialty societies collated data on the typical number of blocks associated with each of the previously approved vignettes. In addition to the CAP, other specialty societies involved included AAD, ACLA, APC, and ASDP. All of the individual lab data was sent to and compiled by CAP staff. The data was compiled for each CPT code and the following statistical data resulted.

CPT Code	Cases Reviewed	Median Number of Blocks
88302	128	1
88304	371	3
88305	411	4
88307	151	14
88309	120	21

This independent evidence confirms the conservative estimation by the CAP of the appropriate typical number of blocks associated with each of these services and which the RUC recommended, based on the data presented and on their own clinical knowledge. **Based on this additional independent evidence, it is the considered opinion of the CAP that the current (2013) CMS assumptions about the numbers of blocks for CPT codes 88302-88309, originally approved by the RUC, have now been thoroughly substantiated.**

At the January 2013 RUC meeting, CAP representatives look forward to discussing the methodology and results of this study with the AMA RUC and CMS representatives. If you have any questions before the meeting, please contact, Todd Klemp, Assistant Director of Economic and Regulatory Affairs at (847) 832-7403 or [tklemp@cap.org](mailto:tklemp@cap.org)

Sincerely,



# College of American Pathologists

Jonathan L. Myles, MD, FCAP  
RUC Advisor  
College of American Pathologists

cc: Edith Hambrick, MD, JD, CMS  
Sherry Smith, AMA  
Rosa Karbowiak, AMA  
Pam Johnson, CAP Staff  
Todd Klemp, CAP Staff  
Ayanna Wooding, CAP Staff

The AMA RUC submitted direct PE input recommendations for CPT code 86153 (Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood); physician interpretation and report, when required) that describes a laboratory physician interpretation code. As we discuss in section III.M.3.a. of this final rule with comment period, CPT code 86153 is a professional component-only CPT code that will be considered a “clinical laboratory interpretation service,” which is one of the current categories of PFS pathology services under the definition of physician pathology services at §415.130(b)(4). This code must be billed with the “26” modifier to be paid under the PFS. Therefore, CPT code 86153 -26 should be valued exclusively without direct practice expense inputs. Therefore, we are not accepting the recommended direct PE inputs for CPT code 86153.

(i) Pathology and Laboratory: Surgical Pathology (CPT Codes 88300, 88302, 88304, 88305, 88307, 88309)

For surgical pathology CPT codes 88300, 88302, 88304, 88305, 88307, 88309 (Surgical Pathology, Levels I through VI), the AMA RUC recommended creating several new supply and equipment items in direct PE input database that we will not incorporate for CY 2013 in addition to several new direct PE inputs that we are adopting on an interim basis. The new supply items that we will not incorporate were called “specimen, solvent, and formalin disposal cost,” and “courier transportation costs.” We do not believe that specimen and supply disposal or courier costs for transporting specimens are appropriately considered as disposable medical supplies. Instead, we believe the costs described by these recommendations are incorporated into the PE RVUs for these services through the indirect PE allocation. We note that the current direct PE inputs for these and similar services across the PFS do not include these kinds of costs as disposable supplies.

In addition to the recommendation to include these new supply items, the AMA RUC

recommended that we create new equipment items called “equipment maintenance cost,” “Copath System with maintenance contract,” and “Copath software” as direct PE inputs for these codes. Our standard equipment cost per minute calculation includes a maintenance factor to incorporate costs related to maintenance in amortizing the cost of the equipment itself. Therefore, we will not incorporate separate maintenance costs for particular items. Regarding the “Copath” system and software equipment, the AMA RUC forwarded materials from a manufacturer that included a description of a computer system that is used to interface with other data systems to provide inbound demographic information and export laboratory results and billing information. Based on the way those functionalities were presented in this information, we believe that this computer system and associated software reflects an indirect practice expense since the clerical and other administrative functionality seem central to its purpose. We note that no similar equipment is currently included as a direct PE input for these services. All direct PE inputs for these services are interim for CY 2013 and open to comment. We would consider additional information regarding whether this computer system and associated software might be considered a direct cost as medical equipment associated with furnishing the technical component of these surgical pathology services for CY 2014 rulemaking. We are especially interested in understanding the clinical functionality of the equipment in relation to the services being furnished.

In addition to this information, we are also seeking additional public comment regarding the appropriate assumptions regarding the direct PE inputs for these services. We note that the AMA RUC recommendations for these potentially misvalued codes were developed based on an underlying assumption regarding the typical number of blocks used each time a service is reported. The number of blocks assumed to be used has significant impact on the quantity of other supplies and the number of clinical labor and equipment minutes assigned as direct PE

inputs to each code. After conducting an initial clinical review of these direct PE inputs, we are concerned that the number of blocks assumed for each code may be inaccurate. For 88300, no blocks are assumed. For 88302, one block is assumed. For 88304 and 88305, the assumed number of blocks typically used is 2. For 88307, the assumed number of blocks is 12 and for 88309, the typical number of blocks is assumed to be 18. We are accepting the AMA RUC's recommended direct PE inputs that derive from these assumptions on an interim basis for CY 2013, but we are seeking independent evidence regarding the appropriate number of blocks to assume as typical for each of these services. We are requesting public comment regarding the appropriate number of blocks and urge the AMA RUC and interested medical specialty societies to provide corroborating, independent evidence that the number of blocks assumed in the current direct PE input recommendations is typical prior to finalizing the direct PE inputs for these services.

(j) Pathology and Laboratory: Cytopathology (CPT Codes 88120 and 88121)

The CPT Editorial Panel created CPT codes 88120 (Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual) and 88121 (Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology) to describe in situ hybridization testing using urine samples, effective for CY 2011.

As we explain in section III.M.3.a. of this final rule with comment period, we believe that the work and direct PE inputs for existing CPT codes 88365, 88367, and 88368 should be reviewed alongside CPT codes 88120 and 88121 to ensure the appropriate relativity between these two sets of services (76 FR 73153 through 73154). The AMA RUC has stated that it intends to do so after CY 2012 utilization data are available to assess how these services are

	A	B	C	D	E	F	G	H	I
1	<b>88300 - 88309 Direct Practice Expense Recommendation</b>			<b>88300</b>	<b>88302</b>	<b>88304</b>	<b>88305</b>	<b>88307</b>	<b>88309</b>
2	Meeting Date: January 2012 Specialty: Pathology, Dermatology, Urology, Gastroenterology <b>TAB 24 - REVISED</b>			Level I - Surgical pathology, gross examination only	Level II - Surgical pathology, gross and microscopic examination Appendix, incidental...	Level III - Surgical pathology, gross and microscopic examination ...	Level IV - Surgical pathology, gross and microscopic examination ...	Level V - Surgical pathology, gross and microscopic examination ...	Level VI - Surgical pathology, gross and microscopic examination ...
		<b>CMS</b>	<b>Staff</b>						
3	<b>LOCATION</b>	<b>Code</b>	<b>Type</b>	Non Facility	Non Facility	Non Facility	Non Facility	Non Facility	Non Facility
4									
6									
7	<b>GLOBAL PERIOD</b>								
8	<b>TOTAL CLINICAL LABOR TIME</b>			<b>13.00</b>	<b>23.50</b>	<b>29.50</b>	<b>29.50</b>	<b>111.00</b>	<b>139.00</b>
9	<b>TOTAL HISTOTECHNOLOGIST</b>	L037B	Histotech	<b>5.00</b>	<b>10.00</b>	<b>14.00</b>	<b>16.00</b>	<b>82.00</b>	<b>111.00</b>
10	<b>TOTAL LAB TECHNICIAN</b>	L033A	Lab Tech	<b>8.00</b>	<b>13.50</b>	<b>15.50</b>	<b>13.50</b>	<b>29.00</b>	<b>28.00</b>
11	<b>TOTAL PRE-SERV CLINICAL LABOR TIME</b>			<b>-</b>	<b>0.50</b>	<b>0.50</b>	<b>0.50</b>	<b>1.00</b>	<b>1.00</b>
12	<b>TOTAL SERVICE PERIOD CLINICAL LABOR TIME</b>			<b>12.00</b>	<b>19.00</b>	<b>24.00</b>	<b>25.00</b>	<b>97.00</b>	<b>125.00</b>
13	<b>TOTAL POST-SERV CLINICAL LABOR TIME</b>			<b>1.00</b>	<b>4.00</b>	<b>5.00</b>	<b>4.00</b>	<b>13.00</b>	<b>13.00</b>
14	<b>PRE-SERVICE</b>	Blocks 0 1 2 2 12 18							
15	<b>Start: When containers/requisitions prepared for physician</b>								
16	Order, fill, label, restock and distribute specimen containers .	L033A	Lab Tech	-	0.50	0.50	0.50	1.00	1.00
17	<b>End:When specimen is ready for examination by pathologist</b>								
18	<b>SERVICE PERIOD</b>								
19	<b>Start: When specimen is ready for examination by pathologist</b>								
20	Accession specimen in lab computer system including the following: Unwrap and/or remove specimen bottle and requisition slip from plastic bag. Check demographics to ensure they are correct and to ensure proper billing. Check requisition slip against bottle to see if patient name and/or specimen location (s) match each other. Distribute requisition form and specimen to grossing station.	L033A	Lab Tech	6	6	6	6	6	6
21	Prepare tissue cassettes	L037B	Histotech		1	1	1	2	3
22	Photograph gross specimen, download file into lab computer system (88307-9 only)	L037B	Histotech					5	5
23	Obtain and display applicable specimen radiographs.	L033A	Lab Tech					1	
24	Assist pathologist with gross specimen examination	L037B	Histotech	5	1	2	3	15	20
25	Clean grossing area between specimens	L033A	Lab Tech	1	1	1	1	2	2
26	Load solutions into tissue processor. Load and sort cassettes into tissue processor includes drain cassette basket, place basket in processor, put lid on basket, close lid, set processor. Confirm settings. Take requisitions to secretary.	L037B	Histotech		1	1	1	5	5
27	Confirm specimen ID. Embed tissue in paraffin includes: Review applicable gross information (number of fragments, orientation, size) Take cassette out of embedding chamber, open cassette, put paraffin in bottom of embedding mold, embed tissue, put cassette on top of mold and fill mold with paraffin. Put mold on cold plate. Take embedded specimen out of mold, transfer to cutting cold plate. Add paraffin to embedding melting pot and clean embedding center.	L037B	Histotech		2	2	3	15	20
28	Retrieve paraffin block from freezer and place on ice tray at microtome. Place paraffin block in microtome. Change and insert knife. Rough-cut block. Place block on ice. Retrieve block and section. Place section on water bath. Confirm specimen ID. Label microscopic slides with slide labeler and place section on microscopic slide from water bath. Put on drain tray. Put in staining basket and put staining basket in oven. Remove from oven, set clock for cool time, and put handle on basket.	L037B	Histotech		3	6	6	36	54
29	Prepare automated stainer with solutions and load microscopic slides. Set and confirm stainer program.	L037B	Histotech		1	1	1	2	2
30	Prepare automated coverslipper, remove slides from stainer and place on coverslipper	L037B	Histotech		1	1	1	2	2
31	Complete workload recording logs. Collate slides and paperwork. Deliver to pathologist.	L033A	Lab Tech		1	1	1	3	3
32	Clean grossing station includes; Load dirty cutting board, knives, forceps, etc. (instrument pack) in dishwasher, clean counter, clean sink, dispose of and package trash, restock, set up gross area for next day	L033A	Lab Tech		1	1	1	1	1
33	Pack specimens for short term storage prior to disposal	L033A	Lab Tech			1		2	2
34	Other Clinical Activity (please specify)								
35	<b>End: When specimen examination by pathologist is complete</b>								
36	<b>POST SERVICE - PERIOD</b>								
37	<b>Start: When specimen examination by pathologist is complete</b>								
38	Clean tissue processor, embedding and staining area	L033A	Lab Tech		1	1	1	5	5
39	Recycle xylene from tissue processor and stainer	L033A	Lab Tech		1	1	1	2	2
40	Dispose of remaining chemicals	L033A	Lab Tech		1	1	1	2	2
41	Discard remaining specimen after designated period following case sign out	L033A	Lab Tech	1		1		2	2
42	File blocks, slides, and requisitions	L033A	Lab Tech		1	1	1	2	2
43	<b>End: When specimen, chemical waste and record handling is complete</b>								

	A	B	C	D	E	F	G	H	I
1	<b>88300 - 88309 Direct Practice Expense Recommendation</b>			<b>88300</b>	<b>88302</b>	<b>88304</b>	<b>88305</b>	<b>88307</b>	<b>88309</b>
2	<b>Meeting Date: January 2012</b> <b>Specialty: Pathology, Dermatology, Urology, Gastroenterology</b> <b>TAB 24 - REVISED</b>			Level I - Surgical pathology, gross examination only	Level II - Surgical pathology, gross and microscopic examination Appendix, incidental...	Level III - Surgical pathology, gross and microscopic examination ...	Level IV - Surgical pathology, gross and microscopic examination ...	Level V - Surgical pathology, gross and microscopic examination ...	Level VI - Surgical pathology, gross and microscopic examination ...
		<b>CMS</b>	<b>Staff</b>						
3	<b>LOCATION</b>	<b>Code</b>	<b>Type</b>	Non Facility	Non Facility	Non Facility	Non Facility	Non Facility	Non Facility
44	<b>MEDICAL SUPPLIES</b>		<b>Unit</b>						
45	gloves, non-sterile, nitrile	SB023	pair	1	2	2	2	2	2
46	gown, staff, impervious	SB027	item	0.1	0.1	0.1	0.1	0.1	0.1
47	mask, surgical	SB033	item	0.1	0.1	0.1	0.1	0.1	0.1
48	biopsy sponge (Histo-Prep)	SD005	item		-	-	2		
49	blade, microtome	SF004	item		0.10	0.20	0.20	1.20	1.80
50	scalpel with blade, surgical (#10-20)	SF033	item		1	1	1	2	3
51	eye shield, non-fog	SG049	item	0.1	0.1	0.1	0.1	0.1	0.1
52	bleach	SL020	ml	10	10	10	10	10	10
53	cover slip, glass	SL030	item		1	2	6	12	18
54	specimen container 86 oz	SL034	item	1				1	
55	specimen container 163 oz	see invoices 1a #1	item						1
56	cup, biopsy-specimen non-sterile 4oz	SL035	item		1	1	1		
57	embedding cassette	SL058	item		1	2	2	12	18
58	embedding mold	SL060	item		1	2	2	12	18
59	embedding paraffin	SL061	kg		0.008	0.016	0.005	0.096	0.144
60	eosin solution	SL063	ml		4.00	8	8	48	72
61	fixative (for tissue specimen)	SL068	ml		50	100	50	500	750
62	fixative processing (buffered formalin)	SL070	ml		14	28	28	170	252
63	histology freezing spray (Freeze-It)	SL078	oz		0.10	0.10	0.20	0.20	0.20
64	label for microscope slides	SL085	item		1	2	6	12	18
65	mold release agent, liquid	SL093	ml		0.10	0.20	0.20	1.20	1.80
66	mounting media (Histomount)	SL095	ml		1	1	2	4	6
67	slide, microscope	SL122	item		1	2	6	12	18
68	stain, hematoxylin	SL135	ml		16	32	32	192	288
69	xylene solvent	SL151	ml		30	60	60	360	540
70	formaldehyde spill control	SM017	grams		5	10	5	15	15
71	wipes, lens cleaning (per wipe) (Kimwipe)	SM027	item		1	1	2	15	20
72									
73	specimen, solvent, and formalin disposal cost	see invoices 2a/ cost calc/ specimen disp. Invoices	dollars		0.18	0.35	0.35	1.85	1.85
74	marking dyes	see invoices 1a #4	ml				3	5	3
75	acetic acid 5%	SH001	ml			2	1	5	3
76	paraffin repel	see invoices 1a #5	ml		1	1	1	2	2
77									
78	clarifier	see invoices 1a #7	ml		2	4	4	24	36
79	Q-tips	see invoices 1a #8	item				3	3	1
80	towel, paper (Bounty) (per sheet)	SK082	item	2	2	2	2	8	10
81	gauze, non-sterile 4in x 4in	SG051	item		2	4	4	8	10
82	Courier transportation costs	see invoices 2a/ cost calc	dollars	2.02	2.02	2.02	2.02	2.02	2.02
83	100% alcohol	SL189	ml		30	60	60	360	540
84	95% alcohol	SL248	ml		18	36	36	216	324
85	70% alcohol	SL190	ml		4	8	8	48	72
86	<b>Equipment</b>								
87	balance, scale	EP005	minutes			1		2	3
88	grossing station w-heavy duty disposal	EP015	minutes	6	2	5	2	16	30
89	microscope, compound	EP024	minutes		5	10	20	24	60
90	paraffin dispenser (two-gallon)	EP032	minutes		1	2	2	12	18
91	slide coverslipper, robotic	EP033	minutes		1	2	6	12	18
92	tissue embedding center	EP039	minutes		1	2	2	12	18
93	water bath, general purpose (lab)	EP043	minutes		3	6	6	36	54
94	instrument pack, basic (\$500-\$1499)	EQ137	minutes		5	10	10	40	50
95	equipment maintance cost	see invoices 2a/ invoice #9	dollars		0.61	0.61	0.61	0.61	0.61
96	microtome	ER041	minutes		3	6	6	36	54
97	slide dryer	EP034	minutes		1	1	1	1	1
98	slide stainer, automated high-volume throughput	EP036	minutes		2	4	12	24	36
99	tissue processor	EP040	minutes		5	10	10	234	351
100	solvent recycling system	EP038	minutes		2	4	4	24	36
101	Freezer	see invoice #10	minutes		1	1	1	2	2
102	automated cassette labeler	see invoice #11	minutes		1	1	1	2	2
103	camera, digital system, 12 megapixel (medical grade)	ED005	minutes					5	5
104	hood, fume	EP017	minutes		1	1	1	2	2
105	Copath System with maintenance contract	see invoices #12- 14/LabInfoSys	minutes	3	3	5	4	10	12
106	Copath software	see invoices #12- 14/LabInfoSys	minutes	3	3	5	4	10	12
107	loupes, standard, up to 3.5x	EQ176	minutes				1		
108	slide labeler	see invoices 2a	minutes		1	1	1	5	5



November 30, 2012

Dear Valued Member:

The American Academy of Dermatology (AAD) and the College of American Pathologists (CAP) is in immediate need of your assistance to gather important advocacy data. CAP is conducting a study to determine the number of paraffin blocks typically produced for six specified anatomic pathology vignettes associated with CPT codes 88304-88305.

We ask that you review your service logs from the last month to complete this study on the attached Excel worksheet. Each service has designated a common or typical vignette as a reference. Please review your logs and identify the most recent 5 cases from your service logs that fit these vignettes. The patient's age and gender need not be matched exactly and data on more than 5 cases is encouraged. Smaller laboratories in which less than 5 cases can be identified are also encouraged to submit data.

Please complete the attached spreadsheet and email your responses by December 12<sup>th</sup> to:

Todd Klemp  
Assistant Director of Economic and Regulatory Affairs  
College of American Pathologists  
[tklemp@cap.org](mailto:tklemp@cap.org)

If you have questions please contact Todd at 847-832-7403

December 5, 2012

Dear Valued Member:

The College of American Pathologists (CAP) is in immediate need of your assistance to gather important advocacy data. The CAP is conducting a study to determine the number of paraffin blocks typically produced for six specified anatomic pathology vignettes associated with CPT codes 88302-88309.

We ask that you review your service logs from the last month to complete this study on the attached Excel worksheet. Each service has designated a common or typical vignette as a reference. Please review your logs and identify the most recent 5 cases from your service logs that fit these vignettes. The patient's age and gender need not be matched exactly and data on more than 5 cases is encouraged. Smaller laboratories in which less than 5 cases can be identified are also encouraged to submit data.

Please complete the attached spreadsheet and email your responses by December 12<sup>th</sup> to:

Todd Klemp  
Assistant Director of Economic and Regulatory Affairs  
College of American Pathologists  
[tklemp@cap.org](mailto:tklemp@cap.org)

If you have questions please contact Todd at 847-832-7403

CAP is conducting a study of the number of blocks typically used for the following service vignettes. The patient age and gender need not be matched exactly, but the specimens must be strictly comparable to those described in terms of their processing. We ask that you review your service logs from the last month and complete the table below, providing data from the most recent 5 cases per CPT code. Smaller laboratories in which less than 5 cases can be identified are also encouraged to submit data.

Your participation is important. Please complete this project and return your results to Todd Klemp at [Tklempe@cap.org](mailto:Tklempe@cap.org) by December 12th.

Thank you; if you have questions, please contact Todd at 847-832-7403.

CPT Code	Vignettes	Number of blocks for case #1	Number of blocks for case #2	Number of blocks for case #3	Number of blocks for case #4	Number of blocks for case #5
88302	Ventral hernia specimen from a 48 year old female.					
88304	5 cm subcutaneous lipoma excised from the thigh of a 50 year old male.					
88305	Excision of a 1 cm pigmented skin lesion with irregular borders from the back of a 35 year old female.					
88307	5 cm breast lumpectomy specimen following needle localization of microcalcifications and requiring assessment of margins removed from a 55 year old female.					
88309	A 67-year-old male presents with rectal bleeding. He undergoes low anterior resection of an adenocarcinoma of the rectum. The pathologist performs the gross and microscopic examination of the specimen and issues a written report of the results.					

Members: Scott Collins, MD (Chair), M. Douglas Leahy, MD (Vice Chair), Charles Koopmann, Jr, MD, James Georgoulakis, PhD, JD, David Hitzeman, DO, Walt Larimore, MD, Brenda Lewis, DO, Marc Raphaelson, MD, Christopher Senkowski, MD, George Williams, MD, Sandra Reed, MD, Lawrence Martinelli, MD

**I. Research Subcommittee October 24, 2012 Conference Call Meeting Report**

**The Research Subcommittee report from the October 24, 2012 Conference Call is included in Tab 33 of the January 2013 agenda materials for approval by the RUC.**

**II. Research Subcommittee November 5, 2012 Conference Call Meeting Report**

**The Research Subcommittee report from the November 5, 2012 Conference Call is included in Tab 33 of the January 2013 agenda materials for approval by the RUC.**

**III. Review of Vignettes**

**Cholecystectomy (47600 & 47605)**

*American College of Surgeons*

CPT Codes 47600 *Cholecystectomy* and 47605 *Cholecystectomy; with cholangiography* were identified as part of the CMS Request - NPRM for 2012 screen and surveyed in April 2012.

In the Final Rule for 2013, CMS noted that the AMA RUC agreed that the typical patient undergoing an open cholecystectomy begins with a laparoscopic approach and is then converted to an open procedure for clinical reasons. CMS expressed concern that the vignettes associated with these procedures imply that the work of the failed laparoscopic approach is included in the work of the cholecystectomy. CMS requested that the AMA RUC review the vignettes for these services.

The Research Subcommittee noted that these vignettes along with medical literature were thoroughly reviewed and discussed in November 2011. The Subcommittee continues to acknowledge that nearly all patients are scheduled for a laparoscopic approach and the majority of open procedures would appropriately include the work of the failed laparoscopic approach. It is rare that a cholecystectomy is scheduled as an open procedure. The ACS presented data that this occurs for less than 10% of all cases.

Dr. Hambrick noted that the Agency was concerned that they would be seeing more vignettes for open procedures that are laparoscopic to open conversions. The Subcommittee agreed with the general surgeons that laparoscopic to open conversion is typical for open gallbladder removal cases, but not typical for any other open general surgery procedures. There is no anticipation that the RUC (or CMS) will be seeing other open general procedures with vignettes that are laparoscopic to open conversion. The RUC is aware of CMS' concern and will be diligent in monitoring vignettes.

**The Research Subcommittee recommends the vignettes for CPT codes 47600 and 47605 as submitted to accurately describe the typical patient.**

**IV. Review of Alternative Methodology**

**Pathology Consultations (88300-88307)**

*College of American Pathologists*

Approved by the RUC-Saturday, January 26, 2013

CPT codes 88300-88309 were surveyed for physician work at the April 2010 RUC meeting. These codes were then identified as part of the July 19<sup>th</sup> 2012 NPRM Screen and surveyed only for direct practice expense at the January 2012 RUC meeting. The RUC submitted the following recommendations for typical number of blocks assumed for anatomic pathology services:

CPT Code 88300: 0  
CPT Code 88302: 1  
CPT Code 88304: 2  
CPT Code 88305: 2  
CPT Code 88307: 12  
CPT Code 88309: 18

In the Final Rule for 2013, CMS requested public comment regarding the appropriate number of blocks and urged the RUC and medical specialty societies to provide evidence that the number of blocks assumed is indeed typical. In response to this request, CAP along with AAD, ACLA, APC and ASDP contacted over 1,000 laboratories of various sizes and locations to confirm number of blocks typically used for CPT codes 88302-88309 using RUC approved vignettes during November and December 2012. The Research Subcommittee reviewed two survey instruments with cover memos: one for CPT codes 88304-88305 and a second for CPT codes 88302-88309. The Subcommittee noted that each laboratory was asked to review service logs from the previous month and provide data on a minimum of five cases, if available. **The Research Subcommittee recommends the methodology utilized to confirm number of blocks. The PE Subcommittee will review the survey data at the April 2013 RUC meeting.**

### **Ultrasound (76645, 76705, 76770, 76775 and 76856)**

#### *American College of Radiology*

American The College of Radiology (ACR) submitted a request to crosswalk Ultrasound codes which were identified on the RAW's screen of CMS/Other codes with Medicare utilization of 500,000 or more to recently RUC validated ultrasound codes. Specifically, the ACR proposed to crosswalk CPT codes: 76645 (*Ultrasound, breast(s) (unilateral or bilateral), real time with image documentation*), 76705 (*Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)*), 76770 (*Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; complete*), 76775 (*Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited*) and 76856 (*Ultrasound, pelvic (nonobstetric), real time with image documentation; complete*). The Subcommittee members agreed that a crosswalk may be inappropriate for these high volume codes which also include high intra service time. In addition, the current time of these codes is based on CMS/Other rather than RUC survey data; therefore, it would be difficult to validate time. **The Research Subcommittee recommends that the specialty society use the standard survey methodology and present survey data and direct practice expense inputs at the October 2013 RUC meeting, time certain.**

### **Breast Biopsy (191XX1-191XX6, 1929XX1-1929XX8)**

#### *American College of Radiology*

The Research Subcommittee reviewed and discussed a request submitted by ACR to use a targeted sample in addition to random survey sample. The ACR, American College of Surgeons and American Society of Breast Surgeons conducted a random RUC survey for the breast biopsy codes which were scheduled to be presented at the January 2013 RUC meeting. The specialty societies were delayed launching their surveys due to several CPT issues and also received an insufficient number of survey responses. The specialty societies intend to present the data collected at the April 2013 RUC meeting and

will also identify members who are familiar with this service and randomly send surveys to those physicians. **The Research Subcommittee recommends the use of the targeted survey sample in addition to the random sample and expects the specialty societies to present both the combined and separated data to the RUC at the April 2013 meeting.**

## V. Review of Reference Service List, Survey Instrument, Survey Sample

### Psychotherapy (90785, 90839 & 90840)

#### *American Psychiatric Association*

The Research Subcommittee reviewed and discussed a request from several specialty societies involved in surveying three psychotherapy codes, +90785 *Interactive complexity (List separately in addition to the code for primary procedure)*, 90839 *Psychotherapy for crisis; first 60 minutes* and +90840 *Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)* to modify the survey tools as follows:

- Add “Physician/Healthcare Professional” throughout to be consistent with CPT language
- Allow survey respondents to identify their specialty society. Results will be sorted by specialty
- Defining “organization” in the financial disclosure section and noting that if the survey respondent affirmatively answers any of the questions, they do not have to complete the survey. The Subcommittee recommended that the specialty societies do not allow the survey respondent to continue if they check “yes” to any of the questions.
- Eliminating language regarding hospital and E/R work
- Eliminating moderate sedation section
- Include CPT approved introductory language/guidelines
- Modify Q2 on ZZZ survey instrument regarding time to include definitions for pre, intra and post

**The Research Subcommittee recommends modifications to the survey instruments which are consistent with the previously approved and utilized psychotherapy surveys.**

The Research Subcommittee reviewed and discussed the reference service list for each of the three codes. The Subcommittee members determined that CPT code 92618 *Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)* should be removed from the RSL for CPT code 90840. In addition, CPT code 99244 *Office consultation for a new or established patient* should be removed from the RSL for CPT code 90839. The Subcommittee suggested that the specialty societies consider combining the RSLs for CPT code 90839 and 90840. The Subcommittee reviewed the RSL for CPT code 90785 and agreed that the previously approved ZZZ RSL which was used to survey psychotherapy in April 2012 should be used for this code. **With these modifications, the Research Subcommittee recommends the reference service list as submitted by the specialty societies.**

The Research Subcommittee discussed the request for a convenience sample. The society would like to administer a survey at an upcoming state leadership meeting scheduled in March 2013. The society will also develop a random survey sample. **The Research Subcommittee recommends the use of a convenience sample under the condition that it is proctored.**

The Research Subcommittee discussed an alternative proposal to survey CPT code 90785. This add-on code describes interactive complexity added to certain psychiatric procedures. It does not include intra service time, but rather adds only intensity/complexity and pre and post service time. The Research Subcommittee considered the use of an expert panel; however, this alone would not satisfy RUC standards. The specialty societies may consider using an expert panel in conjunction with a RUC survey. **The Research Subcommittee recommends surveying psychotherapy with and without interactive**

**complexity and psychotherapy with an E/M with and without interactive complexity to determine the appropriate increment.**

## **VI. Request to Modify Survey Instrument**

### **Insertion of Anterior Segment Device (6618X1)**

#### **Aqueous Shunt (66180 and 66185)**

*American Academy of Ophthalmology*

The Research Subcommittee reviewed a request submitted by AAO to modify the survey instrument to require attestation from each survey respondent that the survey was completed independently of outside coaching. This request was driven after the specialty society detected a thread that encouraged survey respondents to provide higher valuations through the use of specific reference codes while monitoring listserv discussions. The specialty society immediately addressed the issue and collated two data sets. There was consensus that language should be added to ensure surveys are completed independently without external coaching; however, the Subcommittee determined that it would be more appropriate to add this language to the cover memo rather than modify the survey instrument. **The Research Subcommittee recommends development of language to be used by specialty societies in their survey cover memos. The Research Subcommittee will draft this language and share with specialty societies.**

## **VII. Review of Extant Databases**

The Research Subcommittee reviewed [www.radiologyinfo.org](http://www.radiologyinfo.org) as a potential source of extant data. There was consensus that this site does not meet the extant database criteria and should therefore not be used to support or validate physician work or time. The website is not a database, but rather a source for general background and practical information on various radiology procedures. **The Research Subcommittee does not recommend [www.radiologyinfo.org](http://www.radiologyinfo.org) as an extant database.**

At the October 2012 RUC meeting, the Research Subcommittee was charged with exploring the use and availability of extant databases among specialty societies and how databases that meet our criteria can be incorporated into future recommendations. The Research Subcommittee will solicit specialty societies to determine how many databases are currently available or in development that may or may not meet our criteria and plans to submit for approval. The Subcommittee reviewed the following questions for the survey to specialty societies:

- 1) **Does your specialty society currently have a database that meets these criteria?**  
Yes (see Q2)  
No  
No, but in development
- 2) **If yes, does your specialty society plan on submitting your database for use and approval to the RUC?**
- 3) **If yes to Q2, when do you expect to submit your request to use the database?**

The Subcommittee recommended two additional questions:

- If your specialty society currently has a database, but it does not meet the above defined criteria, please specify which standards are not met and why.

- Are there databases available that have not been developed by the specialty society? If yes, please list below and provide specific details, if appropriate.

**With these modifications, the Research Subcommittee recommends the survey to be approved and disseminated to specialty societies. After completing the solicitation, the Subcommittee will reassess other potential sources of extant data.**

#### **VIII. Practice Expense Subcommittee Items**

At the October 2012 RUC meeting, the Practice Expense Subcommittee referred a request to Research to approve a formal process based on RUC standards to require compelling evidence for increases to practice expense. Compelling evidence will be required if a specialty society is requesting an increase over the standard or current PE inputs. The specialty society must present compelling evidence to the PE Subcommittee that the standard or current PE input is not appropriate for the codes in question in writing on the Practice Expense Summary of Recommendation form. The Research Subcommittee reviewed compelling evidence criteria and recommends the following modifications for practice expense purposes:

Delete:

Comparison to similar services. For example, a similar service consistently has higher times for clinical staff than the PE standards.

Add:

“Evidence that there has been a change in equipment or practice expense cost”

“Evidence that there has been a change in clinical staff type”

“Evidence that previous practice expense inputs were based on one specialty, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data”

**With these modifications, the Research Subcommittee recommends the compelling evidence criteria for practice expense inputs.**

The Practice Expense Subcommittee also referred a request to develop a mechanism for societies to provide representative schedules from one or more practices or institutions as supplemental validation of the reported staff and equipment times. The Research Subcommittee expressed concern that scheduling logs can be problematic in that they may not always reflect time, but rather could be representative of demand. **The Research Subcommittee recommends that if specialty societies are interested in using scheduling logs to support recommendations, they must seek and obtain approval from the Research Subcommittee. If the Practice Expense Subcommittee is requesting scheduling logs, the society does not need approval from the Research Subcommittee.**

#### **IX. Other Business**

The Research Subcommittee discussed strategies to streamline and improve RSL development. The demand for Research Subcommittee review and approval of RSLs has increased over the years. The Subcommittee has noted several problems with the current process including lack of comparable codes the specialties can select, especially when an entire family is under review; limited number of high and low valued codes; minimal use of Multi-Specialty Points of Comparison (MPC) codes; etc. **The Research Subcommittee recommends the creation of a workgroup to address standardization of Reference Service Lists.**